WELCOME TO THE FOURTEENTH NATIONAL SYMPOSIUM ON CHILD SEXUAL ABUSE!

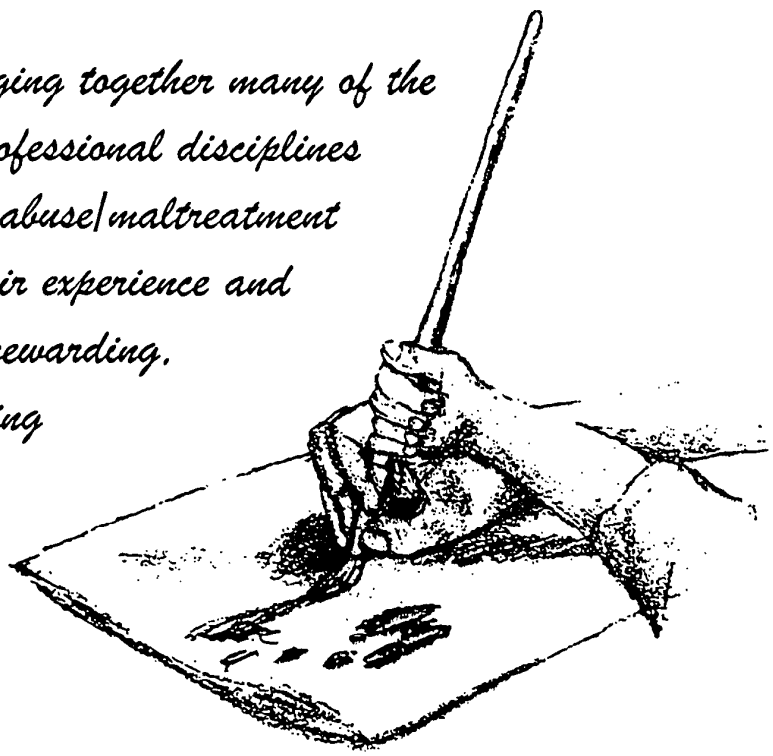
This volume contains resource material for the workshops being presented. Additional materials will be handed out in some of the workshops not represented in the index.

The agenda, program notes, and other workshop information can be found in the program booklet which is included in your materials package.

Evaluation forms for the workshops and an overall symposium evaluation are in the front pocket of your notebook.

Continuing education forms may be picked up and processed in the Exhibit Hall at the CEU Tables. Personnel will be there to assist you Wednesday and Thursday 8:00 a.m. to 6:00 p.m. and Friday 8:00 a.m. to 4:00 p.m.

We are excited about bringing together many of the foremost leaders in the professional disciplines dealing with child sexual abuse/maltreatment and hope that sharing their experience and expertise will result in a rewarding, educational, and networking experience for you.



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the National Children's Advocacy Center

Providing Multidisciplinary Prevention, Intervention, Training and Technical Assistance for Child Sexual and Physical Abuse

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ncac@HiWAAY.net

Charles Wilson, M.S.S.W.
Executive Director

Programs

[redacted]by Families North Alabama

◆

Mother Advocates

◆

Multidisciplinary Team

◆

Professional Education & Training Services

◆

SCAN (Stop Child Abuse and Neglect)

◆

Southern Regional Children's Advocacy Center

Charter member of the National Network of Children's Advocacy Centers

Member organization of the United Way of Madison County

The National Children's Advocacy Center (NCAC) is a leader in the field of child sexual abuse. The Huntsville program began in 1985, under the leadership of U.S. Congressman Robert (Bud) Cramer, Jr., then Madison County district attorney. It has become a national model for the multidisciplinary team approach.

The Center is located in a house that provides a warm, non-threatening environment where professionals responding to child abuse cases meet with their young clients and where the multidisciplinary team meets to track the case through the system and to see that all young victims receive the care and treatment they deserve.

The NCAC offers young victims and their families comprehensive treatment services, including both individual and group therapy for the child victim of any age, and treatment services for non-offending parents and adult survivors. Juvenile offenders are provided treatment at a separate location.

The National Symposium on Child Sexual Abuse, the largest gathering of multidisciplinary professionals in the country that addresses exclusively the subject of child sexual abuse, is presented annually by the NCAC. Tours of the NCAC are a part of each symposium.

Technical assistance is available from the NCAC and is tailored to meet the needs of the requesting community. A videotape, *Sanctuary*, an award winning film that describes the motivation for developing the Children's Advocacy Center, is available for purchase or rental. Visitors from throughout the United States and other countries come to Huntsville to see the NCAC and learn from its staff.

The NCAC is also a leading training resource for professionals working with abused children and their families. The training department produces customized trainings for a negotiated fee and produces satellite video conferences in a cost-share partnership with local sites across the nation. Video tapes of these conferences are available for purchase. For training information call (205) 534-1328.

The staff of the National Children's Advocacy Center is known world-wide for their knowledge, expertise and willingness to share that knowledge. If you would like to know more about the National Children's Advocacy Center, write them at 106 Lincoln Street, Huntsville, Alabama 35801, or call 205-\533-5437.

Action Plan

If you hear any good ideas or ways of performing a task a better way, this is the spot for you to write them down. It has been found that if new ideas aren't used within 24 hours, they are generally forgotten. When you get back to work, put this sheet in a prominent place and make sure that you try all of the things that you made note of!

1. _____
2. _____
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About Our Trainers . . .

Gene G. Abel, MD, is the Director of the Behavioral Medicine Institute of Atlanta, Inc. He is internationally regarded as a distinguished psychiatrist and researcher in the field of sexual misconduct and sexual aggression. Dr. Abel has authorized over 100 scientific publications, lectured extensively throughout the U.S. and abroad, directed six National Institute of Mental Health research projects, and received numerous awards and honors for his notable professional accomplishments. Development the *Abel Assessment for Sexual Interest* is among the many contributions he has made to aid in prevention of sexual victimization.

Veronica D. Abney, PhD, LCSW, is a licensed clinical social worker and diplomate in clinical social work in private practice in Santa Monica specializing in the treatment of child, adolescent and adult survivors of childhood sexual trauma and is also on the clinical faculty at UCLA's Neuropsychiatric Hospital. She is currently doing doctoral research on African American psychoanalysts. Dr. Abney is Secretary of the American Professional Society on the Abuse of Children and a board member of the California Professional Society on the Abuse of Children. She is an Associate Editor of *Child Maltreatment* and *The APSAC Advisor.*

Steven K. Aldridge, JD, is the Assistant District Attorney of Madison County, Alabama. He specializes in the prosecution of child sexual abuse and sexual assault cases. Mr. Aldridge is a graduate of Cumberland School of Law, where he was associate editor of the *Cumberland Law Review.* He formerly served as an attorney with the U.S. Army Missile Command, coordinating the investigation and prosecution of all government contract and procurement fraud cases. He has been in private practice and served as city prosecutor to both Muscle Shoals and Leighton, Alabama, and as a municipal judge in Cherokee, Alabama.

Randell Alexander, MD, PhD, serves on faculty at The University of Iowa College of medicine, having both inpatient and outpatient responsibilities, and is actively involved in research on child abuse.. He has served as Vice-Chair, U.S. Advisory Board on Child Abuse and Neglect and as an officer in many organizations dealing with child abuse issues. Dr. Alexander has lectured frequently and published extensively in the area of child abuse.

Kenneth Anderson, MS, is a professional counselor who has worked in the field of mental health for 17 years as an individual and family therapist. He occasionally works as an instructor teaching psychology courses at Oakwood College, Alabama A&M University, and Calhoun Community College. Currently, he is the sole proprietor of Maximum Life Enhancement, an educational consulting business promoting lectures, interactive workshops and professional seminars on interpersonal relationships, student success, cultural inclusion, mentoring, African American issues and conflict resolution. He is also the founder of the *Conference on the African American Family*, an annual national conference addressing the issues of the African American community, held each October in Huntsville, Alabama.

Lucy Berliner, MSW, is a nationally recognized researcher in the field of child sexual abuse. Her background in the field of sexual victimization began in 1970, and continues until the present. She has worked at Harborview Medical Center, Seattle, in the Sexual Assault Center since 1973. Ms. Berliner sits on the Advisory or Executive Board for many national organizations which assist child sexual abuse victims, but is, perhaps, best known for her publications and films on child sexual abuse treatment issues.

Bobby R. Berryhill has been the Madison County Coroner for the past 7 years, the assistant Coroner for 20 years, and a contract employee for the Department of Forensic Sciences for 2 years. He has also been employed with Spry Funeral Home for 31 years. Mr. Berryhill attended Athens State College and is a graduate of Jefferson State Mortuary College. He is a native of Colbert County, Alabama and has lived in Huntsville, Alabama since 1966.

Shay Bilchik is the Administrator of the Office of Juvenile Justice and Delinquency Prevention. Prior to that, he served as Associate Deputy Attorney General. Mr. Bilchik's career began in Florida where he worked 17 years as a prosecutor. He served as a Chief Assistant State Attorney and as the coordinator of many special programs, including all juvenile operations as the Police-Juvenile Prosecutor Liaison and the School-Juvenile Prosecutor Liaison.

Jeff Brickman, JD, is a Senior Assistant District Attorney for DeKalb County, Georgia. He received his law degree from the University of Florida and his Masters in Litigation from Emory Law School. He has served as head of the Crimes Against Children Unit, and he has tried many cases in which children were victims. He is a member of the Board of Directors for the Georgia Center for Children and serves as a lecturer for the Georgia Council on Child Abuse. He is also a lecturer for the National College of District Attorneys where he speaks on closing arguments in child abuse cases.

Pamela Brown, MEd, LPC, is Program Director for the Georgia Council on Child Abuse. She has developed and implemented personal safety education materials and has 17 years experience in direct service delivery to at-risk families and children, staff training and supervision, and program planning and management.

Connie R. Carnes, MS, LPC, is the Clinical Director for The National Children's Advocacy Center, Huntsville, Alabama. Ms. Carnes provides therapy and forensic evaluation for abused children, directs the Intervention Services Program of the NCAC and serves as clinical liaison to the Madison County Multidisciplinary Team. She has developed a Forensic Evaluation Protocol for use in the extended evaluation of children alleged to have been sexually abused and has developed a research project based upon this protocol which will examine when and how children disclose in a clinical setting. She has a Master's Degree in Psychology from Lamar University in Beaumont, Texas and is a Licensed Professional Counselor in the State of Alabama. She has 10 years of therapy experience and has focused her practice on children for the past five years.

Mary E. Case, MD, is a graduate of the University of Missouri, Columbia, Missouri and St. Louis University School of Medicine. She did her residency training in pathology at St. Louis University Health Sciences Center and is board certified in anatomical pathology, neuropathology and forensic pathology. Dr. Case is an Associate Professor of Pathology at St. Louis University. She serves as Chief Medical Examiner for St. Louis, St. Charles, Jefferson and Franklin Counties. Dr. Case's primary practice of medicine is forensic pathology. She has special interests in the areas of children's injuries and head trauma.

Mark Chaffin, PhD, is a Psychologist who is an Associate Professor of Pediatrics and Clinical Associate Professor of Psychiatry at the University of Oklahoma Health Sciences Center's Center on Child Abuse and Neglect. He has served on the Board of Directors of the American Professional Society on the Abuse of Children and currently serves as Editor-in-Chief of Child Maltreatment: The Journal of the American Professional Society on the Abuse of Children.

Nancy Chandler, ACSW, LCSW, is the Executive Director of the National Network of Children's Advocacy Centers. Ms. Chandler's responsibilities include overall leadership and management of the Network's finances, resource development, training, program development, communications, membership services, and supervision of staff. Prior to this appointment, Ms. Chandler served as the Executive Director of the Memphis Child Advocacy Center.

Sandra Conley is presently the HOPE Place Victim Advocate/First Responder. This program, in partnership with the Huntsville Police Department, provides immediate supportive services to victims of domestic violence when they call for law enforcement assistance. The adult and child victims of domestic violence are provided information on shelter, options to living without violence, education, and community resources. Ms. Conley is a former AmericaCorps VISTA member who served a one year term of service for the Alabama Coalition Against Domestic Violence at the domestic violence shelter HOPE Place, Inc. in Huntsville, AL.

Bud Cramer is a United States Congressman from Alabama's Fifth District. Prior to this election to Congress, this Huntsville native served as Madison County's District Attorney. During his ten years in that office, Mr. Cramer became known as a national advocate for children's rights. He was instrumental in establishing the Children's Advocacy Center in Huntsville, Alabama which has evolved into a national model, embracing the experience of many programs around the country.

Thomas F. Curran, JD, MSW, LSW, is an attorney in the Child Advocacy Unit of the Defender Association of Philadelphia, where he exclusively represents maltreated children. Mr. Curran is also a Clinical Assistant Professor of Psychiatric Mental Health Nursing at the University of Pennsylvania, the former Executive Director of the Philadelphia Children's Advocacy Center and a two-term member of APSAC's National Board of Directors.

Shannon M. Dammann, PsyD, is the current Program Specialist for the Survivor Support Program and Prevention Education Services for the Georgia Council on Child Abuse. She is also in private practice as a psychotherapist and a certified massage therapist at Open House, Inc. in Atlanta. Her research has focused on "ethical decision making regarding the use of touch in psychotherapy."

Deborah Daro, PhD, is the Director of the National Center on Child Abuse Prevention Research, a program of the National Committee to Prevent Child Abuse. Dr. Daro has sought to improve the quality of program evaluations through the development of innovative research designs and methods of data collection. She has directed some of the largest multi-sized program evaluations completed in the field. As both a lecturer and author, her commentaries and findings are frequently cited in the rationale for numerous child abuse prevention and treatment reforms.

Nancy Davis, PhD, is a therapist in private practice; she specializes in treating victims of trauma and is author of Therapeutic Stories to Heal Abused Children and Therapeutic Stores to Teach and Heal. Dr. Davis has testified as an expert witness in more than 125 court procedures, most of which have involved sexually and physically abused children.

Elda M. Dawber, LICSW, became the Director of Education and Training of the Rhode Island Rape Crisis Center after a 21 year career in public child welfare.. She is a specialist in the area of child sexual abuse and a consultant, educator, and clinician who has trained and presented at local and national conferences on a variety of issues related to interpersonal violence.

Diane DePanfilis, PhD, is an Assistant Professor at the University of Maryland at Baltimore School of Social Work. With over twenty years of experience in the child maltreatment field as a caseworker, supervisor, program manager, national trainer, consultant, and researcher, she has presented at numerous conferences and workshops. She is currently Principal Investigator of an NCCAN funded demonstration project that is providing early intervention to families at risk of neglect.

Harry M. Elias, JD, is a Municipal Court Judge for the North County Judicial District, San Diego County. Prior to that he was a Deputy District Attorney in a specialized unit which handles the prosecution of domestic violence, child stealing, child abuse and child homicide cases. He participates in numerous local and national organizations, and has served on the Board of Directors of Voices for Children and was on the Board of Directors of the California District Attorney's Association. He was also on the advisory board to the National Center for the Prosecution of Child Abuse as well as the ABA/AAP Board on Child Fatal Maltreatment.

Patti van Eys, PhD, a licensed clinical psychologist, is an Assistant Professor of the Practice of Clinical Psychology in the Department of Psychology and Human Development at Vanderbilt University in Nashville, Tennessee. She has been a trainer for the National Training Program for Effective Treatment Approaches in Child Sexual Abuse and a former member of the therapeutic staff of the National Child Advocacy Center, Huntsville, Alabama. Trained in clinical psychology at Bowling Green State University and interning at Harvard Medical School (Children's Hospital), Dr. van Eys received her doctoral degree in 1989. As well as treating individual victims and survivors of sexual abuse, Dr. van Eys has led groups for non-offending parents and sexually aggressive children. She has recently authored an article, *Group treatment for prepubescent boys with sexually aggressive behavior: Clinical considerations and proposed treatment techniques* in Cognitive and Behavioral Practice, Dec. 1997.

Kathleen C. Faller, PhD, ACWS, DCSW, is Professor of Social Work at the University of Michigan. She is also Faculty Director of the CIVITAS Child and Family Programs, programs to train masters practioners and doctoral level practioners and researchers for work with abused and neglected children, and Director of the Family Assessment Clinic, a multidisciplinary team that evaluated complex child maltreatment cases at the University of Michigan. She is involved in research, clinical work, teaching, training, and writing in the area of child sexual abuse. She is the author of a number of books and articles dealing with child sexual abuse. She is a former member of the Board of Directors and the Executive Committee of the American Professional Society on the Abuse of Children.

Sergeant Byron A. Fassett has been with the Dallas Police Department for 17 years. He is responsible for supervising the Child Exploitation Squad which consists of 2 teams. He has instructed a number of Texas Police Academies and also trains for the Southern Regional Children's Advocacy Center. He is the current president of the Crimes Against Children Investigators' Association which is comprised of law enforcement and child protective services investigators in the North Texas region.

Detective Rick Fenter has been a law enforcement officer in the state of Washington for the past ten years and has been assigned to patrol, field training, narcotics, and community policing. He is a Master Defensive Tactics instructor and teaches at the State Academy. Detective Fenter has been with the Snohomish County Sheriff for the past five years and assigned to the Crimes Against Children's Unit as a Detective for the past two years. He specializes in suspect interrogation, one party consent telephone recordings, and the presentation of demonstrative evidence at the time of trial.

Daniel A. Feucht has more than 20 years of experience in law enforcement and was retired as a sergeant from the Appleton, WI Police Department. He has extensive training in the field of crime scene technology and developed and implemented various related training programs statewide. Since 1986, he has been a certified instructor for Fox Valley Technical College and also teaches within the Police Academy. Dan is a member and certified crime scene analyst with the International Association for Identification and has been an active member with the Wisconsin Association of identification since 1980 and served as president during the 1994-95 term.

Nancy van Fleet, LSW, LPC, is the Executive Director of the Family and Child Abuse Prevention Center in Toledo, Ohio. She is also a representative of the Safe Kid/Safe Streets project, one of five locations in the United States.

Kathleen E. Fountain, MPH, MSN, CPNP, has a pediatric trauma background and was charge nurse for many years in the emergency department at The Children's Hospital of Alabama. In 1995 she founded CHIPS, a multidisciplinary program. Currently Ms. Fountain works for the Alabama State Department of Public Health and serves as the Program Coordinator for the Alabama Child Death Review System. She is a charter member of the American Professional Society on the Abuse of Children - Alabama Chapter and is active in several child-focused organizations. As a strong advocate, she lectures widely on child abuse and has published in the child abuse literature.

David Freeman, CPA, is the Financial Director of the National Children's Advocacy Center in Huntsville, Alabama. He has served in this capacity since August 1995. In the last 11 years Mr. Freeman has worked in accounting and financial management in both public practice and private industry and has been instrumental in creating and auditing financial and internal accounting systems for both domestic and international companies. In his capacity with the National Children's Advocacy Center, Mr. Freeman oversees the financial management of a $2 million agency that receives funding from multiple sources, including federal, state, and local governments and foundations as well as private individual and corporate donations.

William N. Friedrich, PhD, ABPP, is Professor and Consultant in the Department of Psychiatry and Psychology at the Mayo Clinic and the Mayo Medical School in Rochester, Minnesota. His position at Mayo includes clinical practice as well as teaching, consultation, and training. He is a Diplomate with the American Board of Professional Psychology in both clinical psychology and family psychology. He has also authored more than 100 publications.

Seth Goldstein, JD, is a consultant in private practice and the Executive Director of the Child Abuse Forensic Institute which he created in 1992. He was the investigator and Project Director for the Child Abuse Vertical Prosecution Unit of the Napa County District Attorney, Napa, California for four years. Previously he worked for the Santa Clara County District Attorney and the Police Department in Berkeley, California. He has written several articles on the subject of sexual exploitation of children which have been published nationally and has received several awards for his work.

Patrick F. Guyton, MPA, MTS, MS, is the Executive Director of the Child Advocacy Center in Mobile, a center that provides a wide range of services to child victims of sexual and serious physical abuse under one roof. He has worked there for the past ten years. He previously worked in Washington, D.C. for Mississippi's United States Senator John C. Stennis and then in North Carolina in the Office of Plans and Programs of the State Department of Human Resources. He is a member of the American Professional Society on the Abuse of Children, The Alabama Professional Society on the Abuse of Children, The Alabama Network of Children's Advocacy Centers, the National Network of Children's Advocacy Centers, The Alabama Task Force on Children's Justice, the Child Welfare League of America and other organizations. He has presented on child abuse issues at 16 national and regional child abuse conferences.

Jo Hanson, LICSW, has been employed by the Madison County Department of Human Resources in Huntsville, AL as a social worker for over 20 years. She has worked in the Child Protective Service Branch for the last 13 years and has been involved in investigating possible child abuse and neglect. She has approximately 500 hours of specialized training in conducting child sexual abuse investigations and working with child victims and has interview ed over 600 children as possible victims of child sexual abuse and has had extensive court involvement at various levels.

George Hardesty, JD, is an Assistant District Attorney for Mobile County where he directs the Mobile County District Attorney's Office Child Abuse Prosecution Unit. He works full-time at the Mobile Child Advocacy Center where he serves as chair of the Center's Case Review Team and provides vertical prosecution services in cases referred for prosecution. He currently has a 95% conviction rate in child abuse prosecutions. A graduate of the University of Alabama Law School, he has worked previously as an Assistant Attorney General for the State of Alabama and as City Prosecutor for the City of Mobile. Hardesty is a Commander in the U.S. Naval Reserve with over eighteen years of active and reserve duty. He serves as head of the D.A.'s Child Advocacy Team and has presented on child abuse prosecutions to a dozen national and regional conferences.

Jim Hartline, MEd, MSSW, is currently employed as a guidance counselor with the Davidson County Public School System in Nashville, Tennessee. He also co-facilitates the court preparation group in Nashville, as well as a Non-Offending Parent group for the Child Advocacy Center. He has been active with the Child Sexual Abuse Council of Middle Tennessee since 1987 and served as president in 1995. His previous employment includes work with sexual abuse victims and offenders at the Rape and Sexual Abuse Center and as a crisis counselor for the Victim Intervention Program (Metropolitan Police Department).

Lieutenant Michael Hertica, MPA, MFCC Intern, has been with the Torrance Police Department since 1969. During his career, he has worked numerous assignments including commanding the Juvenile Unit which was responsible for the investigation of all juvenile criminal activity as well as all child abuse and sex abuse cases. Lt. Hertica has received and provided several thousand hours of training in child abuse and has published several articles on the subject. In addition, he is currently an MFCC Intern in private practice for the YMCA and 1736 Family Crisis Center in a Domestic Violence Shelter where he works with children victimized by domestic violence.

Jan Hindman, MS, LPC, has studied and researched the problem of sexual abuse for the past 23 years through a variety of endeavors within the educational realm, the mental health discipline, and private practice. She is noted as a pioneer in the field of sexual abuse and has served on several national task forces regarding sexual exploitation and victimization. She is a past president of the Association for the Treatment of Sexual Abusers and currently serves as Chair of the Ethics Committee for ATSA. It's About Childhood-The Hindman Foundation is the non-profit organization of Jan Hindman and her colleagues. She has published a variety of books and pamphlets and is an active member of the Malheur County Multidisciplinary Team in Ontario, Oregon, where her non-profit practice is located.

Lori S. Holmes, MA, LISW, has a Master of Arts degree with a double major in educational psychology/counseling and criminal justice and is licensed by the Minnesota Board of Social Work. Her professional experience includes work at Hennepin County as a principal social worker in child protection and as a protective services program consultant with the Minnesota Department of Human Services. Lori has been the Training Coordinator at CornerHouse, an Interagency Child Abuse Evaluation Center since 1993. Lori presents at several conferences each year.

Brian K. Holmgren, JD, joined the staff of the American Prosecutors Research Institute National Center for Prosecution of Child Abuse as a Senior Attorney in November 1995. Prior to that he was an Assistant District Attorney in Kenosha County, Wisconsin, for 10 years where he directed their sensitive crimes unit. As an Assistant District Attorney, Mr. Holmgren tried more than 160 jury trials including 125 felonies, and handled hundreds of child abuse cases. He was a Board Member of the Wisconsin chapter of the American Professional Society on the Abuse of Children, and a frequent lecturer on child abuse topics at statewide and national conferences.

Rachel Hopper has been an investigator since 1983 and has been assigned to the Child Assault Unit of the Madison County District Attorney's Office since 1986. She has more than 1000 classroom hours of training with special emphasis on the investigation of child sexual/physical abuse.

Mark Horwitz, MSW, JD, is a teacher, trainer, consultant, psychotherapist and attorney. He has presented psychological trauma trainings to over 4000 social workers across the United States. He teaches practice and policy courses at the Smith College School for Social Work and the School of Social Welfare at SUNY-Albany. He is a Licensed Independent Clinical Social Worker, a Board Certified Diplomate in clinical social work and member of the Massachusetts bar.

Kenneth J. Hunter has been the Chief Postal Inspector in the restructured U.S. Postal Service since 1992. The Postal Inspection Service is responsible for protecting Postal Service assets, the work environment of postal employees, and the integrity of the mail and its use through a variety of audit, preventive, and criminal investigations programs. He has extensive and varied postal experience having served as letter carrier, clerk, postal inspector, and other management positions in the postal service. Mr. Hunter attended the University of Colorado and Colorado State University and completed the Senior Executive Program at Stanford University.

Dan Jarboe, MA, LPC, began working in the field of child sexual abuse intervention in 1986. Since the completion of his graduate study in 1988, Dan has served in many different capacities, specializing in the assessment and treatment of child maltreatment. Dan has been serving as the Director of Investigative Services for the Jefferson County Children's Advocacy Center in Lakewood, Colorado since January 1994, conducting forensic interviews of children where abuse concerns have arisen. Mr. Jarboe has interviewed over 1,000 children. He currently serves as President for COPSAC, the Colorado chapter of the American Professional Society on the Abuse of Children. He routinely lectures and provides training to mental health professionals, law enforcement, attorneys, and other professionals on topics related to interviewing children and the evaluation/treatment of child sexual abuse.

Michelle C. Jezycki is a Principal Associate with Public Administration Service in McLean, Virginia. Ms. Jezycki is the National Missing and Exploited Children Comprehensive Action Program Director, a program funded by the Office of Juvenile Justice and Delinquency Prevention. Ms. Jezycki is responsible for the maintenance of nearly 30 national sites, as well as bringing new sites on board. Before moving to the D.C. area, Ms. Jezycki worked with the Washoe County School District in Reno, Nevada.

Detective Mike Johnson has been in law enforcement for 14 years. He is a certified instructor in child abuse prevention, detection, and investigation. In addition to attending federal, state, and local training in this area, he also conducts child abuse training for police officers and lectures to citizens' groups. He is a founder of the Collin County Children's Advocacy Center and is currently assigned to the Center as a Child Abuse Investigator. He has served on the Board of Directors for the National Network of Children's Advocacy Centers and on Senator Florence Shapiro's Blue Ribbon Committee that formulated "Ashley's Laws" for the state of Texas. He is also on the Advisory Board of the Junior League of Plano and served on the Advisory Board for the Education and Training Division of Child Protection for the Children's National Medical Center in Washington, D.C.

Toni Cavanagh Johnson, PhD, is a licensed clinical psychologist in private practice in South Pasadena, California. She has been working in the field of child abuse for 19 years as a researcher, trainer and clinician. For the past 12 years she has provided highly specialized treatment for children under the age of 12 with sexual behavior problems. She has published articles, games and books relating to sexual abuse. Dr. Johnson has lectured on child abuse nationally and internationally and provides consultation to protective service workers, mental health professionals, attorneys, the police, probation officers, and the courts in the area of sexual victimization and perpetration.

Diane Koehler is Director of Kansas City KIDSAFE, a program of Heart of America United Way in partnership with numerous community organizations. This program works with neighborhood residents and leaders, public and private agencies, grassroots organizations and religious institutions to enhance services to families and children and reduce child abuse and neglect. Prior to coming to KIDSAFE, Ms. Koehler was with the Missouri Division of Family Services, Child Protection Services for 28 years.

David Kolko, PhD, is Associate Professor of Child Psychiatry and Psychology at the University of Pittsburgh Medical Center. He is affiliated with the Center for Children and Families at Western Psychiatric Institute and Clinic. He was principal investigator of Project IMPACT, a service demonstration project funded by the National Center on Child Abuse and Neglect that evaluated psychosocial interventions with physically abusive families. He is also completing a study, funded by NCCAN, designed to evaluate CPS operations and community service delivery in the treatment of child abuse. He is a member of the Board of Directors of APSAC and is Co-Chair of its Research Committee. His primary interests are in the area of child antisocial behavior/youth violence, child physical abuse, children with sexual behavior problems, and family violence.

Nancy Lamb, JD, is the Assistant District Attorney for the First Judicial District in the state of North Carolina. Nancy was the lead attorney in the high-profile Little Rascals day care case and worked for one year as an Associate Attorney General for the state of North Carolina specifically on this particular case. She is a member of APSAC and serves on the Board of Directors of the North Carolina Professional Society on the Abuse of Children. Nancy has presented at more than 16 national or regional child abuse conferences around the country and has served as a consultant to many professionals regarding child abuse investigation.

Ronald C. Laney was appointed Director, Missing and Exploited Children's Programs in May, 1994. From 1981 through April, 1994, he had been the Law Enforcement Program Manager in OJJDP. He has developed a series of National Law Enforcement Training Programs that are offered throughout the country today. Prior to coming to OJJDP, Ron Laney served as a program manager in the Law Enforcement Assistance Administration for five years. He has a bachelor's Degree in Criminology from the University of Tampa and a Master's Degree in Criminal Justice from the University of South Florida.

Kenneth V. Lanning is a Supervisory Special Agent assigned to the Missing and Exploited Children Task Force at the FBI Academy in Quantico, Virginia. He is a founding member of the board of Directors of the American Professional Society on the Abuse of Children and is currently a member of the Advisory Board. He is also a member of the U.S. Interagency Task Force on Child Abuse and Neglect, and the Boy Scouts of America Youth Protection Expert Advisory Panel. Mr. Lanning is the 1996 recipient of the Outstanding Professional Award from APSAC for outstanding contributions to the field of child maltreatment. He has trained thousands of police officers and criminal justice professionals.

Diya LeDuc, MSW, LGSW, is a therapist at the National Children's Advocacy Center where she provides forensic evaluation and therapy for abused children. She also provides coordination for the Mother Advocates Program and works as a member of the Multidisciplinary Team.

Cassandra Leslie received her B.S. degree in General Management from the University of Alabama in Tuscaloosa in 1981. She has worked as a Case Aide for the Madison County Department of Human Resources in the Independent Living Program for foster teens. In February 1996 she joined the new Mother Advocates program at the National Children's Advocacy Center. The aim of the program is to support non-offending parents of sexually abused children.

Larry Lewach is the founder and Assistant Project Director and Community Education Coordinator of the Kidsafe Collaborative of Chittenden County, VT. He has directed that community's multi-disciplinary teams for two years, and also developed the Champlain Children's Advocacy Center. He lives and works in Burlington, VT.

Anne Lynn, MSW, MLSP, is the Project Director of the Northeast Regional Children's Advocacy Center in Philadelphia, PA. Her responsibilities include the provision of training and technical assistance to Children's Advocacy Centers and multidisciplinary child abuse response teams in the nine northeastern states. This includes the coordination of regional training conferences and outreach to communities to promote the concept of multidisciplinary team investigations and Children's Advocacy Center program development. Prior to this position, Ms. Lynn worked in public child welfare for over sixteen years as a child abuse investigator/supervisor, placement and adoption services administrator, and director of a county children and youth social services agency.

Lee Anne Mangone, JD, is a Senior Assistant District Attorney in the DeKalb County District Attorney's Office in Decatur, Georgia. She currently heads the Crimes Against Children Unit. In her career as a child abuse prosecutor, she has handled well over a hundred cases involving the physical abuse, sexual abuse and homicide of children. She has presented at the conferences of the American Professional Society on the Abuse of Children, the Georgia Center for Children, the Georgia Council on Child Abuse, Emory University School of Law, Emory University School of Medicine and numerous civic and religious groups.

Kee MacFarlane, MSW, is a consultant of the Education and Training Department at Children's Institute International in Los Angeles. She has been an Associate Clinical Professor in the Department of Child Psychiatry at the University of Southern California School of Medicine where she taught courses on the evaluation and treatment of child abuse. Prior to moving to California she spent six years as the Child Sexual Abuse Specialist for the National Center on Child Abuse and Neglect, where she also served as the first director of the U.S. Office on Domestic Violence. She has served as a consultant and advisory board member to numerous national organizations in the field of child abuse and is on the editorial and review boards of two professional journals. She has worked in the field of child abuse for more than 20 years, delivered more than 500 presentations, and has co-authored four books and more than 50 journal articles and chapters on the subjects of child abuse and molestation.

Sharon A. McGee, MS, LPC, is a Licensed Professional Counselor in private practice in Montgomery, Alabama. She also serves as a therapist in the counseling center and as an Adjunct Faculty member in the Department of Psychology at Auburn University at Montgomery. Ms. McGee has presented at conferences nationally and has been a member of the training team for the National Resource Center on Child Sexual Abuse. Ms. McGee has more than nine years' of experience specializing in child sexual abuse, adult survivors of sexual abuse, dissociative identity disorder, adolescent victims, domestic violence and children's responses to disaster.

James A. Monteleone, MD, is Professor of Pediatriacs at Cardinal Glennon Children's Hospital in St. Louis, MO. He has worked in the field of pediatrics and child abuse since his graduation from medical school in 1962 and has served on numerous committees dealing with child maltreatment and has presented extensively on this topic.

J. Tom Morgan, JD, is the District Attorney for DeKalb County, Georgia. Prior to being elected district attorney he was head of the Crimes Against Children Unit. He has lectured extensively for the National College of District Attorneys, the National District Attorneys' Association, and was a plenary speaker for the National Symposium last year. He is a founding board member of the National Association of Child Advocacy Center, and the Georgia Center for Children, and is currently a member of the United States Advisory Board on Child Abuse and Neglect.

David Muram, MD, is Professor of Obstetrics and Gynecology, University of Tromso in Norway. He is also Professor Emeritus of Obstetrics and Gynecology, University of Tennessee, Memphis. He graduated from the Hebrew University, Jerusalem, did his post graduate training at McGill University, University of Ottawa, and his fellowship in Pediatric and Adolescent Gynecology at the University of London. His research is focused on sexual assault, child sexual abuse, gynecologic care for the mentally and physically disabled, and gynecologic surgery in children.

John E. B. Myers, JD, is Professor of Law at the University of the Pacific, McGeorge School of Law in Sacramento, California. He is a frequent speaker at conferences and training sessions, having made more than 200 presentations in the U.S., Canada, and Scotland. John has written 84 chapters and articles, primarily on child maltreatment and his writing has been cited by more than 135 courts, including the United States Supreme Court. He is on the faculty of the National Judicial College, the National Council of Juvenile and Family Court Judges, and the National Center for Prosecution of Child Abuse.

Debra Nelson-Gardell, PhD, LCSW, is an Assistant Professor in the School of Social Work at The University of Alabama in Tuscaloosa where she is a teacher and a researcher. She has a broad-based practice background and has worked as a treatment provider, supervisor, program evaluator, consultant, presenter, educator, and researcher in the area of child sexual abuse intervention.

Sergeant Gary O'Connor is a 30 year veteran law enforcement officer and a nationally recognized trainer for various criminal justice agencies. He has instructed and consulted for the U.S. Justice Department and the Federal Law Enforcement Training Center, as well as for various state and local law enforcement agencies.

Nancy O'Leary, MSW, is the Project Director of the Southern Regional Children's Advocacy Center, which is operated by the National Children's Advocacy Center, Huntsville, Alabama. Nancy has a Master's degree in social work and a BA in psychology and has worked in the area of child abuse for over eight years, specializing in child advocacy centers. Prior to receiving her Master's degree, Nancy worked in the field of adoptions and with seriously emotionally disturbed children in a community mental health program. She has provided training both locally and nationally in areas such as board development, funding, program development, multidisciplinary case review, child abuse, team building, volunteer program development, and court school program development. Nancy is a member of the Board of Directors for the National Network of Children's Advocacy Centers and a member of the American Professional Society on the Abuse of Children (APSAC).

Kevin Olsen, MD, is the Director of Pediatric Emergency Services at Huntsville Hospital in Huntsville, AL. He has worked in pediatrics since his graduation from medical school in 1982. He has served as Medical Director for a SCAN Team, Medical Advisor for Safe Kids, on the board for Nevada Governor's Conference on Child Abuse, and as representative on the Clark County Child Death Review Team as well as an expert witness for physical and sexual abuse.

Christine Pawelski, EdD, is one of a team of Associates affiliated with the Abuse and Disabilities Network in New York City. This is a multi-faceted training program which began in 1986 at the Lexington Center, Inc. in Jackson Heights, NY for the purpose of developing prevention and intervention resources statewide and nationally around the issues of abuse involving children with disabilities and their families. Dr. Pawelski initially directed this program and began the training model working with child protective workers in the New York City system. She is based at the National Center for Disability Services where she is involved in educational reform efforts and also directs the Smeal Learning Center which is a state-of-the art training facility involved in video/audio production and distant learning projects on multiple topics around disabilities.

Jan J. Payne, MSW, LGSW, is Program Manager for Healthy Families North Alabama, a prevention program of the National Children's Advocacy Center. She received her Masters in Social Work from the University of Alabama in 1989, with a concentration in Planning and Management. She was recently selected by the National Committee to Prevent Child Abuse as a Peer Reviewer for Healthy Families America. Her background includes work in the areas of both medical social work and, most recently, several years as a sexual abuse investigator for Fairfax County Child Protective Services in Fairfax, Virginia.

Donna Pence is a Special Agent with the Tennessee Bureau of Investigation. She currently works in investigative services and criminal allegations in Lincoln and Moore Counties with a focus on child abuse and homicide cases. She has been with the Bureau since 1976, and prior to that was a patrol officer with the Nashville Park Patrol. Her assignments with the Bureau have included field investigator, narcotics investigator, child abuse specialist, Special Agent in charge of Staff Development, and Special Agent in Charge of Drug Enforcement. Ms. Pence has lectured at the local, state, national, and international levels on child abuse investigations, and she has published a number of works. She is a member of the FBI National Academy Associates (125th Session), International Association of Women Police, APSAC, and the Tennessee Network for Child Advocacy.

Sharon Porier has worked in fundraising for nearly 13 years, and has served as the Development Officer for the NCAC for three years. She helped run the Center's first capital campaign and was responsible for instituting the Membership Program - major source of unrestricted dollars for the NCAC. She is currently responsible for all fundraising activities of the NCAC and for raising over $230,000 annually. Mrs. Porier was a member of the Board of Directors of the Children's Center from 1985 to 1993, serving as fundraising chairman for several of those years. She is a member of the National Society of Fund Raising Executives.

Frankie L. Preston, PsyD, Licensed Psychologist, is cofounder of the North Alabama Sex Offender Group Treatment Program (established in 1989). He is a private practitioner who has regularly collaborated with the *National Children's Advocacy Center's* multidisciplinary team concerning offender evaluation and treatment, as well as providing forensic assessment for abuse victims. Most recently, he has established a Juvenile Sex Offender Group Treatment Program which is part of the *Safe Kids/Safe Streets* initiative that is being funded by a U.S. Department of Justice grant.

Detective Chief Inspector Jim Reynolds is a career detective who works for the Organized Crime Group of the Metropolitan Police, based at New Scotland Yard, London, England. He is Head of Scotland Yard's Pedophile Unit, which investigates the activities of professional predatory pedophiles, not only in London, but throughout the United Kingdom and Internationally. He has been a police officer for the last 36 years and a detective for 33 of those years and has served as an Instructor at the Metropolitan Police Detective Training School, where he was Head of the Sex Crimes Syndicate.

Sylvia Rimm, PhD, directs Family Achievement Clinic at MetroHealth Medical Center in Cleveland, OH and is a clinical professor of psychiatry and pediatrics at Case Western Reserve University School of Medicine. Dr. Rimm speaks and publishes nationally on family and school approaches to guiding children toward achievement. She hosts the national call-in program on public radio, called *Family Talk With Sylvia Rimm*, has a syndicated newspaper column and appears regularly on television including a monthly parenting series on NBC's *Today* show called *Raising Kids in the 90s*.

Randy Rogers grew up in North Louisiana and received his BA from Louisiana Tech University in 1979. After working as a Sheriff's deputy throughout college, he began a 15-year career in the high-tech industry as a Marketing Representative with IBM and District Sales Manager with Lotus Development Corporation. He is now the owner of Technology Helps Co., a company that offers software application for police and non-profits to help organize and track information gathered in all areas of criminal case investigation. He is currently assisting the National Network of Children's Advocacy Centers in the deployment of case tracking software.

Commander Bradley J. Russ has been a senior instructor for the Department of Justice, Office of Juvenile Justice and Delinquency Prevention since 1986. During that time he has provided training to more than 5,000 law enforcement officials, protective services workers, prosecutors, school administrators, judges, and mental health workers. Commander Russ heads the Bureau of Investigative Services in the Portsmouth, New Hampshire Police Department. His responsibilities include management and supervision of the criminal investigative, youth services, narcotics, and crime prevention programs.

Investigator George Ryan has been an employee with the First Judicial District Attorney's office since 1991. He has 14 years of law enforcement experience from the US Department of Justice and Gates County Sheriff's Department and is a North Carolina Certified Instructor in Criminal Justice. Mr. Ryan's experience in the area of child abuse has made him a proactive agent in combating child abuse. He is a trainer for the Southern Regional Children's Advocacy Center and is available to assist and train others in a 17 state region in establishing child-focused programs that promote coordination among agencies involved with child abuse victims.

Investigator Carl Sample has been employed with the Huntsville Police Department for the past 25 years. He has worked Patrol, Traffic and is currently assigned to the Investigations Division. Investigator Samples has worked with a local company to develop software to aid police departments in the tracking and compliance with public notification work. This software is not limited to sexual related investigation; domestic violence studies have also been run with this product.

Susan D. Samuel has been a social worker in the Kentucky Cabinet for Children and Families for 9 years. She has conducted more than 1500 investigations of child maltreatment. She and Detective James Starks have been on an investigative and training team for eight years.

Daniel W. Smith, PhD, earned his doctorate in Clinical Psychology at Rutgers University and completed his internship and post-doctoral training at the Medical University of South Carolina's National Crime Victims Research and Treatment Center. Now an Assistant Professor at the University of Arkansas, he specializes in the assessment and treatment of child sexual abuse victims and children's adjustment to adoption. He also co-founded the Children's Safety Center, Arkansas' first multidisciplinary child advocacy center.

Michael L. Smith, SA, is with the Tennessee Bureau of Investigation assigned to the Middle Tennessee Criminal Investigation Division. His primary duties consists of administering specific issue polygraph examinations for a twenty eight county area. SA Smith is a P.O.S.T. certified child sexual abuse investigator and has spent sixteen years in the field of law enforcement. He has lectured on the use of polygraph in law enforcement and criminal investigations on the local, state and national levels.

Inspector Raymond C. Smith is a Program Manager with the U.S. Postal Inspection Service assigned to National Headquarters, Office of Criminal Investigations, in Washington, D.C. He has program management and oversight responsibility for all child exploitation investigative operations and programs conducted by the Postal Inspection Service. His law enforcement career spans a 23-year period. Prior to entering federal law enforcement in 1982, Inspector Smith served as a New Jersey police officer for seven years.

Linda S. Spears has been involved at both the practice and senior management levels in child welfare services for more than 18 years. Concerned with improving the effectiveness of agency and community responses to at-risk children and families Linda has worked to develop many innovative programs that promote the integration of child welfare services with services focusing on domestic violence, substance abuse, health, and homelessness. Linda currently provides management and programmatic consultation and training services to public child welfare agencies and heads Child Welfare League of America's child protection initiatives. She is also a member of the advisory committee of the National Resource Center on Child Maltreatment, and an advisor to the National Resource Center for Domestic Violence, Child Protection and Child Custody.

Sergeant Sherry Spears is a thirteen-year veteran of the Huntsville Police Department. She is currently a Second Shift Sergeant of the Baker Precinct where she supervises eleven Uniform Patrol Officers. Two days of the week she acts as the Shift commander for Uniform Patrol, Second Shift. Prior assignments include, third shift patrol, D.U.I. Task Force, Vice and narcotics and DARE. Along with her Supervisory duties, she is Chairperson of the Domestic Violence Committee for the Huntsville Police Department. Sherry has a master's Degree in Justice and Public Safety from Auburn University.

Detective James Starks has been with the Kentucky State police for 25 years. For the last 12 years he has been a General Investigation Detective and has concentrated on child sexual abuse investigations. He has also been a detective in undercover narcotics and undercover organized crime as well as a trooper and a dispatcher with the agency. Since 1990, Detective Starks has conducted training in more than two dozen states for law enforcement and related disciplines.

Caryl T. Steele, MA, LPCC, is the founder of Sexual Assault Treatment Services, Inc., a private counseling practice specializing in the treatment of adult survivors of trauma. She is a recognized national trainer and author of *Double Bind: A Guide to Recovery and Relapse Prevention for the Chemically Dependent Sexual Abuse Survivor.* She is known for her humor and user-friendly techniques in treating the dual diagnosis of PTSD and addiction.

Paul D. Steele, PhD, is Associate Professor of Sociology and Director of the Center for Applied Research and Analysis at the University of New Mexico, a Senior Research Associate at the Vera Institute of Justice in New York City and Visiting Scholar at the School of Industrial and Labor Relations at Cornell University. He has engaged in basic and evaluation research concerning domestic violence, sexual assault and child sexual abuse for more than 20 years. He is currently involved in assessing Children's Advocacy Centers and their Statewide Networks, and developing state-of-the-art information systems for CACs.

Melissa Steinmetz, ACSW, CCSW, has worked in the field of child sexual abuse since 1985. Presently she is the clinical consultant for four Indiana Children's Advocacy Centers. She also serves as a child interviewer for the U.S. Department of State, Diplomatic Security, in international child abuse investigations. She is also on staff with Holy Cross Counseling Group providing treatment to adolescent, adult, and intellectually impaired sex offenders. She has conducted trainings on national, regional, and local levels and had published her first book on interviewing for child sexual abuse.

Paul Stern, JD, is a senior deputy prosecuting attorney for Snohomish County, Washington. He has been involved in the prosecution of cases of child sexual and physical abuse since 1985. Mr. Stern serves on the Executive Committee of the American Professional Society on the Abuse of Children and is former president of the Washington State Chapter of APSAC. Mr. Stern is the author of numerous articles and book chapters dealing with child abuse issues.

Ellen Stirling, MSN, obtained an MS in the Nursing Care of Children and Adolescents from Wayne State University in Detroit, Michigan, researching the Child's Concept of Death and Dying. Previously, she worked with the Pediatric Oncology and Hematology Department at Children's Hospital, Ann Arbor, Michigan, as a Nurse Clinician. She has limited her nursing practice to helping families in grief since 1983. She is a member of the Oregon Chapter of Association for Death Education and Counseling and the National Council of Hospice Professionals. She is currently the Bereavement Manager at Hospice Southwest. She has presented workshops regarding children and grief to a wide variety of audiences.

John Stirling, Jr., MD, has been a practicing general pediatrician for 18 years and has worked as a consultant in child abuse for that time. He received his bachelor degree in Psychology from the University of Michigan and his medical doctorate from the University of Michigan School of Medicine. He has taught on medical child abuse issues and on parenting skills.

Cassandra Thomas is the Director, Rape Crisis Program, Houston Area Women's Center. In addition to her responsibilities of directing the Rape Crisis Program she trains nationally and internationally on sexual assault issues. She has appeared on many television programs, most recently NBC's *Today Show* debating Judge McSpadden on the castration issue. Ms. Thomas is also featured in Ruthe Winegarten's book *Black Texas Women: 150 Years of Trial and Triumph*, for her achievements at the Houston Area Women's Center and as Immediate Past President of the National Coalition Against Sexual Assault.

Joyce N. Thomas, RN, MPH, PNP, is a program administrator, national and international specialist on all aspects of child maltreatment, and Co-Founder and President of the Center for Child Protection and Family Support, Inc. of Washington, D.C. Ms. Thomas is the former Staff Director of the Prevention Committee for the White House Conference for a Drug Free America. In this capacity, she participated in the development of the policy recommendations and a final report which was submitted to Congress and the President.

Patti Toth, JD, is a lawyer and expert consultant on issues related to the investigation and prosecution of child abuse cases. Her previous experience includes working as a federal child exploitation prosecutor, directing the National Center for Prosecution of Child Abuse, and trying cases as a Washington state prosecutor. She lives in Washington state and serves as an elected member of the Executive Council of the International Society for the Prevention of Child Abuse and Neglect and was 1994 President of APSAC.

Theresa Kern Vo, PhD, is a licensed psychologist and clinical member of the American Association for Marriage and Family Therapy. She has more than 14 years' clinical experience in the field of child abuse and neglect and has worked as a multidisciplinary team member in an advocacy center setting. She is a trainer for the Southeast Regional Children's Advocacy Center and a consultant with the US Department of Juvenile Justice and Delinquency Prevention. She has extensive experience as an expert witness in the area of child sexual abuse and the Administrator of Catholic Charities in Dallas. Ms. Vo also maintains a private practice where she specializes in stress management and burnout prevention.

Anne Graffam Walker, PhD, a former court reporter, is a forensic linquist who received her postgraduate degrees in Sociolinguistics from Georgetown University. Her work on language and law appears in several textbooks and journals; she is co-writer and editor with Judith N. Levi in *Language in the Judicial Process* (1991; Plenum). Her *Handbook on Questioning Children: A Linguistic Perspective* (1994), was written at the request of, and published by the American Bar Association. Since 1987, she has focused her research and teaching, nationwide and in Canada, on the linguistic aspects of the child interview.

Lieutenant Bill Walsh is a 17- year veteran of the Dallas Police Department and commander of the Investigation Section which includes the Child Abuse Unit, the Family Violence and the Child Exploitation Unit. He co-founded the Dallas Children's Advocacy Center and has been a member of numerous child abuse prevention societies and committees. Lt. Walsh has lectured widely on the investigation of child abuse and family violence, both nationally and internationally.

Eidell Wasserman, PhD, is a clinical psychologist who has spent the past 9 years working in victim assistance programs in Indian Country. Her experience included provision of treatment to child abuse victims, clinical supervision to staff working with abused children, consultation to tribes throughout the country, and training and technical assistance for tribal programs designed to assist victims of crime and to improve the investigation and prosecution of child sexual abuse cases in Indian Country. She is a nationally known trainer on family violence, grant writing, program development, child abuse, protocol development, multidisciplinary and child protection team development, dynamics of victimization, elder abuse, victim compensation and juvenile offenders and victims.

Judith F. Weigman, MA, LICSW, is a Clinical Supervisor with CornerHouse, a child abuse evaluation center in Minneapolis, Minnesota. As an Interview Specialist, she has interviewed more than 1,000 children on videotape. Ms. Weigman provides clinical supervision to the interview staff, trains the forensic interviewers, interviews children, and conducts forensic interview training at both basic and advanced levels. She has presented at numerous professional conferences and meetings and is a member of the American Professional Society on the Abuse of Children. She is a charter member and present board member of its Minnesota Chapter. Judy was also a co-founder of the New Genesis Therapy Center in Richfield, Minnesota.

Kathleen A. Wells is a founder and Executive Director of HOPE Place, Inc., a domestic violence agency serving Northeast Alabama. Before becoming Director at HOPE Place, Kathy served as Assistant Director of the National Resource Center on Child Sexual Abuse and Project Director for the National Training Program on Effective Treatment Approaches in Child Sexual Abuse. She was recently appointed to the Governor's Domestic Violence Advisory Council and is serving her second year as President of the Board of Directors of the Alabama Coalition Against Domestic Violence. She leads workshops, conducts training and speaks on domestic violence.

Patty Wetterling is the mother of Jacob Wetterling, who was abducted October 22, 1989 near his home in St. Joseph, MN. The former teacher, now self-described "stay-at-home-mom" with four children has become a respected national spokesperson on child safety issues. Using the personal tragedy of their family, Patty and her husband, Jerry, cofounded a not-for-profit foundation to educate parents and children so that children are not abducted, molested, or exploited in the first place while continuing to search for Jacob and the thousands of other children who are missing each year.

Debra Whitcomb has worked in the field of child abuse and neglect for more than 15 years. Author of *When the Victim Is a Child*, she has conducted comprehensive studies of the investigation and prosecution of child sexual abuse cases in more than 20 communities nationwide. She is Editor-in-Chief of *The APSAC Advisor*, and she sits on the Board of Trustees of the Suffolk County (Mass.) Children's Advocacy Center.

J. M. Whitworth, MD, is a Professor of Pediatrics at the University Health Science Center in Jacksonville, Florida. He is also the Founder and Executive Medical Director of Children's Crisis Center, Inc., which was the first of 23 multidisciplinary child assessment teams in the state. His primary focus is on child sexual abuse, and he operates a quality assurance peer review and consulting program for all teams in Florida. He was a founding member of the American Academy of Pediatrics' Committee on Child Abuse and Neglect.

Charles Wilson, MSSW, is the Executive Director of the National Children's Advocacy Center in Huntsville, Alabama. Previously, he was Director of Child Welfare for the Tennessee Department of Human Services and a past president of the American Professional Society on the Abuse of Children. Mr. Wilson directed the child protection, foster care, adoption and family preservation programs in Tennessee. He has presented at more than 20 national or regional child abuse conferences around the country in the past two years and served as a consultant for the states of Washington and Hawaii. He has co-authored two books and several articles with Donna Pence.

Sandy K. Wurtele, PhD, is currently a Professor of Psychology at the University of Colorado at Colorado Springs. She was the recipient of a First Award from NIMH to study the prevention of CSA and has published a book (*Preventing Child Sexual Abuse: Sharing the Responsibility*), 3 chapters, and over 25 articles on child sexual abuse.

Under One Roof:

Multiple Agencies Assigning Staff to Work at One Central Location

Presented by

Patrick F. Guyton, MPA, MTS, MS and
George Hardesty, Jr., JD

AN INTERAGENCY AGREEMENT

ESTABLISHING A CASE REVIEW TEAM MANAGEMENT PROCEDURE FOR CASES OF SEXUAL AND SERIOUS PHYSICAL ABUSE OF CHILDREN IN MOBILE COUNTY, ALABAMA

THE CHILD ADVOCACY CENTER, INC.

September 26, 1988

I. PURPOSE

The undersigned representatives of public agencies, private agencies, units of city, county, and state government, law enforcement agencies, primary health care providers, emergency health care providers, mental health care providers, and educational institutions hereby agree to coordinate the prevention, education, information, reporting, investigation, prosecution, and treatment components of sexual and serious physical abuse of children (hereinafter used in this agreement as "child abuse") by establishing a unified system designed to provide the citizens of this county with an effective Case Review Team management approach of dealing with child abuse incidents and victims in order to promote the well being and rights of child victims of sexual and serious physical abuse in Mobile County.

The Child Advocacy Center/facility will function as an arm of the District Attorney's office in the investigation and case preparatory function of child abuse cases in Mobile County.

II. AUTHORITY

This agreement is entered into by the undersigned pursuant to the spirit and the provisions of the Code of Alabama (1975): Section 26-14-1 et seq. (definition of child abuse, required mandatory reporting to DHR, immunity from liability, etc.) and Section 26-16-13 (mandatory interagency sharing of information to prevent or discover abuse or neglect of children).

III. TERMS AND ABBREVIATIONS USED IN THIS AGREEMENT.

A. Child Abuse

As used in this agreement, the term " child abuse" refers only to cases involving allegations of sexual abuse or serious physical abuse of the child where either (1) a report has been received from a hospital, physician, coroner or other Department of Forensic Science personnel regarding observations during treatment or examination of a child, (2) upon referral from DHR from a report which has been determined founded or indicated by DHR, (3) upon referral from the DHR Law Enforcement Screening Team, either prior to a DHR investigation or after a founded or indicated determination by DHR, (4) or upon referral from a law enforcement agency.

B. Child Advocacy Center, Inc. (CAC) Located at 1351 Springhill Avenue, the Child Advocacy Center is utilized by multi-disciplinary agencies (participating agencies) for purposes of case review, interview and prosecutory preparation of child abuse cases in Mobile County.

C. District Attorney (DA) The office of the Mobile County District Attorney is the agency responsible for prosecuting child abuse cases and protecting the rights of child victims in the judicial system of Mobile County.

D. Law Enforcement Agencies (LEA) This category includes official municipal police departments and the Office of the County

Sheriff that are responsible for enforcing the laws of the State of Alabama and the laws of their respective county and municipal jurisdictions.

E. Primary Health Care Providers (PHCP) This category includes medical doctors, nurses and other health care providers who work in a private and/or public setting who provide primary health care services. Public and private hospitals, agencies, clinics, and other health care institutions which provide primary health care services are also included.

F. Emergency Health Care Providers (EHCP) Included in this category are those medical doctors, nurses, and other health care providers working in a private and/or a public setting to provide emergency health care services. Also included in this category are those public and private hospitals, agencies, clinics, and institutions which provide emergency health care services.

G. Mental Health Care Providers (MHCP) This category includes those agencies, organizations, institutions, clinics, group homes, hospitals, psychiatrists, psychologists, social workers, counselors, and therapists who provide mental health care services through individual and/or family and/or group therapeutic environments.

H. Child Abuse Prosecution Unit (CAPU) Established within the D.A.'s office, the CAPU is made up of assistant District Attorneys who provide specialized, vertical prosecution of all child abuse cases identified for prosecution by the Case Review

Team. Located at the Child Advocacy Center, the CAPJ Director, an assistant District Attorney, works with colleagues in the DA's office and coordinates the case review process of all cases through the judicial system.

I. Law Enforcement Child Abuse Coordinators (LECAC) are members of the Mobile Police Department and Mobile County Sheriff's Office who are primarily responsible for coordinating law enforcement investigations of all child abuse cases within their respective jurisdictions.

J. Victim Advocate Coordinator (VAC) The VAC is responsible for training volunteers to prepare child victims and their families for participation in the criminal justice system. The VAC will carefully screen all volunteers, coordinating this screening with DHR and law enforcement agencies and checking personal and employment references on all volunteers. Volunteers will be taught the absolute necessity for confidentiality in dealing with abused children, their families, and their records. The VAC will assist child victims and their families secure funds from the Alabama Crime Victims Compensation Fund.

K. CAC Medical Coordinator (CACMC) The Chair of the Child Advocacy Center's Medical Advisory Committee, called in this agreement the CAC Medical Coordinator, will coordinate the professional training of medical personnel in the specialized medical protocol developed for child abuse cases. This person is also responsible for updating the CAC Medical Protocol used by all

PHCP and EHCP that are signatories of this document.

L. Case Review Team (CRT) The CRT is that group of professionals who meet on a weekly basis to review/coordinate cases of child abuse referred as appropriate to be handled through the CAC. This team does not replace Mobile County DHR's Multidisciplinary Team or the Law Enforcement Screening Team. It is intended that the CRT will evaluate cases referred to the CAC, determine whether or not each case is appropriate for the CAC, recommend treatment plans as appropriate, make appropriate referrals, and make recommendations regarding prosecution and alternatives available for perpetrators. The CRT will consist of representatives from LEA, representatives from the Department of Human Resources, the CAC Director, the CAC Medical Coordinator, the LECA Coordinators, the CAPU Director, the VAC, selected MHCP, PHCP, and EHCP.

M. Department of Human Resources (DHR) The Mobile County Department of Human Resources is the agency legally mandated to receive and investigate all child abuse reports in Mobile County. Responsible for providing protective services to children and families, this agency plays a key role in this interagency agreement in coordinating its work with that of the other signatories of this document. Social workers from DHR will serve with officers from LEA on the specialized investigation teams. They will also serve on the CRT.

IV. AGREEMENTS

A. INITIAL REPORTING OF CHILD ABUSE CASES

1. All signatories of this document agree to strict adherence to Code of Alabama 1975: Title 26, Chapter 14 (1) et seq. requiring immediate reporting of all suspected child abuse cases to the Department of Human Resources (DHR).

2. During regular office hours if DHR should receive an emergency child abuse report (i.e.: cases involving hospital emergency room treatment or the Department of Forensic Sciences) involving a potentially life threatening situation or an imminent threat or an actual case involving serious bodily harm or sexual harm to a child, DHR shall immediately notify the appropriate LEA and the CAPU Director at the CAC. After hours and on weekends the CAPU Director should be notified at home. If the CAPU Director cannot be reached, then notification needs to be made to the District Attorney. In his absence, the person to notify would be the Chief Assistant. The telephone numbers of the aforementioned people will be provided to DHR and LEA.

3. When a report of sexual abuse and serious physical child abuse which has not been referred previously to the CAC is determined to be founded, the DHR worker who investigated said report is responsible for contacting the CAPU Director within forty-eight (48) hours, excluding holidays and weekends, from the time that the worker determines that the report is founded and

providing the following information:

a. The date and time when the report of abuse was received.

b. Name of person at DHR who received it.

c. Type of abuse reported.

d. Circumstances of the abuse.

e. Name and phone number of the original reporter.

f. Name, address, and phone number of child victim.

g. Place of abuse (geographical location).

h. Worker and supervisor assigned to the case.

4. Emergency Health Care Providers (EHCP) and Primary Health Care Providers (PHCP) who receive as patients child victims of sexual or serious physical abuse shall immediately notify DHR and LEA's and request immediate intervention.

B. INVESTIGATION OF CHILD ABUSE CASES

1. The signatories of this document agree to the concept of investigating all appropriate cases of child abuse (defined above) under a team investigation process involving officers from appropriate LEA and social workers from DHR with assistant DAs from the CAPU when possible. It is the goal and intent of all agencies which are party to this agreement to conduct team interviews with children at the CAC unless specific circumstances prevent it. It is recognized, however, that in those cases originated by DHR, DHR may need to conduct independent interviews with children at various locations in order to make an indicated

or founded determination prior to referral to CAC.

2. The DHR, the LEA, and the DA which are signatories of this document agree to provide specially trained professionals with skills in child abuse interviewing and investigation to be jointly assigned as teams to investigate appropriate cases of child abuse.

3. Once a case of child abuse has been referred to the CAC and a file has been opened, it will be the responsibility of the CAPU Director to coordinate and consult with all parties involved in the investigation.

4. The CAPU Director will be responsible for making sure that all involved agencies have completed the relevant sections of the CAC Team Worksheet and have placed the necessary and required documents, materials and statements in the respective CAC file so that all documentation is ready for the weekly Case Review Team meetings. All signatories of this document agree to provide such information as requested by the CAPU Director.

5. The CRT and CAC agree within six months of the signing of this document, to develop, within the parameters of this agreement a detailed, written policy for dealing specifically with the use of videotaping in child abuse cases.

6. The CAC agrees to provide for the signatories of this document, on a regular basis, training opportunities for enhancing skills in conducting investigations and interviews in child abuse cases. The signatories of this document agree when possible/

practical to send representatives from their respective agencies to these training sessions and to other training opportunities to enhance such skills.

7. The Mobile Police Department and the Mobile County Sheriff's Office shall assign officers to serve as LECA coordinators at the CAC. These officers will coordinate the criminal investigation aspects of child abuse cases within their jurisdictions. The LECA Coordinators will be members of the weekly Case Review Team meetings held at the CAC.

8. The Office of the DA agrees to provide an assistant DA to serve full-time as the CAPU Director. The duties of this person are defined above. The DA agrees, when possible, to assign to the CAPU additional assistant DA's sufficient to handle the child abuse caseload in providing vertical prosecution in such cases. The CAPU Director will be located at the CAC while other members of the CAPU will be located at the DA's office.

9. The DA and CAC agree to provide a Victim Advocate Coordinator (VAC) for the CAC. This person shall attend the weekly Case Review Team meetings and will be responsible for familiarizing child victims and their families with the legal system and preparing them for court. This person shall be responsible for recruiting, screening, and training, along with other CAC staff, a group of volunteers who will provide direct victim services. All volunteers shall be required to sign a confidentiality agreement. All victim service volunteers

providing direct services to children must provide references regarding their character and suitability to work with children and must submit to and be cleared by a state and federal criminal records background check. This person will assist child victims and their families to apply for compensation from the Alabama Crime Victims Compensation Commission.

10. The CAC Medical Coordinator (CACMC) agrees to coordinate with PHCP and EHCP the conducting of such necessary medical exams as requested by the officials above and report the results from such findings as soon as possible to the CAC. These reports will be placed in the respective file of the examined child victim. The CACMC agrees to be a member of the CRT and to assist with the prosecution of offenders.

11. In many cases the CAPU Director will request the CACM Coordinator either to conduct personally or refer the child victim to a PHCP or EHCP for a medical exam using the established CAC Medical Protocol which is a part of this agreement. Only those PHCP and EHCP which are signatories of this agreement will be used for referral services, and they must agree to use the CAC Medical Protocol in their exams and agree to forward the results of the exams to the CAC as quickly as possible.

12. CAC agrees to attempt to find funds, including funds from the Alabama Crime Victims Compensation Fund, to pay for medical exams if necessary.

C. CASE REVIEW TEAM MANAGEMENT OF CASES

1. A Case Review Team (CRT) made up of representatives of the various professions named above will be formed for the specific purpose of reviewing/coordinating all cases referred to the CAC from the time of referral through the investigation, prosecution, and treatment phases of this process.

2. The CRT will be composed of: the CAPU Director who will coordinate the weekly CRT meetings, the CAC Director, the LECA Coordinators, the VAC, the CAC Medical Coordinator, officers from LEA, representatives from DHR , MHCP who are involved in cases for review, and MHCP and EHCP when requested. (At such time in the future when the CAC has sufficient space and funding, a Clinical Services Coordinator will be hired to coordinate the therapy of child abuse victims and their families. This person will be a member of the CRT.)

3. If the CRT refers a case for prosecution, the CAPU Director will be responsible for managing that process. At this point the VAC will be responsible for contacting the family and victim to prepare them for the judicial process.

4. In all founded cases of child abuse, referred to the CAC, whether referred for prosecution or not, it will be the policy of the CAC to refer child victims and their families to MHCP for treatment and counseling.

5. Notwithstanding the provisions of this agreement, each agency of this agreement retains full authority given it by

law in child abuse cases.

D. TREATMENT AND COUNSELING

1. The CAC agrees to keep a list of MHCP who are signatories of this agreement for referral of child abuse victims and their families for treatment and counseling.

2. Only those MHCP who are signatories of this agreement will be used by the CAC for referral purposes.

3. The CAC will use the approved MHCP list on a rotation basis with a choice of at least 3 MHCP's.

4. The rotation process can be bypassed when the needs of the victim require specific treatment provided by a particular agency or therapist as deemed by the CRT.

5. The MHCP who are signatories of this document agree to the following:

a. That they are licensed as individuals or as an agency to practice in the State of Alabama and where applicable in their discipline and profession.

b. They will get specialized education and training in the treatment of child abuse cases.

c. That they will take advantage of therapy/treatment training opportunities for treating child abuse cases offered to them by the CAC and other organizations in the community and training opportunities within their own disciplines.

d. That they will take cases referred to them by the CAC on a rotation basis without regard to the victim's or family's ability to pay or having insurance.

e. That the initial meeting with the child and family will take place at the CAC when possible.

6. The CRT will follow the progress of the child victims and/or their families in therapy. Should a MHCP report that a child victim and/or family, on whom DHR has an active case, is refusing therapy or not keeping appointments, the CAPU Director will be informed and will immediately contact DHR who will contact the family about the importance of long-term treatment for child abuse cases.

E. PROSECUTION

1. All signatories of this document agree to cooperate with the CAPU Director and the LEA in prosecuting founded cases of child abuse that are referred for prosecution from the CRT.

2. The prosecution phase in child abuse cases may be initiated at several points during the case management:

a. It may start early in the investigation phase if there is a strong case against the perpetrator and he/she is arrested. In this event, after the arrest is made by LEA and charges are filed, a preliminary hearing is held.

b. The more typical procedure by which prosecution

is initiated is after a case has been revieved by the CRT.

3. The decision to pursue prosecution will be a considered one made by the CRT on the basis of many factors such as:

a. the facts in the case
b. input of DHR, LEA, PHCP, EHCP, MHCP
c. results of medical and/or mental health exam results
d. age of child
e. potential trauma to the child
f. ability of the child to relate the facts, and the effect testifying will have on the child
g. attitude of the family
h. presence of corroborating evidence

4. The CAPU and the DA agree to provide vertical prosecution in all child abuse cases. The same assistant DA of the CAPU who initially handles the case will carry that case all the way through the criminal justice system including bringing the case to the grand jury, preparing the case for trial, agreeing on a plea bargain, arguing the case in court, and handling appeals.

5. The DA and the CAPU agree to avoid continuances of cases as much as possible, thus ensuring that cases are brought to trial or final disposition in a timely manner.

6. The CAPU/DA will make recommendations to the court on

the sentencing based on the attitude of the child, relation of the child to the offender, family status, and the protection of society.

7. The CAC and the DA agree to provide specialized training in child abuse for all assistant DAs assigned to the CAPU. Training in child abuse will also be offered for judges.

F. EDUCATION/INFORMATION/PREVENTION

1. The signatories of this document agree to work with the CAC in developing programs that will educate and inform the general public of Mobile County about the epidemic of sexual and serious physical abuse of children in our county.

2. The signatories agree to provide personnel when requested by the CAC, when practical and possible, for the purposes of:

a. making speeches

b. appearing on local electronic media

c. developing public service announcements

d. developing educational programs for children in all grade levels of schools (k-12)

3. The CAC working with the signatories of this agreement, agrees to develop proposals and secure funding for major educational programs designed for all school aged children of Mobile County (k-12). These educational programs will include grade level and age appropriate information about child sexual and physical abuse, how to report child abuse, what happens after a

report is made, how the "team" concept of the CAC works, and why it is important to report all suspected cases of child abuse.

4. Educational programs shall also be offered by CAC for teachers, other school personnel, and parents of children in school. Parent/Teacher Associations will be urged to sponsor these in-school and after school educational programs.

V. CONFIDENTIALITY OF RECORDS

All signatories to this agreement, within the bounds allowed by law, agree to maintain the confidentiality of all records and information gathered on all child abuse cases as outlined in Code of Alabama 1975, seq. 26-14-8. All signatories further agree not to release any records or information on any child abuse cases except as it relates to legitimate program operations of their agency. No general media or public access to information and records will be allowed.

VI. MANAGEMENT OF THIS INTERAGENCY AGREEMENT

A. This agreement shall become effective on the date below when the following parties of this agreement gather at the CAC to affix their signatures to this document: DA, DHR, one MHCP, one EHCP, one PHCP, CAC, representatives from signing LEA's.

B. This agreement shall, during the first year, be reviewed by all signatories after six months. Six months later, on the

first anniversary of the effective date of the agreement, it shall be reviewed by all the parties again. Thereafter, this document shall be reviewed by the signatories on an annual basis or more frequently if needed.

C. Any signatory may terminate participation in this agreement by providing 30 days advance notice in writing to the other signatories.

VI. ATTACHED PROTOCOLS

All protocols referred to in this agreement will be attached to and become a part of this interagency agreement.

CHILD ADVOCACY CENTER

MOBILE, ALABAMA

CAC PROTOCOL FOR CHILD ABUSE INVESTIGATIONS

JANUARY 1996

(AGENCIES) AGREED TO BY:	(SUPERVISORS) REPRESENTED BY:
MOBILE COUNTY DEPARTMENT OF HUMAN RESOURCES	MARGARET LOVVORN ROSA MICKLES VANESSA PATTON
MOBILE COUNTY SHERIFF'S DEPARTMENT	SGT. JAMES CROSBY
MOBILE COUNTY DISTRICT ATTORNEY'S OFFICE	STEVE GIARDINI
CITY OF MOBILE POLICE DEPARTMENT	LT. MIKE ROWLAND SGT. TOMMY MENTON
MOBILE MENTAL HEALTH	DIANE ROBERSON-HILL MAGGIE MARQUES
CHILD ADVOCACY CENTER	PATRICK GUYTON DR. JOHN SHRINER, M.D.

CHILD ADVOCACY CENTER
MOBILE, ALABAMA

CAC PROTOCOL FOR CHILD ABUSE INVESTIGATIONS

I. MISSION STATEMENT. The mission of the agencies that are part of the CAC Team is to protect children and reduce the effects of the trauma of multiple investigations/interviews through joint/team investigations of sexual and serious physical child abuse while continuing to provide services to victims and their families, all through a multidisciplinary approach.

II. INTAKE/REPORTS. Reports of child abuse will be made primarily to the Mobile County Department of Human Resources and/or local law enforcement agencies. Reports made to law enforcement should be forwarded as soon as possible to DHR for intake into the DHR Central Registry.

III. COORDINATION OF INVESTIGATIONS. Each discipline will follow the investigative policies of its respective agency. Ideally all child sexual abuse cases will begin as team investigations by a CAC DHR and law enforcement team. At this time the policies of all involved agencies agree with the coordinated investigative team response to child abuse. Neither DHR nor law enforcement will initiate an investigation until it has been determined whether or not a case will be team investigated.

Sharing of Information: Members of all Investigative teams shall provide their investigative counterparts with any and all information pertinent to the investigation in which they are involved unless otherwise directed by agency policy or state law. However, any and all information not specifically excluded as a violation of law or policy shall be shared.

IV. NOTIFICATION OF TEAM. When a report is received by DHR, the Staffing Form will go from DHR to the respective law enforcement agency after the DHR and law enforcement supervisors get together. The Staffing Form will state who from each agency will form the investigative team conducting the investigation. When a report is received by law enforcement, the officer will notify DHR and review the case for possible team investigation. The names of both investigators shall be entered on the Staffing Form for assignment by DHR and law enforcement supervisors.

V. CONVENING THE TEAM. The investigation starts as soon as the Staffing Form is received and the investigative team convenes in order to initiate the investigation.

VI. LOCATION OF INTERVIEWS. Investigative teams should interview at the Child Advocacy Center when possible. Choosing the location of the interview with the child is important and it is generally recommended that it occur in a neutral environment.

When the investigative team responds to an emergency at a hospital it will be the objective of the team to get the facts and provide support and victim services information. Extended interviews may have to be conducted at the hospital, but if possible they should be conducted later.

VII. ORDER OF INTERVIEWS. The investigative team will decide on a case by case basis in which order it will interview the child/children, alleged perpetrator, siblings, parents (non-familial cases), and non-offending parent (familial cases).

A. Interview with Alleged Child Victim. The investigative team will determine how the child interview will be conducted. The team should decide who will take the lead in the interview, what interview techniques will be utilized, and who will document the interview.

B. Interview with Siblings/Other Possible Victims/Possible Child Witnesses. Investigative team members should interview siblings, teachers, child care providers, or others who may have observed behavioral or physical changes in the child or may have heard statements made by the child which may support, explain, or provide additional information for follow-up interviews with the alleged victim, non-offending parent, or alleged perpetrator.

C. Interview with Non-Offending Parent. The non-offending parent should be informed of the allegations, particularly the child's account of the events. If the investigative team has reason to believe the child was abused, it needs to know if this parent is able and willing to protect the child and how this will be accomplished. The parent should be given the names of the investigative team and information on how to make contact with both members of the team as well as telephone numbers for crisis and support services.

After the interview of the non-offending parent is completed, the team will advise the Victim Services Office at the District Attorney's Office of any victims and she/he can make an assessment for services.

D. Interview with Alleged Perpetrator. The investigative team should decide who should take the lead in the interview. The law enforcement member of the investigative team is usually best prepared to do this. If unique case factors dictate otherwise, or law enforcement or DHR will not be able to interview the alleged perpetrator within a reasonable time frame, the DHR social worker or law enforcement officer will need to proceed, keeping the other member of the team informed as soon as possible and providing relevant information. The lead interviewer will need to be familiar with the facts of the case, the statements of others, and any conflicts in prior statements of the alleged perpetrator, including defects in an alibi, if previously offered.

In an interview situation where the custodial status of the alleged perpetrator is unclear, the DHR social worker ought to be present if possible.

If the interview occurs in a custodial setting, unless otherwise decided by the investigative team, the DHR social worker will not be present during the interview but will be provided access to a copy of the perpetrator's statement and the law enforcement report of the matter.

VIII. FORENSIC MEDICAL EXAMS/EXTENDED ASSESSMENT. Reasons for obtaining:

1. General health and mental status
2. Evidence gathering
3. Opportunity for disclosure
4. Reassurance

A. Forensic Medical Exams. The investigative team must decide early in the investigation whether medical examinations will be required. If the child has not already been referred to a medical facility, the investigative team should have the child examined as soon as possible if needed. The investigative team should then consult with the Case Review Team as soon as possible to make proper recommendations for referral. Referrals for forensic medical exams may be made by DHR, law enforcement, the District Attorney, or the Case Review Team. Consultation with the forensic physician who conducts the CAC/SCAN examinations will also be warranted for referral decisions. Where there is uncertainty about referring for exams, the decision will be made by the Case Review Team. Appointments for the CAC/SCAN examinations will be made by the trial coordinator who works under the Assistant District Attorney. The child and parent will be informed about the nature of the examination by the Volunteer Forensic Advocate.

B. Extended Assessment. Referral for Extended Assessment may be made at any point in the investigative or case review process. In cases the investigative team wishes to refer for Extended Assessment with the mental health therapist at the CAC, the parent should be informed and the purpose of the extended assessment process explained. The name and telephone number of the therapist who the child is being referred to for extended assessment should be provided.

IX. CRIME SCENE. While DHR investigators are not directly involved in search and seizure, it is important they understand the rules of procedure in this area so as to be alert to possible objects which should be listed in the search warrant and sought by law enforcement.

X. VALIDATION DECISION MAKING. Once all the evidence has been gathered, the investigative team needs to decide if it believes the child was abused and, if so, by whom. This process, called validation, pulls all the evidence together, including that which supports and refutes the allegation. (A Validation Worksheet is attached in the

Appendix.) The decision should be based on seven classes of evidence:

1. The child's statement
2. Statements of other witnesses including other children, non-offending parents, teachers, other professionals and adults
3. Medical findings
4. Physical evidence
5. Behavioral indicators
6. Any relevant psychological information involving the child, family, or alleged perpetrator
7. The statement of the alleged perpetrator

XI. CASE REVIEW TEAM/CASE REVIEW PROCESS

A. Case Review Team. The CAC Case Review Team will be made up of the presenting law enforcement/DHR joint investigative teams as well as the supervisors/administrators from the following: law enforcement agencies within Mobile County, the Mobile County Department of Human Resources, the Executive Director of the Child Advocacy Center, Mobile Mental Health, the Assistant District Attorney of Mobile County, the Victim Witness Advocate of the CAC and the Mobile County District Attorney, the CAC Forensic Medical Director, and other mental health professionals.

From time to time other professionals or interns may have reason to temporarily be a part of the CRT. They should sign the Confidentiality Form detailed below before attending CRT meetings. As a general policy visitors, interns, and other guests should not comment on cases under review unless asked to do so by the CRT chair.

B. Case Review Process. The following are items that will be presented/covered at case review team meetings:

1. Facts of the case
2. Protection issues
3. Referrals
4. Extended assessment
5. Treatment issues
6. Medical examinations
7. Legal and evidentiary issues
8. Victim services
9. Other services
10. Mental health issues

In order to better coordinate services and intervention, early case reviews of cases is urged. All "indicated" cases should be reviewed by the CRT as soon as possible. Investigative teams wishing to schedule a case for review by the CRT should schedule their cases with the Trial Coordinator/Case Manager at the CAC who will prepare an agenda of scheduled cases for advance distribution to all members of the CRT and applicable supervisors. The investigative team members presenting cases at the CRT meeting should come to the meeting prepared to present the information in the format requested by the Team Review

Validation Worksheet. The attitude of the CRT meetings should be "supportive". As this policy initiates early case presentations, it is expected that cases may be presented to the CRT two or more times before final disposition is reached.

Chairing of the CRT will be rotated among the members of the CRT. The Chair will appoint a Recorder who will fill out the Team Review Validation Work Sheets at each CRT meeting.

It is the policy of all agencies involved with this protocol that their staff members and applicable supervisors will attend all scheduled CRT meetings to present their scheduled cases. Supervisors of the agencies covered by this agreement should attend all CRT meetings.

It is the goal of all agencies involved with this protocol to refer child abuse victims as quickly and as early as possible to: (1) forensic medical exams if needed; (2) mental health extended assessment if indicated; (3) victim services. While these services will be covered in CRT meetings, investigative team members should refer children for these services as soon as possible.

C. Confidentiality. Each member of the Case Review Team and each person sitting in on Case Review Team meetings will annually sign a document with the following wording: " As a member of the Case Review Team, I, within the bounds allowed by law, agree to maintain the confidentiality of all records and information gathered on all child abuse cases as outlined in the Code of Alabama 1975, et seq. 26-14-8 and 38-2-6(8) and presented at CRT meetings. I further agree not to release any records or information on any child abuse case except as it relates to legitimate program operations of my agency. I agree that no general media or public access to information and records will be allowed." It will be the responsibility of the CRT Chair to make sure that all guests attending CRT meetings sign a confidentiality form at the beginning of each meeting.

D. Notification of Families. The Assistant District Attorney will notify the families in cases reviewed at CRT of the final disposition of the cases.

XII. PROTOCOL SUMMARY. This protocol was developed to provide guidelines for fostering multi-disciplinary response to child sexual and physical abuse within the realm of acceptable professional practice.

D R A F T

CAC PROTOCOL FOR CHILD ABUSE INVESTIGATIONS

A P P E N D I X

(It was agreed at the conclusion of the drafting session that each major agency would write a brief description of its mission/work to be included in the protocol. This section is where agencies could describe their philosophies and method of operations at the CAC. I have included them exactly as I received them.)

(It was also agreed that the Appendix would contain examples of a Validation Worksheet. Two are attached. Please ask your staff which, if either, they prefer.

DISTRICT ATTORNEY'S OFFICE

The role of the District Attorney assigned to the Child Advocacy Center is primarily threefold:

1. To evaluate the results of investigations by law enforcement and DHR investigators in terms of possible prosecution.

2. To provide guidance to law enforcement and DHR investigators during the course of their investigations when such guidance is sought.

3. To prosecute appropriate cases in the state criminal courts of Mobile County. Cases are to be prosecuted vertically, involving the District Attorney at bond hearings, arraignments, preliminary hearings, grand jury presentations, trials, and post-trial hearings.

ROLE DESCRIPTION

CAC PROTOCOL

DEPARTMENT OF HUMAN RESOURCES:

The primary goals of DHR intervention in child abuse investigations are to protect children at risk of maltreatment and, through principles outlined in the R.C. Consent Decree, to alter the conditions in families which created the risk of maltreatment. These goals are met through investigation of the allegations, assessment of the family's strengths and needs, and provision of services as needed to the child and family.

A specialized unit (five social workers and a supervisor) will be housed at the Child Advocacy Center to facilitate the team approach in investigating reports of suspected sexual abuse and severe physical abuse.

LAW ENFORCEMENT

The role of law enforcement in investigating child exploitation is that of an objective fact finder. It is their responsibility to determine if a crime has occurred, offer protection for the victim(s), gather and preserve evidence that will prove the particular crime discovered, apprehend, and bring to court the individual responsible.

This process is not performed in a vacuum, however. The line officers and specialized investigators work in close conjunction with other professionals in a multidiscipinary setting. Pooling resources, sharing problems, and dedication to the children of the community are hallmarks of this spirit of cooperation.

VICTIM ADVOCATE'S ROLE

PURPOSE: To provide a sympathetic and trained ear to help victims ventilate fear and anger, rebuild self-esteem, cope with their sense of vulnerability, avoid self-blame, and reduce feelings of shame, and relieve uncertainty. To inform,guide, and support victims as they go through the criminal justice system. To be an active participant in all Multidisciplinary meetings and represent the interest of the victim.

SERVICES PROVIDED:

Personal Advocacy - acting on behalf of the victim to ensure that they are treated fairly by social services agencies and the criminal justice system.

Referral-recommending or obtaining other sources of assistance not provided directly by the Victim Assistance Program.

Court Orientation- providing information on the criminal justice system and the victim's responsibilities in court. Child victims are provided two (2) different programs in orientating about court-1. Grand Jury orientation 2.Court Orientation for both the child victim and the caretaker.

Transportation - Arranging transportation for victims to the orientation programs or to court. This is done through the Child Advocacy Center.

Court escorting- accompanying victims to the courtroom and sitting with them during testimony. This is done either by the Victim Advocate or Volunteer Victim Advocates

Child waiting rooms- Two (2) waiting rooms especially equipped for the age of the victim are available on the Victim's Assistance wing of the District Attorney's office, 5th floor.

PROGRAMS: The Victim's Advocate will develop programs as needed to provide broader services to the victim. The Advocate will coordinate and direct those programs already in place to i.e. Court Orientation, Grand Jury Orientation, Forensic Advocate Program, S.T.E.P.,Volunteer Advocate Program, and Christmas for Kids.

ROLE OF THE MENTAL HEALTH REPRESENTATIVE
(Pence, 1994)

1. Assisting in the interpretation of psychological information received by the team.

2. Making treatment recommendations for children.

3. Conducting extended assessments.

4. Providing treatment for children and secondary victims.

This list is not intended to be exclusive but is to be a guideline of the responsibilities performed by the Mental Health Representative.

ROLE OF THE CHILD ADVOCACY CENTER

The Child Advocacy Center is the agency established by many different agencies and programs to provide space for various agencies in the community to house professionals for a multidisciplinary approach to handling cases of sexual and serious physical abuse of children. The Center provides space for investigative team interviews, meetings of the Case Review Team, office space for assigned staff from all agencies that are party of this protocol, support services for all assigned staff as able, training for support staff, court preparation space for victims and families going to court, space for individual and group therapy, and provides education and information services on child abuse in the community.

Medical Examinations in the Investigation of Child Abuse

Medical examination of the victim when there are allegations of child sexual abuse are, in most cases, an integral part of the investigation.

The following are reasons for performing medical examinations:

1) Determination of the presence or absence of physical findings that are specific for or campatible with allegations of child sexual abuse.

2) Obtaining an assessment of the victim's general health, mental level, growth and development, old injuries, and signs of nutritional or other neglect.

3) A unique opportunity for further disclosures is given.

4) Assurance can be given to child about his or her general health and serves as a further reminder that concern and intervention by caring professionals exists.

The decision on obtaining or not obtaining a medical examination is to be made by the DHR investigator, the law enforcement investigator, or the assistant district attorney When there is uncertainty concerning the need for a medical examination this can be resolved at an early case review meeting and with consultation with the physician who conducts SCAN examinations. It is important that that physician be given information concerning the investigation. Appointments for the examination will be made by the trial coordinator who works under the assistant district attorney. The victim and the parent will be be informed of the nature of the examination by a Volunteer Forensic Advocate.

Checklist for Determining the Likelihood Sexual Abuse *Occurred*

Child's name_____ Date_____

I. The child's ability to describe (either verbally or behaviorally) the sexual behavior.

A. Sexual knowledge beyond what would be expected for the child's developmental stage. Y N Comments:_____

B. Sexual behavior described from a child's viewpoint. Y N Comments:_____

C. Explicit accounts of sexual acts. Y N Comments:_____

II. The child's ability to describe the context of the sexual abuse.

A. Where it happened. Y N NA* Comments:_____

B. When it happened. Y N NA* Comments:_____

C. What the offender said to obtain the child's involvement. Y N NA* Comments:_____

D. Where other family members were. Y N NA* Comments:_____

E. What the victim was wearing. Clothing removed. Y N NA* Comments:_____

F. What the offender was wearing. Clothing removed. Y N NA* Comments:_____

G. Child's recollections regarding emotional state during abuse. Y N NA* Comments:_____

H. Whether the offender said anything about telling or not telling. Y N NA* Comments:_____

I. Whether the child told anyone. Y N NA* Comments:_____

J. Reactions of persons child has told. Y N NA* Comments:_____

K. Frequency and/or duration. Y N NA*
Comments:_____

L. Other (specify)_____

III. The child's affect when recounting the sexual abuse.
A. Reluctance to disclose. Y N
Comments:_____

B. Other (e.g embarrassment, guilt, anxiety, disgust, anger, sexual arousal, fear) (describe) Y N
Comments:_____

IV. Medical evidence Y N
Comments:_____

V. Confession of the offender (e.g full, partial, or indirect admission) Y N
Comments:_____

VI. Other witnesses
A. Children Y N
Comments:_____

B. Adults Y N
Comments_____

VII. Victim statements in other contexts (specify)
Y N
Comments:_____

VIII. Police evidence Y N
Comments_____

IX. Other information Y N
Comments_____

* Not Asked
(Faller, 1993)

TEAM REVIEW
VALIDATION WORKSHEET

CHILD's NAME: _____ D.O.B. or AGE: _____

ALLEGED PERPETRATOR: _____ RELATIONSHIP TO VICTIM: _____

1. Is Medical/Psychological Evidence Present: Yes __ No __
   If Yes, Describe.

2. Does the Alleged Perpetrator(s) Admit to the Abuse? Yes __ No __

   Summarize His/Her Statement.

3. Are There any Credible Witnesses Who Saw the Alleged Abuse? Yes __ No __
   If Yes, Identify the Witness(es) and Describe What They Reported.

   Are There any Witnesses Who Verify, Corroborate, or Refute Other Evidence?
   Yes __ No __
   If Yes, Identify the Witness(es) and Describe What They Reported.

4. Assessment of Child's Statement

   A. Sexual Abuse

      In Analyzing the Child's Statement Were There:

      (1) History

         Multiple Incidents Reported? Yes __ No __
         If Yes, Explain:

B. Physical Abuse

(1) Does the Child's Statement Match With the Medical Evidence and Documented Physiological Indicator? Yes __ No __
Explain:

(2) Who do They Say Hurt Them?

(3) Did Anyone Else Know it was Going on? Yes __ No __
Explain:

(4) How Did They Try to Help?

(5) Has This Type of Injury Ever Happened Before? Yes __ No __
Explain:

(6) Are There Other Factors Which Affect our Assessment of This Child's Statement? Yes __ No __
If Yes, Explain:

5. Were any Physiological Indicators Observed by the Counselor? Yes __ No __
If Yes, Describe:

Elements of Progression Present? Yes __ No __
If Yes, Describe

(2) Details

Explicit Details of Sexual Activity? Yes __ No __
If Yes, Were They Beyond the Child's Developmental Level?
Yes __ No __ If Yes, Describe:

Richness of Detail? Yes __ No __
If Yes, Explain:

Consistency in the Child's Statement? Yes __ No __
If Yes, Explain:

(3) Elements of Secrecy, Yes __ No __
If Yes, Describe:

(4) Elements of Coercion, Yes __ No __
If Yes, Describe:

(5) Are There Other Factors Which Effect our Assessment of This Child's Statement Which Corroborate or Refute the Statement? Yes __ No __
If Yes, Explain:

Were These Indicators Recorded on Photographs, Audiotape or Videotape?
Yes __ No __

6. Was any Physical Evidence Obtained? Yes __ No __
If Yes, Describe:

7. Were any Behavioral Indicators Noted? Yes __ No __
If Yes, List Indicators and Who Observed:

	INDICATORS	OBSERVED BY WHOM	DATE
1.			
2.			
3.			
4.			
5.			
6.			

8. Was Circumstantial Evidence Linked to Allegations? Yes __ No __
If Yes, Describe:

Medical examinations in investigation of child sexual abuse.

Medical exammination of a child who is suspected of having been sexually abused ought to be done in most cases. Such examinations are especially important in cases in which digital, vaginal, or anal penetration has been disclosed or suspected. Failure to have disclosed, early in the investigation, more than fondling may, of course, be only a partial disclosure. Evidence of penetrating injury is found when there is no disclosure of it. Non-penetrating sexual maltreatment may transmit a specific disease. A finding of evidence of penetration may, in some cases, prompt a more complete disclosure.

Medical examinations in cases of child sexual abuse ought to be done only by a physician who is thoroughly trained in performing SCAN examinations and who has an understanding of the investigative process. They are to be done unhurriedly and with a kindly manner in a well equipped and quiet clinical setting. It must be realized that such examinations involve far more than simply "looking for evidence". Experience and expertise in seeing pediatric patients in a kindly and reassuring manner, in taking a medical history, in properly assessing the child's behavior, development, growth, cognitive level, concerns and fears are important. The child may have other illnesses, past or presently, that may or not be related to abuse.

Information on and preparation for the SCAN examination is important and ought to be effected by a a child advocate, such as a Forensic Advocate, a nursing, o other professional volunteer.

All those involved in investigation of child sexual abuse need to understand the nature of SCAN examinations.

Techniques for Therapeutic Group Intervention with Sex Offenders

Presented by

Melissa Steinmetz, ACSW

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S.O.A.R. GROUP EVALUATION-CLIENT VERSION

OBJECTIVE: This evaluation will be completed by the facilitator(s) at the end of the group cycle which lasts 12 weeks. Offenders are expected to participate in group for the duration of their treatment.

Sexual offenders avoiding relapse group (S.O.A.R.) is designed to enable sexual offenders to state honestly and directly to the group members that they were totally responsible for the sexual exploitation of their victim(s) and to enable them to begin to take positive control over their lives and decrease the likelihood of re-offending.

CLIENT_____ DATE_____

INDIVIDUAL COUNSELOR_____

GROUP FACILITATOR(S)_____

INITIAL ENTRY DATE:_____WEEKS ATTENDED: _____OUT OF_____

AWARENESS AND KNOWLEDGE OF SEXUAL ABUSE

A=Accomplished W=Working On NW-Needs Work NYA=Not Yet In Group NA=Not Applicable

The offender:

_____ 1. is continuing to tell increasingly more details about his sexual abuse.
- _____ a. shares methods of coercion, intimidation, force or threat.
- _____ b. shares methods of inappropriate use of power and control.
- _____ c. shares methods used to maintain the sexual abuse(s).
- _____ d. able to describe how they set up the sexual abuse.
- _____ e. shares how they exploited their victim(s)

_____ 2. accepts full responsibility for the molestation.

_____ 3. admits betrayal of trust of the victim.

_____ 4. understands how victim(s) feels now and at the time of the abuse.

_____ 5. has developed the cycle of abuse for when he was abusing and now.

_____ 6. has developed his own written protection and prevention plan and demonstrates an ability to use it.

_____ 7. recognizes and acknowledges how the sexual abuse(s) was(were) harmful to members of victim(s) families and self.

_____ 8. understands why the law is the way it is, understands why the community responded to his actions, and believes many reasons why not to re-molest.

SELF-EVALUATION

A=Accomplished W=Working On NW=Needs Work NYA=Not Yet In Group NA=Not Applicable

The offender:

_____ 1. is able to identify own strengths as well as shortcomings.
_____ 2. is able to identify ways in which power and control were used to manipulate others.
_____ 3. is able to demonstrate appropriate ways to problem solve.
_____ 4. identifies appropriate areas of pleasure in life and demonstrates the ability to take care of self.
_____ 5. has demonstrated an ability to manage anger appropriately.
_____ 6. is able to identify the many parts of a healthy relationship and demonstrates an ability to participate in healthy relationships.
_____ 7. is able to discuss how the sexual abuse(s) affected his behavior and self-image.
_____ 8. is able to demonstrate appropriate forgiveness of self for the sexual abuse(s).
_____ 9. has worked out a way to regain some trust of family members.
_____ 10. is able to identify past destructive sexual behaviors, attitudes, and thinking errors.

COMMUNICATION

A=Accomplished W=Working On NW=Needs Work NYA=Not Yet In Group NA=Not Applicable

The offender:

_____ 1. communicates honestly with others.
_____ 2. is able to identify and verbalize feelings.
_____ 3. is able to recognize past and present poor communication.
_____ 4. is able to demonstrate direct communication patterns.

PARTICIPATION

A=Accomplished W=Working On NW=Needs Work NYA=Not Yet In Group NA=Not Applicable

The offender:

_____ 1. comes to group prepared to contribute actively to the group process.
_____ 2. can appropriately support and challenge other group members.
_____ 3. is willing to share honestly thoughts, feelings and opinions with other group members.

TYPES OF DENIAL

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1. Denial of Facts - Act as if abuse had not happened - only admit to one deviant act.

2. Denial of Awareness - Lapses in memory - Pseudoamnesia - Blackouts.

3. Denial of Impact - On family and victims - frequently misguided to perpetrator himself.

4. Denial of Responsibility - Seductive behavior of victim - problem with spouse - or benevolent institution - educating the child.

5. Denial of Grooming Oneself. The environment spontaneous and without planning.

6. Denial of Deviant Sexual Arousal. Inappropriate sexualization of non-sexual problems. Does not acknowledge sexual purpose of behaviors.

7. Denial of Denial. Minimizes role of denial or a protection.

GUIDELINES FOR SHARING SEXUAL ABUSE (PERETRATOR)

I. Who was the victim and what relationship were they to you? (i.e. name, sister, daughter, brother, etc.)

a. How many times did abuse take place with this person?
b. What number was this sexual abuse?
c. How was the victim dressed? (i.e., fully dressed, shirts, swimsuit, dress, etc.)

II. Age and time of sexual abuse

a. Your age at time of this sexual abuse.
b. Victims age at time of this sexual abuse.
c. When did sexual abuse take place? (i.e., year, fall, winter, spring, summer).
d. Time of day sexual abuse took place. (i.e., morning, noon, night).

III. What were you doing prior to the sexual abuse? (i.e. viewing pornographic movies, drinking, dancing, playing games, watching minor child, babysitting, etc.).

a. Where did abuse take place? (i.e. bedroom, bathroom, woods, alley, etc.).
b. Where was everyone else when you abused?
c. What were you thinking prior to sexual abuse? (i.e., how you were going to get them to cooperate, what happens if you get caught, thinking about sexual gratification, thinking about sexual activity with victim, etc.).

IV. Details of sexual abuse (tell what happened).

a. How did you set up the victim? (i.e., wrestling with them, being alone with them, playing, etc.).
b. What did you say to the victim that was sexual? (i.e., can I touch you, make love to me, lick me, touch me, etc.).
c. What did the victim say to you? (i.e., stop, no, I don't want to, I want to, let's do it, it hurts, it feels good, etc.).
d. How did the victim react? (scared, puzzled, frightened, enjoyed it, confused, cooperative, uncooperative, etc.).
e. What sexual activity did you do to the victim? (i.e., perform oral or anal sex, vagina intercourse, touching, etc.).
f. What sexual activity did you have the victim do to you? (i.e., perform oral or anal sex, vagina intercourse, touching, etc.).

OVER

g. How did you get the victim to cooperate? (i.e., playing games, manipulation, threats, bribes, enticement, force, promises, intimidation through body language, or tone of voice, coercion, etc.).
h. Did you persuade the victim to keep the abuse a secret? If so, how? (i.e., treats, bribes, promises, manipulation, etc.).
i. Explain what you got or tried to get out of sexually abusing your victim (i.e., sexual gratification, power and control, need for affection, thrill, rush, etc.).

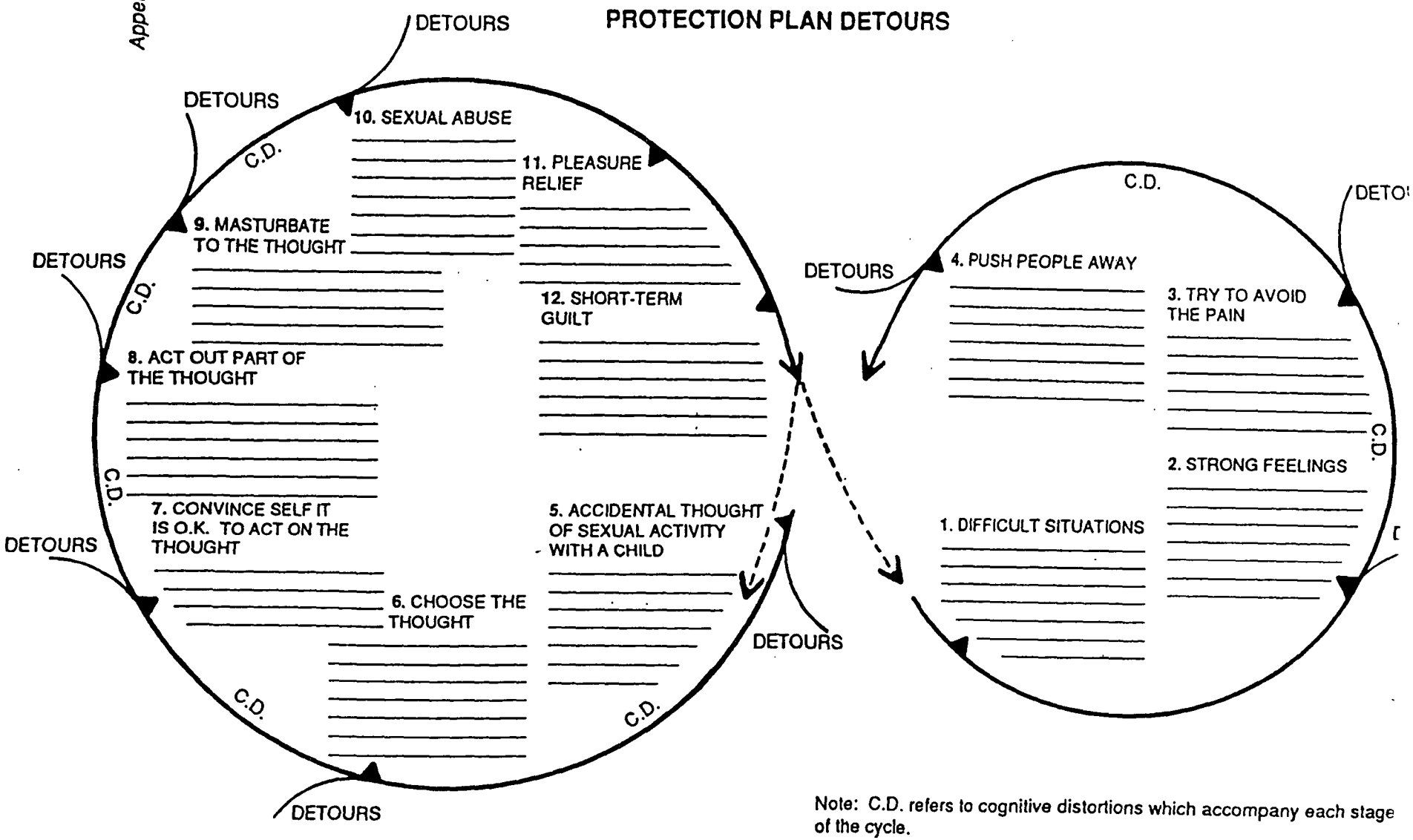
V. Feelings experienced at the time of the sexual abuse (see thinking error worksheet and feeling word handout).

a. What were you thinking and or feeling? (i.e., I hope I don't get caught. They are enjoying this, etc.).
b. How did you feel about the victim? (i.e., easy to manipulate and control, love, hate, just another sex object, they wanted me, they liked it, etc.).
c. How do you feel about yourself? (shameful, guilty, proud, selfish, powerful, etc.).

VI. How has the sexual abuse affected you?

a. Have your behaviors and or feelings changed as a result of your sexual abuse? If so, how? (i.e., won't be alone with minor child, don't hang out where minor children are, don't masturbate to the thought of a minor child, etc.).
b. Have you changed the way you feel about yourself? If so, how? (i.e., embarrassed, guilty, shameful. Feel good about self because I am addressing my sexual abuse issues, etc.).
c. How do you feel about the victim now? (i.e., whore, hate, love, sorry for them, concern for their well-being, etc.).
d. How do you feel about sexual activity now? (i.e., it's great, scared, confused, comfortable, should only take place if married, etc.).
e. What are your motivations to not sexually abuse again? (i.e., fear of getting caught, don't want to hurt more victims, religious convictions, against moral values, etc.).
f. How might your sexual abuse hurt or affected your victim. (See sexual abuse victim worksheet).

CYCLE OF ABUSE WITH PROTECTION PLAN DETOURS



Note: C.D. refers to cognitive distortions which accompany each stage of the cycle.

This Cycle of Abuse was developed with the assistance of John Elsasser and David Muldrow.

Tips to Use When Working with Hostile and Resistant Clients

1. Do not put a premium on getting the client to "like" you; rather you must try to earn his/her respect.

2. If you use a "challenging" style, be sure to be direct and firm but without forcing the client into a corner where an attack is the only way out.

3. Do not think that you must manipulate or do things that are contrived to win the client's favor (ie: use street language, dress in a certain way, etc).

4. Avoid the twin pitfalls of gullibility and cynicism.

5. Be alert to problems of semantics; that is, a client may use a regular every day word and mean something totally different from your interpretation of it. Ask for clarification.

6. If the client is directing, threatening or using intimidating dialogue, remind the client of the "group rules" and that "this type of behavior is not acceptable."

7. If the client becomes threatening to the therapist or to any member of the group, ask the client to leave the group if they can not control their anger.

8. If the client becomes threatening to one of the therapists, it is helpful for the co-facilitator to intervene and let the client know that the topic will be discussed after group with both facilitators.

9. If the client does have a probation officer, it is the therapist's responsibility to inform the probation officer of the client's behavior.

10. If you have a member in group that you know has the potential of losing control, go over a "safety plan" with your co-facilitator (ie: One facilitator can be positioned by the door for easy access; call 911; let the receptionist know before group that there could be a problem and to be ready to call 911).

11. Expect to have to repeat the same point in different ways.

12. Do not be totally consumed by whether the client is currently telling the truth. "Playing detective" (if over done) can stand in the way of what you are doing.

13. Take the position in counseling when dealing with "truthfulness" that it is the client's life whether he/she is sincere. This will eventually come out over time.

14. Avoid ridicule, anger, or sarcasm.

15. Ask yourself before each group "What do I expect to accomplish?" Then ask yourself if this is realistic.

Adapted from: Stanton E. Samenow, Ph.D. Some Considerations in Interviewing Hostile and Resistant Clients.

Managing Adult Sexual Offenders in the Community
A Containment Approach

Five Part Model

I. Overall Philosophy and Goal: Community and Victim Safety.

II. Sex Offender Specific Containment: individualized case management system
- Sex offender specific treatment
- Official supervision and monitoring
- Polygraph exams

III. Collaboration - a multi disciplinary approach
- Inter-agency policy and protocol committee
- Case management supervision teams

IV. Consistent Public Policies
- Avoid no contest pleas
- Avoid please to non-sex offenses
- Avoid deferred judgement

V. Quality Control
A. Monitoring
B. Quality Control

National Institute of Justice
January 1997

Expert Testimony in

Child Abuse Cases

Presented by

Paul Stern, JD

SURVIVING IN THE COURTROOM
Twelve Rules of Testifying as an Expert Witness

By Paul Stern
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It scares both of us, but for different reasons. When the "expert witness" takes the stand in a criminal trial both the witness and the prosecutor generally panic a little. And for good reason.

For the expert witness the fear is that they will say something wrong and all the lawyers will jump up and start carrying on, screaming and pointing shaking fingers in their general direction. As the prosecutor, the fear is that what the witness has told me in my office five minutes ago, are words I may never hear again. Worse yet, that the witness will fall easy prey to the defense attorney's cross-examination, sometimes even before the second question is asked.

Fear no longer.

If both the witness and the prosecutor understand what is expected of them there is no reason to fear. First, learn how the criminal justice system works and learn how to testify without hoping the earth will open up and swallow you whole. Here then to help you through, are 12 Rules of Testifying as an Expert Witness.

Rule #1: Know why you are in court.

The expert is in court for one reason: To educate. This is true whether the expert is a doctor, psychologist, social worker, forensic scientist, or any other professional. As you re-create for the jury what occured, you educate them. First on the facts of what you saw, heard, smelled, felt, touched, etc. And, if you have the expertise (you do, as we will learn in Rule #2) to educate the jury about what all these observations mean.

The expert is not there to convict anyone. You are not there to defend the victim. You are not there to justify another person's actions. You are there to educate. You are to give facts to the jury, and, when asked, and only then, to offer your opinions about the meaning and significance of those facts. This is all in the process of education. And that is the only reason why you are in court.

* * *

Rule #2: You are an expert.

In legalese an expert means someone who has skills, training or specialized knowledge sufficient to "assist the trier of fact to understand the evidence or to determine a fact in issue". An individual may be deemed an expert based upon their knowledge, skills, experience, training or education.

In translation, it means someone who has an opinion that is worth listening to.

You went to college to get specific education and training in your profession. You have read text books and professional journals. You have attended seminars and talked with peers. You likely work in an area of specialization within your profession. You have experience working with some cases similar to the one that has brought you to court. If you have done any one of these you have some knowledge, skills, training or education sufficient to assist the trier of fact to understand the evidence or a fact in issue in the trial.

(Suggestion: Keep a file listing every relevant training, seminar, etc. you have attended. You may think it is unimpressive, but it's more training than the jurors have had. If presented right, the judge and jury will be duly impressed.)

You will be asked to outline all of your training to the judge and jury. Then, you will be able to tell us what you think the facts you talked about (Rule #1) mean. What you think the facts mean is your opinion. Your opinion, based upon your experience. That makes you an expert. The jury will decide if they want to accept your opinion, or reject it. But the fact that you have an opinion and it is based on things outside of the general knowledge of the average juror is what makes you an expert. And you are.

CAUTION: Never give an opinion about things you are not trained in. Never give an opinion you can not support. Which brings us to....

* * *

Rule #3: Don't get carried away.

Now that you have been allowed to give an opinion don't get carried away.

Giving an opinion can be addicting. You might start thinking this is fun. You might start thinking that now that you're an expert, you're an expert on everything. When that happens you are about to become an easy mark. With that attitude a competent defense attorney will soon have you picking stocks for us.

Limit yourself to those areas in which you really, really are trained. Don't get greedy or you'll get humbled. Fast.

* * *

Rule #4: Tell the truth.

Always.

Enough said.

* * *

Rule #5: Don't be a sucker. Shop before you buy.

By this point you will have been permitted to testify about some of your opinions and interpretations of the evidence. You have also properly limited your expertise to only specific areas. You have shown competence and humility. Now show wisdom.

An opposing attorney may try to cross-examine you with articles, books, other peoples opinions, even things you have said previously. You will be confronted with something that appears contradictory in an effort to show that your opinion is inconsistent with these other sources. For example:

Atty: "Do you know of The Book by Dr. I. M. Agenius?"

You: "Well, yes. It is the book in this field."

Atty: "Well, at page 497 Dr. Agenius says 'xyz', which is exactly opposite of what you have told us."

You now have three options. You can say:

1. "Well, I'm right and he's wrong." Do this and you sound like a smart-alec and are only 3-4 questions away from being humiliated. Or picking stocks.

Or 2. "Oh. Well, I guess I am wrong then. Never mind." Thank you for coming in, I can't wait to work with you again. Do send me a bill for your services.

Or 3. "Really? May I see that, perhaps you are taking something out of context or have misunderstood what the Dr. has said." Bingo!!

Ask to see it (sometimes the attorney may not even have the book/article with him) read it, consider it, compare it, and almost every time you'll find that something has been taken out of context, or misrepresented by the attorney. When that happens you can demonstrate that not only are you right (and the other attorney devious) but even Dr. Agenius agrees with you.

* * *

Rule #6: Prepare.

The prosecutor will have read your reports many times. The other attorney will have read your reports many times. When you are fumbling through pages giving us lots of "It's in here somewhere" and "I think I remember....", you sure won't look very professional.

You will be expected to have read your notes and reports and to know the facts cold. Remember you are an expert. You need to look, sound (and dress) like one. If you do not know what is in your report, stay home. You'll be of no help.

Preparation, though, is more than just re-reading your reports and notes. You must meet with the attorney before you testify. You must find out exactly what is expected of you. If the attorney has not called you to arrange a meeting, call him. If he does not call you back, call again. And again. If you still get no response call his supervisor and then the supervisors supervisor if need be. You need to know why you are being called as a witness, and what to expect.

You also need to meet with the prosecutor to help educate him. Preparation sometimes means making sure the prosecutor knows what specific questions to ask you in court to get the most out of your testimony.

(While testifying acknowledge that you met with the prosecutor, if asked. Why?: Because you did. See Rule #4. The prosecutor will establish through his questions the parameters of that meeting.)

Preparation continues even after you testify. Debrief with the prosecutor. Debrief with the court staff and court reporter who heard your testimony. Discuss what you did well and what you did poorly. Discuss what the prosecutor did poorly and what questions were not asked of you that should have been to have gotten more out of your testimony.

Reflect on what points the defense raised in cross-examination. Use the cross-examination as an education. Perhaps you will learn that you should alter your protocols, note-taking practices, etc. Each time you testify you should learn something that will make you a better witness next time.

* * *

Rule #7: Speak English.

Talking to a jury is like explaining to your client/patient your diagnosis. Talk to the jury like you do when you explain to your client/patient what has happened and what they need to do. Keep it simple. Make it easy to understand. Talk at the same level as when you are talking to your 12-year-old nephew. If you use technical words, define them. Look the jurors in the eye (it's okay to physically turn your body to make eye contact) and make sure they are understanding what you say.

Use analogies or examples whenever possible. If you can explain your observations, medical terminology, syndromes, untraditional behavior, etc. by making comparisons to everyday events, you convey your point more graphically.

* * *

Rule #8: Say it three times. At least.

The prosecutor should be able to get you to get your opinion across to the jury at least three separate times. That, if nothing else, increases the odds that all jurors were awake and listening when you offered your opinion. More important, it shows you did your job right. Observe:

1. The first time through you talk about the overall theory of your work. What you are trained to generally look for and why. This educates the jury to the field.

2. The second time through, you talk about either a hypothetical case or a prior, similar one and what you would look for in that case. The jury is educated a second time about what you, as an expert, should do.

3. The third time you'll talk about this case. When you explain what you did, what you looked for, what you observed, etc., the jurors will think, "Ah, she did it right. She did it exactly the way she's supposed to." Your opinion carries even more weight now.

* * *

Rule #9: Be yourself.

It's nice to go and listen to your colleagues testify so you have an idea of what a courtroom looks like, and what might happen. (And to be assured that, yes, you will come out alive.) But when you testify do not copy someone else's style.

Listen to the questions. Think about your answer before you give it. Relax. And tell the truth.

Do not try to be anything, or anyone, you're not.

All you are doing is having a nice, albeit formal, chat with the 12 people who comprise a jury.

* * *

Rule #10: You be the witness, I'll be the lawyer.

Your job is to answer questions. My job is to ask questions and to object to the other attorney's questions. I can't do your job. Please do not do mine.

You can not and should not volunteer information. If the prosecutor did not ask for certain information, please do not give it. There may be valid legal reasons why a specific question was not asked. Volunteering information beyond what the question calls for may jeopardize the case. For example, your answer may violate a prior court order limiting testimony, and your volunteered response may result in a mistrial. Alternatively, your volunteered response may run counter to tactical decisions made by the prosecutor. Accept that. Please, just answer the questions asked and do not try to help.

In Washington State there are 63 Rules of Evidence. Most of them have required appellate court judges to interpret. When an attorney asks a question, you are not to decide if it violates one of these 63 Rules of Evidence (i.e. it's hearsay). That is the attorney's job. It may be an improper question; it may fall within some exception to an evidential rule; it may be objectionable but for tactical reasons the prosecutor may elect to not object. Let the lawyer decide this. You have enough to do being a witness. Don't play lawyer, too.

* * *

Rule #11: There is no such thing as a bad transcript.

In criminal cases, if the defendant is convicted he can appeal. If he is acquitted the State can not appeal. When he is convicted and appeals, a transcript of your testimony will be prepared. If you have done your job properly, i.e. prepared the case, offered an informed, honest opinion, without over-reaching, then, if you're right and everything else works, the defendant may well be convicted and a transcript of what you said will be prepared. If you have not done your job, not prepared or have offered opinions in a lazy, unsupported, or over-reaching manner, then your testimony may sound unprofessional and unconvincing and there will be no transcript, as there will be no conviction.

* * *

Rule #12: Understand that the jury system is, by definition, illogical.

The first thing that happens when a criminal trial starts is both sides get to inquire of the prospective jurors whether they know the defendant, the victim or any of the witnesses. If so they are not allowed to serve as a juror. We then eliminate those who have had experience with the particular type of offense involved in this trial. Next we get rid of those with strong feelings about it. In time we insure that no one sits on the jury if they know anything about the case, the people involved or the issues involved.

Next, we bring before the jury, as witnesses, all the people who were present when the crime was committed and know what happened. But the jury is not allowed to ask these witnesses any questions.

We also make sure that the jury is not allowed to know the answer to the one question they most want to ask: Has this defendant done this stuff before?

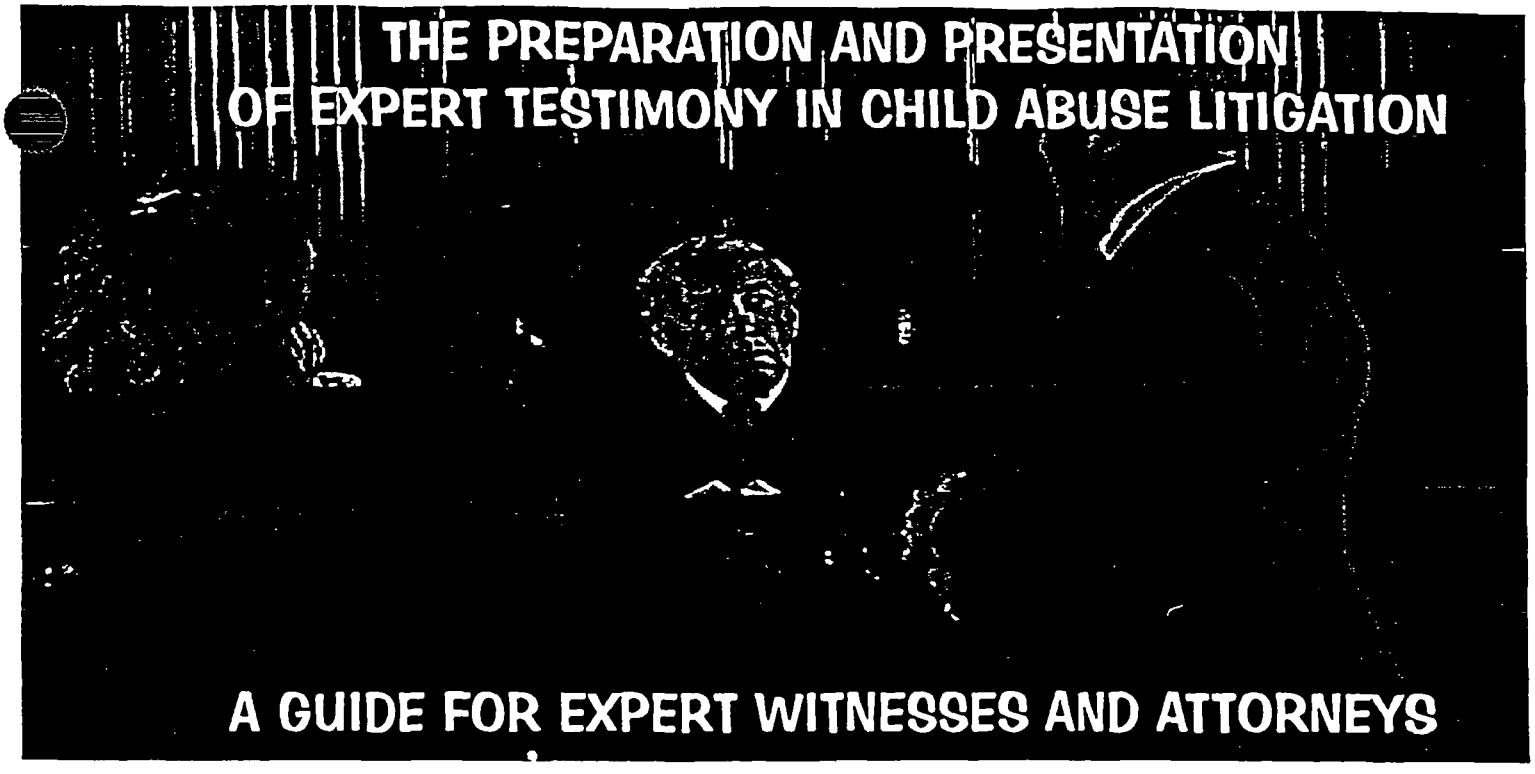
When it is all over, the jury, those people who we select because they know nothing and weren't there, tell all those people who were there what really happened by their verdict.

Understand this and you can see why bizarre verdicts can occur. But you can also understand why so much of the witnesses job is to be a re-creation expert.

Understanding this will also allow you to realize that care as you might, and try as you might, the criminal justice can not be expected to always get it right. This system works better than any other we can create, but it is not always able to guarantee an infallible judgment, or always properly solve a dispute.

The best chance for success however is for the prosecutor and the expert to be fully and properly prepared.

THE PREPARATION AND PRESENTATION OF EXPERT TESTIMONY IN CHILD ABUSE LITIGATION



A GUIDE FOR EXPERT WITNESSES AND ATTORNEYS

***by PAUL STERN**, Senior Deputy Prosecuting Attorney, Snohomish County, Everett, Washington*
with Benjamin E. Saunders

"I found the book extremely interesting and informative. I was particularly impressed with the practical advice given in the text, advice that is often found in the legal literature. . . . The writing is clear and compelling, and Paul Stern's style is perfect: he entertains as he educates."

—Thomas D. Lyon, *The Law Center, University of Southern California, Los Angeles*

Called upon to educate courtroom decision makers, the expert witness provides testimony that is critical to achieving intelligent and just verdicts. Few judges and jury members possess the knowledge base needed to adequately understand complexities of human behavior as they relate to acts of interpersonal violence. While the lay witness can testify to actual incidents or observations, it is the "expert witness" who can provide forensic significance to such evidence. With this vital insight, courts can more accurately assess and weigh evidence, leading to more informed and appropriate decisions.

Timely and accessible, **The Preparation and Presentation of Expert Testimony in Child Abuse Litigation** clearly defines the need for and role of expert witnesses in litigation. Author Paul Stern demystifies the process while providing practical, stepwise guidance for those who want to prepare and present expert testimony with confidence and clarity. Beginning with discussions of the who, what, and why of expert testimony, the book also defines the role of the expert, including ethical and professional issues that may arise. Filled with tips, techniques, and case examples, chapters also show expert witnesses and attorneys how to prepare for court, how to present testimony in the most convincing and credible manner possible, how to deal with cross-examination, and how to cross-examine irresponsible expert witnesses.

Anyone who may be called upon to testify—or participate in court in any way—in cases of interpersonal violence will find this book an invaluable resource. In particular, mental health professionals, medical personnel, dentists, investigators, attorneys, and judges will want to use the book to prepare themselves for the rigors involved in every aspect of expert testimony.

CONTENTS: 1. The Need for Expert Testimony / 2. Who Are the Experts? / 3. The Preparation of Expert Testimony / 4. Presenting Expert Testimony in Court / 5. Dealing with Cross-Examination / 6. Medical and Mental Health Professionals as Experts in Legal Cases *B. E. Saunders* / 7. Cross-Examining the Irresponsible Expert Witness

Interpersonal Violence: The Practice Series
1997 (February) / 202 pages (tent.) / $46.00 (h) (00128) / $19.95 (p) (00136)

Community Based Healing:

A Treatment Model for Native and Rural Communities

Presented by

Eidell Wasserman, PhD

COMMUNITY-BASED HEALING: A MODEL FOR NATIVE AND NON-NATIVE COMMUNITIES

Eidell Wasserman, Ph.D.
Wasserman, Leviton, & Hodder Consultants
5241 Hutchinson Road
Sebastopol, CA. 95472
(707) 824-8308

Through years of working in Native American communities, and talking with many providers and recipients of mental health care in these communities, the need for a community-based approach to the provision of mental health services is obvious. This approach has broad utility beyond Native communities, particularly in rural areas. The same basic principles apply to other small, close-knit communities, particularly those with a history of oppression.

The challenge for service providers is to develop these community-based interventions. Several locales have developed such approaches. The common factors of a community-based healing approach are:

1. The community defines the problem
2. Community members initiate programs and events
3. Service providers provide logistical support
4. The interventions are broadly based
5. The interventions incorporate community values and traditions

Child Sexual Abuse Exam:

Normal and Variants of Normal

Presented by

John Stirling, MD

Medical Terminology Relevant to Child Sexual Abuse

compiled by John Stirling, MD
Vancouver Clinic, Vancouver, WA

Prefixes / Suffixes

a-	not; avascular = not vascular
hyper-	more
hypo-	less
infra-	below
supra-	above
circum-	around
peri-	next to
vaso-	relating to blood vessels
leuko-	white, as in a discharge (leukorrhea)
cyano-	blue
-itis	denotes inflammation
-osis	denotes a process or condition
-rrhea	flow of liquids

Injuries

Abrasion	wound caused by scraping
Excoriation	abrasion, caused specifically by scratching
Laceration	wound caused by incision
Transection	cut or tear through a tissue
Fissure	crack or split in the skin
Hemorrhage	flow of blood from a wound; may be internal or external
Hematoma	mass resulting from blood beneath the tissue surface
Contusion	bruise
Ecchymosis	refers specifically to the discoloration caused by a bruise
Petechiae	small hemorrhages, about pinhead size; usually caused by pressure
Adhesion	scar tissue joining one tissue to another
Synechia	synonymous with *adhesion*

Conditions

Inflammation	condition in which tissues are red, hot, and swollen
Hyperemia	redness due ro increased blood flow
Edema	swelling
Discharge	normal or abnormal production and release of fluids

Male and Female Anatomy

Anus	opening to the rectum
Rectum	last segment of the colon
Pudendum	external genitalia
Perineum	area between the tailbone and the pubic bone
Mucous membrane	any membrane producing mucous secretions; *mucous membranes* cover the internal female genitalia and line the oral cavity

Female Genitalia

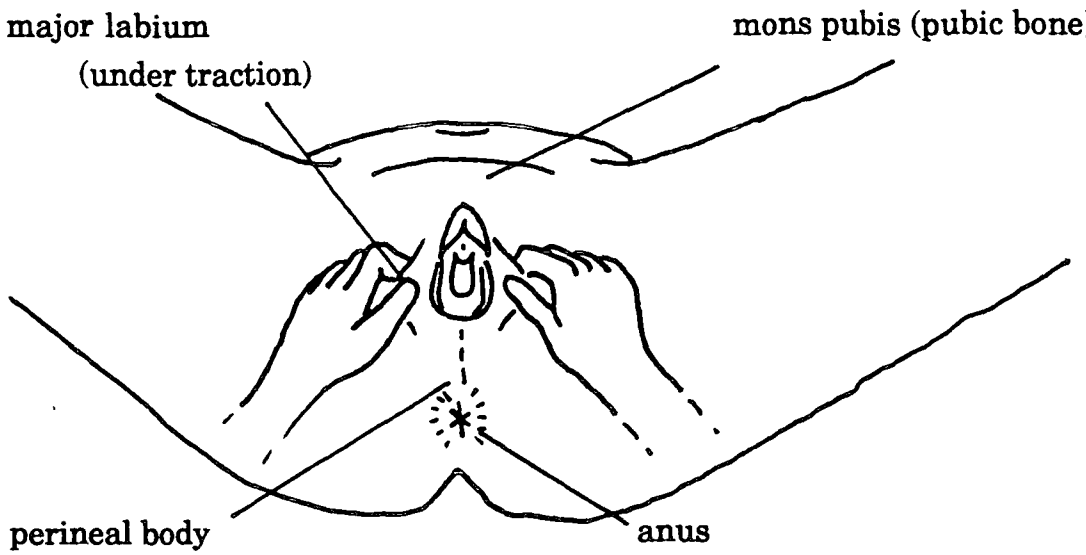
**Major labia*	outer vaginal "lips"; covered with pubic hair when mature
**Minor labia*	inner vaginal "lips"; covered by mucous membrane
**Clitoris*	erectile tissue analogous to male penis; covered by the *clitoral hood*
**Urethra*	opening to the bladder
Vulva	female *pudendum*
**Vagina*	genital canal extending from the *vulva* to the *cervix*
Cervix	the end of the uterus; protrudes into the *vagina*
**Hymen*	a thin, elastic membrane partially occluding the opening to the *vagina*; separates external and internal genitalia
**Sulcus*	trough separating the *hymen* from the *minor labium*
Vestibule	space external to the *hymen*
**Posterior Fourchette*	junction of the *minor labia* below the *vagina*
**Fossa Navicularis*	shallow depression behind the *fourchette*

*(* indicates area designated on diagram of female genitalia)*

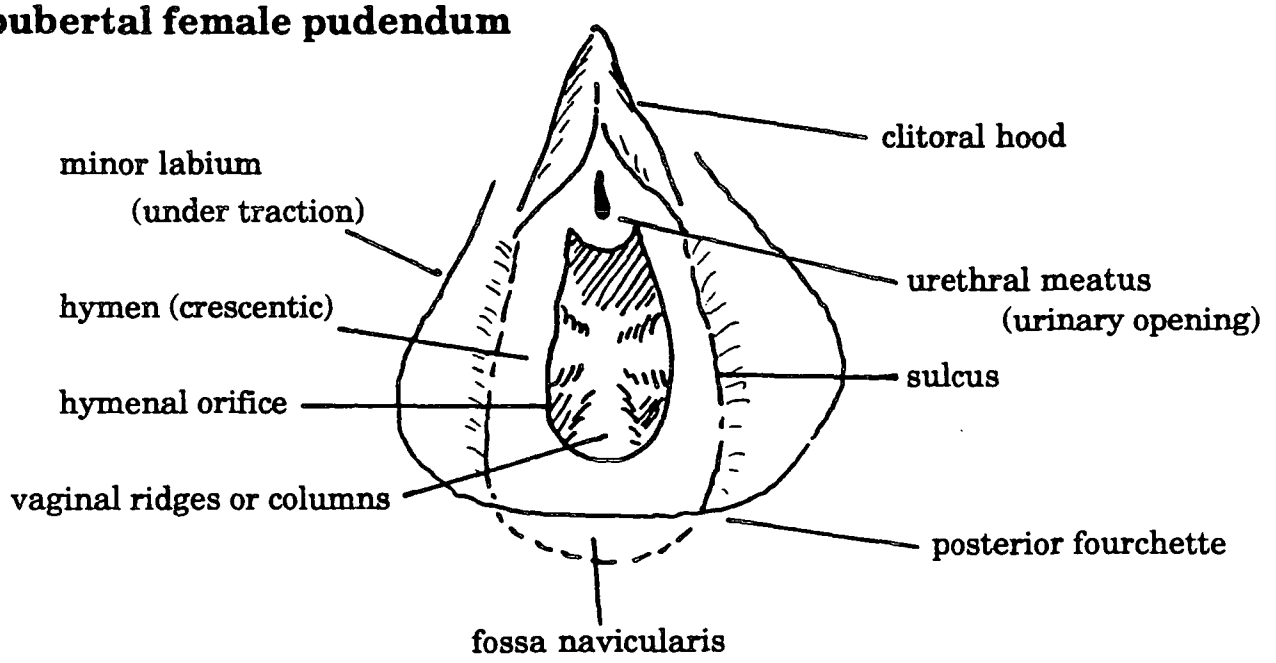
Male Genitalia

Phallus	penile shaft
Glans	bulbous end of the *phallus*
Foreskin	tubular sheath covering the *glans*; removed during circumcision
Urethra	opening to the bladder; longer and more tubular in males
Testes (*dim.* testicles)	male reproductive glands
Scrotum	sack containing the *testes*

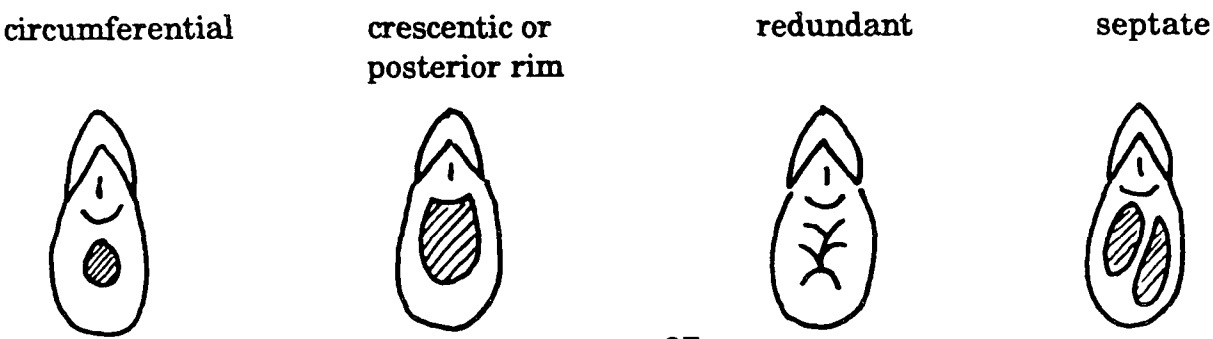
Prepubertal female perineum (supine "frog-leg" position)



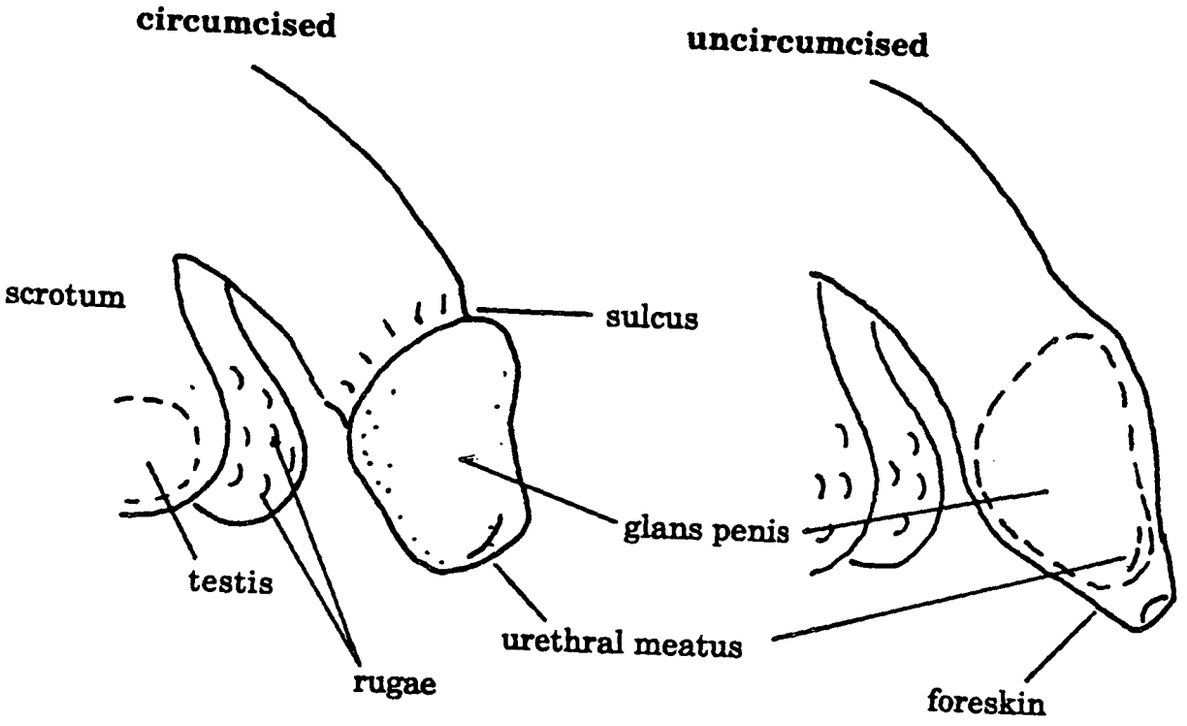
Prepubertal female pudendum



Types of hymen



Male external genitalia



Medical Issues for the Non-Medical Professional: Physical Child Abuse

John Stirling, MD
Child Abuse Intervention Center
Vancouver, WA

General considerations:

differences between child abuse and other medical cases
- history usually unavailable or unreliable
- different "standard of evidence" than medical evaluation
- differential diagnosis

1st concern: Is injury consistent w/ explanation?

Evaluation considers:

- ✔ **Force** involved in injury
  - type
  - amount
  - vectors
- ✔ **Dating** of injury
- ✔ **Pattern** of injury
- ✔ **"Natural history"** of similar injuries

...and compares what is seen with what would be expected.

Common abusive scenarios:

- Skin trauma
  - bruising
    - force - varies
      - impact v area
      - bleeding disorders?
    - dating - inaccurate at best
    - patterns - shapes, locations, ages
  - burns
    - types - scalds, chemical, electrical, flame
    - accidental v neglect v intentional
  - bites
    - forensic significance
- Fractures
  - force - varies
  - dating - x-ray, clinical

screening skeletal surveys - how and for whom?
pattern - significance of location and type of fracture

- Abdominal / thoracic injuries
  - force - significant force needed
  - pattern - shearing v hydrostatic mechanisms
  - dating - can be difficult

- Head injuries
  - fractures
    - pattern - compound, diastatic
    - force - relates to type
  - brain
    - force - shaking v impact
    - dating - CT v MRI
    - pattern - edema, hemorrhage, parenchymal damage
      retinal hemorrhages

- Fatalities
  - special considerations
    - autopsy / ME involvement
    - law enforcement investigators may differ from abuse team
    - role of death review team
  - special cases
    - SIDS v suffocation
    - drownings, poisonings - accidental v neglect v intentional

Resources

General Reference Texts: *up-to-date, broad coverage of the field of child abuse*

- American Academy of Pediatrics, Section on Child Abuse and Neglect. (1994). A guide to references and resources in child abuse and neglect . Elk Grove Village, IL: AAP.
- Briere, J., Berliner, L., Bulkley, J., Jenny, C., & Reid, T. (1996) The APSAC handbook on child maltreatment . Thousand Oaks, CA: Sage.
- Kleinman, P.K. (1987). Diagnostic imaging in child abuse . Baltimore: Williams & Wilkins.
- Reese, Robert M. (1993). Child abuse: Medical diagnosis and management. Malvern, PA: Lea & Febiger.

Periodicals: *can bring the practitioner news long before it appears in texts*

- *The APSAC Advisor;* 407 S. Dearborn, suite 1300, Chicago, IL 60605 (Email at apsacmems@aol.com) *Available quarterly to members of APSAC. Good review articles cover various disciplines; news of the field.*

- *The Quarterly Child Abuse Medical Update* ; Institute for Professional Education, Massachusetts Society for the Prevention of Cruelty to Children; 43 Mt. Vernon St., Boston, MA 02108. $80 / yr. *Quarterly abstracts from current medical journals, with expert commentary.*

Date Rape, Acquaintance Rape and Relationship Violence of Teens

Presented by

Elda Dawber, LICSW

rape crisis center, *n.*, a place where all Rhode Islanders can receive confidential support, advocacy and information about sexual assault.

PROTECTING YOURSELF FROM DATE/ACQUAINTANCE RAPE

FOR WOMEN (and men):

--Examine your feelings about sex
--Set sexual limits
--Decide early if you would like to have sex
--Do not give mixed messages -- be clear
--Be alert to other unconscious messages you might be giving
--Be forceful and firm
--Be independent and aware on your dates
--Do not do anything you do not want to do just to avoid a scene or unpleasantness
--Be aware of specific situations in which you do not feel relaxed and in charge
--If things get out of hand, be loud in protesting; leave; go for help
--Trust your gut-level feelings
--Be aware that alcohol and drugs are often related to acquaintance rape
--Avoid falling for such lines as: "You would if you loved me"
--If you are unsure of a new acquaintance, go on a group or double date
--Have your own transportation, if possible, or cab fare
--Avoid secluded places where you are in a vulnerable position
--Be careful when having someone to your house, or going to his
--Examine your attitudes about money and power
--Think about the pros and cons of dating older men
--Socialize with people who share your values

BE FIRM AND ASSERTIVE. MAKE HONEST, DIRECT STATEMENTS.

TALK ABOUT WHAT YOU LIKE AND WANT.

SAY "NO" FIRMLY TO WHAT YOU DO NOT LIKE AND DO NOT WANT.

300 Richmond Street, Suite 205, Providence, Rhode Island 02903-4222
401 421-4100 Fax 401 454-5565

rape crisis center, *n.*, a place where all Rhode Islanders can receive confidential support, advocacy and information about sexual assault.

FOR MEN (and women):

--It is never OK to force yourself on a woman, even if:

--she teases you
--she dresses provocatively
--she leads you on
--she says "no", and you think it means "yes"
--you've had sex with her before
--you've paid for her dinner or given her gifts
--you think women enjoy being forced or persuaded
--the woman is under the influence of alcohol or drugs
--you are married to her

--Rape is illegal
--If you are getting a double message from a woman, speak up and clarify what she wants
--Do not assume you know what she wants or means or needs
--Be sensitive to women who are unsure
--Do not assume you both want the same degree of intimacy
--Do not let your sexual desires control your actions
--Communicate your sexual desires honestly and early
--If you have any doubts about what your partner wants: STOP! ASK! CLARIFY!
--Your desires may be beyond your control, but your actions are within your control
--Do not assume her desire for affection is the same as a desire for intercourse
--You do not have to "score" to be a real man
--A woman who turns you down for sex is not necessarily rejecting you as a person
--No one "asks" to be raped
--"No" means "NO"
--Taking sexual advantage of a person who is mentally or physically incapable (drunk) is rape
--The fact that you were intoxicated is not a legal defense to rape
--Be aware that a man's size and physical presence can be intimidating to a woman

LISTEN TO, AND RESPECT, WHAT YOUR PARTNER IS TELLING YOU

THERAPEUTIC INTERVENTIONS WITH RAPE VICTIMS

Rape victims are most accessible to intervention during the Acute Phase and the Recurrence Phase.

During the Acute Phase, intervention should be directed at returning control to the victim, helping her to mobilize her social support network and encouraging her to talk about the rape and the feelings it has aroused.

During the Reorganization Phase, the victim is actively working to regain control in her life. She can benefit from support but is likely to be uninterested in exploring her feelings.

During the Recurrence Phase, the victim is usually ready to deal with the issues and feelings which remain. She can benefit from discussing her feelings and concerns.

Therapy should be aimed at helping her accept what has happened and to integrate the experience with her view of herself.

Therapy should also explore her feelings about the offender. Many victims need encouragement to remove the anger and blame for the rape from themselves and to place it on the offender.

Relationship problems and sexual problems may also need to be addressed at this point in treatment.

ACQUAINTANCE RAPE

I) INTRUSION STAGE:

WHERE ONE PERSON VERBALLY OR PHYSICALLY INVADES THE SPACE (LIMITS, COMFORT ZONE) OF ANOTHER PERSON

II) DESENSITIZATION STAGE:

WHERE THE ASSAILANT CONTINUES INTRUSIONS UNTIL THE VICTIM BECOMES DESENSITIZED, OR USED TO THEM.

III) ISOLATION STAGE:

IN WHICH THE ASSAILANT PLANS TO GET THE VICTIM ALONE IN ORDER TO RAPE, BY MANIPULATION OR BRUTALITY

DO'S AND DON'T'S

-DO DEVELOP SPECIFIC SCHOOL POLICIES ABOUT SEXUAL HARASSMENT --AND PROCEDURES, TOO

-PUBLISH AND CIRCULATE POLICIES AND PROCEDURES

-DO ASSIGN AN ADULT YOUTH CAN GO TO IF HARASSED

-DO REPORT SEXUAL HARASSMENT

-DON'T IGNORE WHAT YOU SEE AND HEAR ABOUT

-DO PRACTICE GOOD ROLE-MODELING BEHAVIOR

-DO NOT TELL OR TOLERATE JOKES THAT DEMEAN WOMEN

-DON'T CONDONE HARASSMENT BY MALES OR COLLUSION BY WOMEN OR MEN

-DO ENCOURAGE SCHOOL PAPERS TO DO STORIES ON SEXUAL HARASSMENT IN YOUR SCHOOL

-DO WORK TO REDUCE TEEN DRINKING

-DO FIRMLY GIVE THE MESSAGE THAT <u>NO</u> MEANS <u>NO</u>

-DO ENCOURAGE ASSAULT PREVENTION PROGRAMS IN YOUR SCHOOL, "AWARENESS WEEK", SPEAKERS...

-DO EXTEND PEER HARASSMENT POLICIES TO COVER RACE, DISABILITY AND SEXUAL PREFERENCE AS WELL

-DO FOCUS ON DIGNITY AND RESPECT FOR SELF AND OTHERS

WHY SOME VICTIMS DON'T TELL AND SOME OBSERVERS COLLUDE

--SOME PEOPLE MISTAKE HARASSMENT FOR FLATTERY

--SOME BELIEVE THE BEHAVIOR IS "JUST THE WAY MEN ARE"

--SOME BELIEVE THIS IS HOW TO BE ACCEPTED BY THE GROUP

--SOME FEAR RETALIATION

--SOME CANNOT BELIEVE A "POPULAR" PERSON COULD MEAN HARM

--SOME INITIALLY LIKE THE ATTENTION, THEN FEEL THEY CANNOT COMPLAIN WHEN THE BEHAVIOR ESCALATES

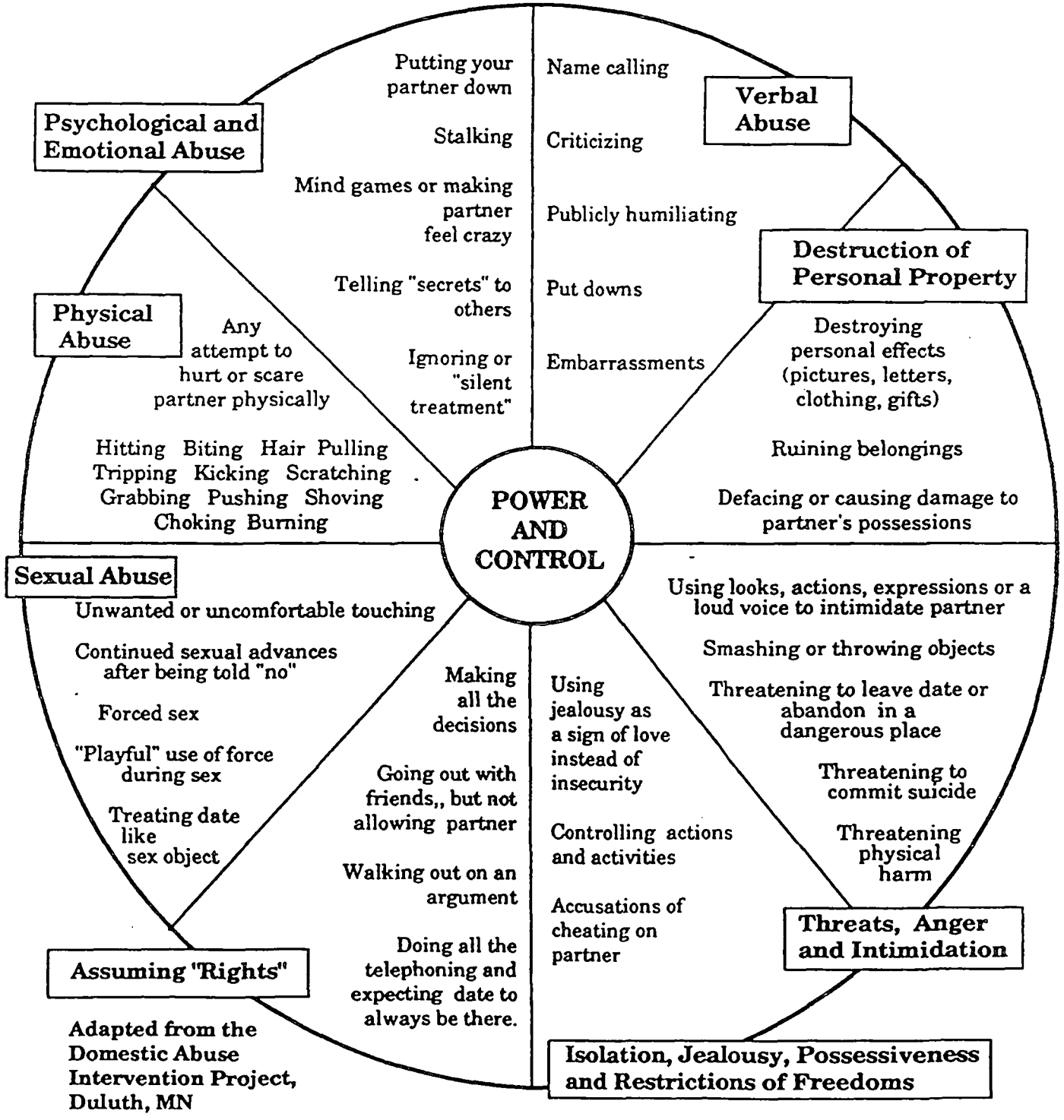
--SOME FEEL HELPLESS OR DON'T KNOW WHAT TO DO

--SOME KNOW THEY WILL NOT BE BELIEVED

--SOME DON'T WANT TO BE LABELED AS SOMEONE WHO "CAN'T TAKE A JOKE", AS A FEMINIST, OR LESBIAN

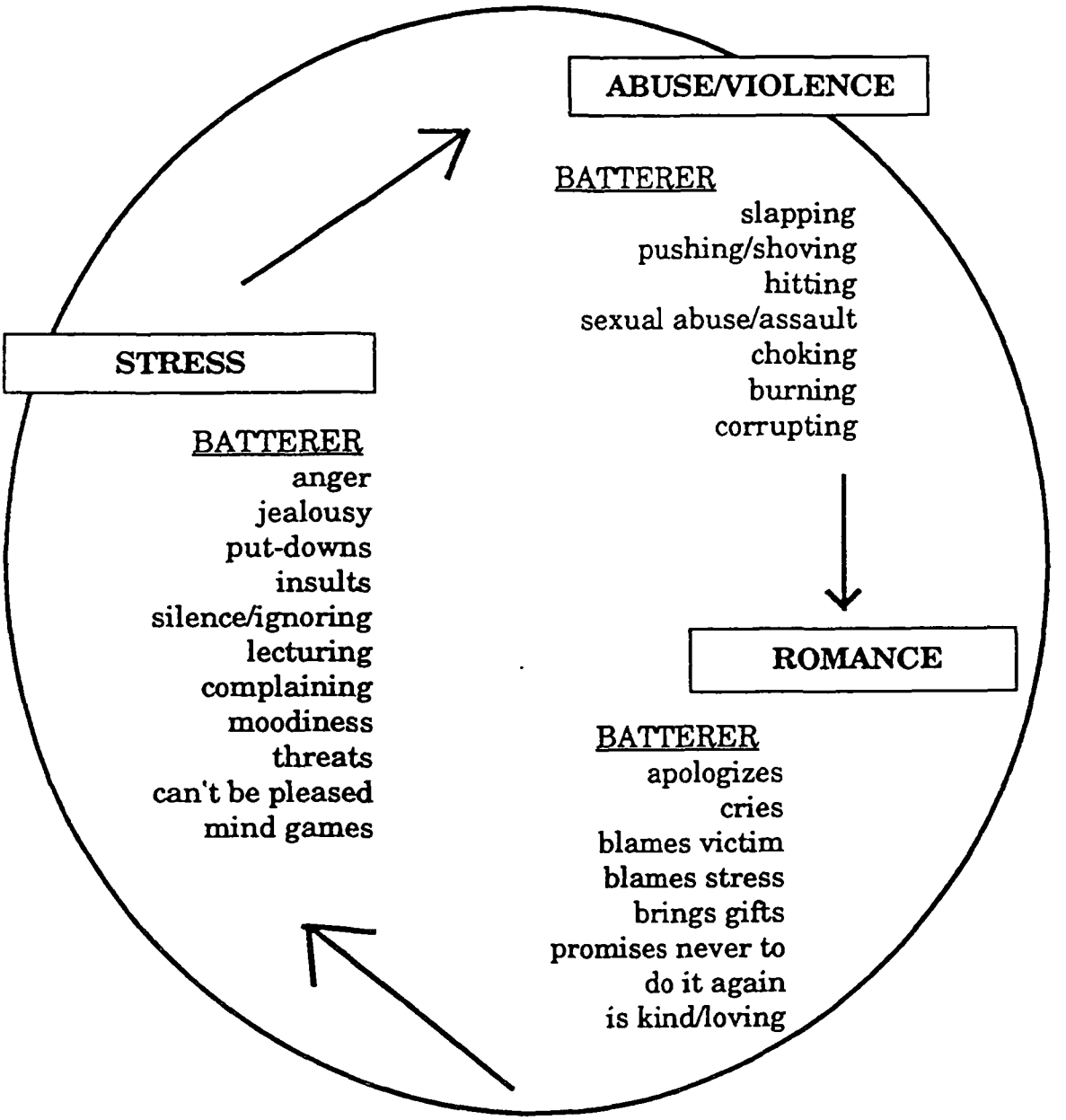
--SOME THINK THE VICTIM ASKED FOR IT BY THE WAY SHE DRESSED, WALKED, LOOKED, TEASED, SPOKE, OR BECAUSE THE VICTIM HAD A "REPUTATION"

POWER AND CONTROL IN DATING



Adapted from the Domestic Abuse Intervention Project, Duluth, MN

CYCLE OF VIOLENCE IN DATING RELATIONSHIPS



DATING VIOLENCE WILL OFTEN BECOME MORE SEVERE AND HAPPEN MORE FREQUENTLY OVER TIME. DATING VIOLENCE IS A CRIME. THERE IS NO EXCUSE.

Adapted from the *Battered Women's Syndrome* by Lenore Walker, Ph.D.

HOW DO I KNOW IF I'M BEING ABUSED?

Sometimes it is difficult to know when you are being abused. Abuse is any behavior that is used to intimidate or control you. These are just some of the examples of abusive behavior.

Does your boyfriend/girlfriend

1. Hit, slap, punch, shove or kick you?
2. Throw objects at you?
3. Threaten to hurt you or your friends?
4. Restrain you?
5. Destroy your property?
6. Consistently ridicule or insult you?
7. Become extremely jealous if you talk to other people or go places on your own?
8. Make you account for every moment?
9. Manipulate you with lies, contradictions or promises?
10. Pressure you for sexual activity?
11. Accuse you of flirting with others?
12. Threaten to harm himself/herself if you break up with him/her?
13. Use drugs/alcohol as an excuse for a violent temper?

How does his/her behavior affect you?

1. Do you feel you don't have the right to say "No"?
2. Are you afraid to disagree?
3. Have you stopped seeing your friends?
4. Do you feel responsible for the abuse?
5. Do you have to get permission to go out with friends, go to parties and school activities?
6. Do you avoid talking to friends for fear that he/she may become jealous and abusive?
7. Are you afraid to break up with him/her?

Relationships And Power

FOUR BUILDING BLOCKS IN UNDERSTANDING DATING VIOLENCE

You are not alone.

Our society often glorifies violence, but then looks the other way and rejects those who are victims of violence, especially victims of interpersonal or sexual violence. Because of this attitude, many people are so ashamed of having been battered that they will not tell even their closest friends. The abuser often isolates the victim or threatens harm if anyone is told. As a result, many victims think that they are the only one involved with an abuser. It is a great relief to find out there are many others dealing with abuse.

The abuse is not your fault.

Everyone's heard the phrase, "You made me do it," or "You pressed my buttons," or "You've got to learn who's boss." All too often the abuser will blame the victim for the abuse. The guilt placed on the victim is a tremendous burden and is the number one cause for lower self-image in victims. Perpetrators are always responsible for their actions. The abuse is *not* the fault of the victim.

If it feels scary, it's abuse.

If you are touched in a personal way that feels scary to you, then it's abuse. If you are touched in a personal way that feels uncomfortable to you, then it's abuse. If you are touched in a personal way that feels bad to you, then it's abuse.

Get some help & support for yourself.

Most abusers refuse to seek help because they don't realize how bad their problem is. Victims often feel too embarrassed or scared to seek help. They also may not realize how bad the problem is. Try to get help from organizations like teen health centers, your local battered women's program, or crisis lines. There are laws to protect victims, shelters for battered women, support groups, and sympathetic people willing to help.

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Child Abuse and Divorce:

Competing Priorities and Agenda

Presented by

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CHILD ABUSE AND DIVORCE: COMPETING PRIORITIES AND AGENDAS

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Abstract: This article addresses the problem of divorce situations in which there are also allegations of abuse. Its focus is on providing guidance for professionals evaluating these cases. It describes the challenges peculiar to cases where divorce and abuse allegations co-exist, relevant research findings, and potential sources of bias. The article suggests a multidisciplinary approach may be the optimal strategy for evaluating these cases. Specific guidelines for evaluation and decision-making are provided.

INTRODUCTION

Children usually suffer when their parents divorce. This suffering is exacerbated when child maltreatment is also an issue. The suffering can be of three types. Children may have to cope with abuse as well as the divorce and its aftermath. They may experience continued abuse when the allegation is not believed because it arose in the context of divorce. Finally true or false, the abuse allegation may become another weapon in the divorce battle, and the children the pawns.

This article will provide guidelines for evaluators in case management and assessment when abuse allegations and divorce co-exist. It is assumed that the reader understands the basics of evaluation of allegations of abuse and of custody/visitation evaluations in divorce. The goal for evaluators should be fairness to all parties involved. However, often the child's interests are overlooked. Accordingly minimizing the child's suffering in these cases will receive special attention.

CHALLENGES FACED BY EVALUATORS WHEN ABUSE ALLEGATIONS AND DIVORCE CO-EXIST

Cases in which adults divorce and child abuse is alleged are especially difficult for professionals. These cases present challenges for at least three reasons. First, the abuse allegations evoke a high degree of skepticism. This is so in spite of research findings indicating that many cases are "likely" (Faller & DeVoe, 1995; Green, 1986; Jones & Seig, 1988; Thoennes & Tjaden, 1990)[1]. A very common interpretation of such an allegation is that one parent, usually the mother, is making allegations of abuse, usually sexual abuse, against the other parent, usually the father, to gain an advantage in custody and access disputes. This reaction makes it difficult for concerned caretakers and professionals to have the allegation taken seriously by decision-makers.

This skepticism has its roots in divorce proceedings that pre-date no-fault divorce. For a couple to have grounds for divorce, there was a legal requirement of some sort of malfeasance by one of the partners. This requirement resulted in a pattern of tall tales and exaggerations. Although no fault divorce statutes are now the norm, there still are advantages to be gained in the division of property and children. Moreover, powerful emotions associated with divorce remain and may result in exaggerations, distortions, and vindictive lies of a variety of types. Therefore, skepticism about allegations made by one party in a divorce against the other persists among judges, divorce attorneys, and others.

Second professionals concerned about possible child abuse must address the allegations in the emotional turmoil brought on by divorce. Parents are often filled with anger and desolation because of the failed marriage. These affects spill over into their relationships with professionals concerned about the abuse allegations and into their relationships with their children. Often the needs of the child become secondary to the battle between the divorcing parents. Moreover, an allegation of abuse may be the last straw. It may cause either parent to lose the capacity to think rationally or to control his/her behavior. Dealing with such volatile cases is difficult and draining for professionals.

Third, these cases present challenges because they are the responsibility of several systems with competing mandates. Thus, abuse allegations are the province of the Child Protection System, handled in the Juvenile or Family Court. Divorces are usually handled in a different court. The mandate of the Child Protection System is to investigate allegations of child maltreatment and make a determination about what, if anything, has happened to the child. The first priority of the Child Protection System and its attendant court is child safety, with family preservation a close second in terms of priority.

[1] These findings will be discussed later in the article.

In sharp contrast is the mandate of the court that decides legal issues in divorce. This court, referred to as the domestic relations court, is charged with settling disputes related to property and custody when parents have decided they don't want the family preserved. Personnel in the social service and legal systems that address situations of divorce have no particular expertise in investigating child maltreatment. In fact, making a determination that one party in a marital dissolution is guilty is, to a degree, antithetical to their primary mission of settling matters so the divorcing adults can go their separate ways.

Moreover, if the criminal justice system becomes involved, yet a third and competing set of mandates comes into play. The goal of the criminal justice system is to investigate crimes and to prosecute those who commit them. The general intent is to make society safe by controlling or incarcerating criminals. When child protection and law enforcement are both involved in a case of abuse, it is common for the criminal justice system goals to take precedence. A child may face not only the dissolution of the family but the incarceration of a parent, an extremely traumatic situation for a child.

The other side of this dilemma is that none of these three systems is eager to take on an allegation of abuse in the context of divorce, especially sexual abuse. The lack of enthusiasm for these cases derives in part from the first problem cited, the level of skepticism they engender.

Many Child Protection Systems (CPS) fail to investigate allegations in divorce. If the child is living with the parent who is concerned about abuse, CPS may respond that there is no risk because the child is not exposed to the alleged offender. The CPS worker may suggest the concerned parent[2] ask the domestic relations court to become involved. This involvement might consist of assessing the allegation or restricting visitation until the situation can be evaluated by a court appointed or privately retained mental health expert.

Alternatively, CPS may very superficially investigate or deny the case because the allegation arises in a divorce context. Illustrative of this phenomenon is study of 18 divorce/abuse allegation cases from Boulder County Protective Services. Only two of these cases had been substantiated. When McGraw and Smith (1992) conducted a record review of these cases, using criteria for substantiation developed in an earlier large sample study (Jones & McGraw, 1987), they found only three fictitious allegations. Eight cases were substantiated according to these criteria, and seven had insufficient information to make a determination. The latter is not a surprising outcome since these cases were inadequately investigated.

The domestic relations court may also be reluctant to take on these allegations. After all, CPS is supposed to investigate allegations of child maltreatment, not the domestic relations court. This court may advise the concerned parent to report the case to CPS or to notify the police. Alternatively the court may tell the parent that he/she must have "more proof" than parental concern before the court is willing to act. Or in some cases, the court may restrict visits temporarily but place the burden on the concerned parent to come up with "proof". In some instances, the concerned parent is threatened with dire consequences, such as loss of custody or being found in contempt of court, if proof is not forthcoming (Faller & DeVoe, 1995).

Finally, the criminal justice system is interested in evidence of abuse that will result in a successful prosecution. Because the alleged victims are often quite young (MacFarlane, 1986; Paradise, Rostain, & Nathanson, 1988), sometimes reluctant to disclose, and often not persuasive, and because these cases arise under suspect circumstances, the required level of proof, beyond a reasonable doubt, may be unlikely. Therefore, the criminal justice system shuns these cases. Cases may not be investigated, or if they are, not in a timely manner. And crime scene investigations are uncommon in divorce cases.

RESEARCH ON ALLEGATIONS OF ABUSE AND DIVORCE

Evaluators of abuse accusations in the context of divorce will perform better if they are cognizant of research findings. Most of the research on abuse allegations in divorce has focused on sexual abuse. These will be critically examined in this section. Of particular importance in examining research findings are sample size, sample source, and criteria used to determine the veracity or falsehood of an allegation. Writers who voice skepticism the loudest and who view most such cases as false provide no data to support their assertions (Blush & Ross, 1986; Gardner, 1987; 1989; 1991; 1992; 1995; Underwager & Wakefield, 1988).

The first studies were based upon small samples, often coming from the writers' private practices (Benedek & Schetky, 1985; Green, 1986; Kaplan & Kaplan, 1981; Paradise, Rostain, & Nathanson, 1988; Schuman, 1986). It is difficult to determine the rate of false allegations from these studies for a variety of reasons. For example, Benedek and Schetky (1985) were interested in studying false allegations of sexual abuse in custody disputes. Benedek (1987) testified in Morgan v Foretich, in which she was one of accused, Eric Foretich's, experts, that she reviews documents to screen for true allegations when she is considering becoming an expert for the accused so that she does not support an offender. Therefore, presumably the Benedek and Schetky findings of 10 out of 18 cases

[2] I will usually employ the term, concerned parent, instead of accusing parent or non-abusive parent, because the concerned parent may not have made the accusation, accused parent may not be abusive, and the concerned parent is not necessarily non-abusive.

false would not represent the false rate for all cases with allegations in custody, but only the rate for cases considered false or possibly false in the first place.

Kaplan and Kaplan (1981) present one case and make reference to a second. Thus, no conclusion about rates can be derived from their article. Furthermore, they do not say directly that the instant case is false, but rather propose possible dynamics for a false allegation, including *folie a deux* and programming. Schuman presents seven cases he defines as false based upon "psychodynamic formulation" and court disposition, but does not give the denominator, that is the total number of cases he examined. Green (1986) and Paradise and colleagues (1988) do provide rates, in both instances approximately one-third. However, Green's sample consisted of only 11 cases, four of which he designated as false. His conclusions were challenged by five experts in sexual abuse (Corwin, Berliner, Goodman, Goodwin, & White, 1987; see also Hanson, 1987) in part because one of his false cases was considered possibly true by two of these experts. They also challenge him for deriving characteristics of false allegations from a sample of four cases.

Studies with larger samples are more instructive about rates of false allegations. Thoennes and Tjaden (1990), in research for the Association of Family and Conciliation Courts, conducted a case record review of 9,000 disputed custody cases from 12 jurisdictions in the United States. They found 169 (1.9%) contained allegations of sexual abuse. Of these the domestic relations courts addressed 124. Using the decision of Child Protective Services and/or the opinion of a court evaluator, they found half of cases were determined "likely"; one third were "unlikely", and 17 percent were "uncertain". Unlikely and uncertain classifications were more common in cases with less severe allegations of sexual abuse, younger children, and rancorous divorces. In 58 cases, the motivation of the accuser was addressed in the file. In eight, the evaluators thought the allegations were maliciously made.

Faller and DeVoe (1995) examined 215 allegations of sexual abuse in divorce cases that were evaluated by a multidisciplinary team at a university based clinic. Seventy-two point six percent were determined likely, 20 percent unlikely, and 7.4 percent uncertain. The substantiation rate is higher than in the Thoennes and Tjaden study, but the criteria for determination are different, a decision of a team of experts in child abuse. This rate is similar to that in a smaller study conducted on cases from the Kempe Center by Jones and Seig (1988), using criteria developed by a team of experts. In a sample of 20 cases, 70 percent were classified likely, 20 percent unlikely, and 10 percent uncertain. The differences in rates for domestic relations courts and specialty programs are likely accounted for by the fact that specialty programs can screen out frivolous complaints, something domestic relations courts cannot do. In addition, the evaluation process of a team of experts is probably more thorough and sophisticated than that of Child Protection workers or court evaluators, who may not be experts in sexual abuse assessment. If these observations are correct, a 70 percent "likely" rate is more accurate.

Further Faller and DeVoe (1995) differentiated cases into those where divorce followed discovery of sexual abuse (14.4%), discovery of sexual abuse followed divorce (25.1%), sexual abuse followed divorce (27%), false and possibly false allegations (19.9%), and allegation unrelated to divorce (12.6%). Of the false or possibly false cases, 10 (4.7%) were determined to have been consciously made. The remainder were classified as misinterpretations. Moreover, Faller and DeVoe noted that 40 concerned parents experienced negative sanctions associated with raising the issue of sexual abuse. Only nine of these parents violated court orders, and only one entered the Underground. These sanctions included being jailed, losing custody to the alleged offender, a relative, or foster care, limitation or loss of visitation, admonitions not to report alleged abuse again to the court, Protective Services, or the police, and prohibitions against taking the child to a physician or therapist because of concerns about sexual abuse in the future. None of the parents experiencing sanctions were ones who apparently made calculated false allegations. In fact, sanctioned cases scored higher on a composite scale of likelihood of sexual abuse[3] and were more likely to have medical evidence than cases without sanctions.

The research to date has its limitations. Especially challenging is developing good definitions of true and false cases. However the research suggests that evaluators should approach these allegations with an appreciation that accusations of sexual abuse in custody disputes are not rampant and a substantial percentage, between on half and three fourths, have been found to be valid.

CASE ASSESSMENT PRINCIPLES

Although there is no empirically demonstrated right or wrong method for conducting an assessment of abuse in cases involving divorce, some professionals hold very strong opinions about how these evaluations should be done. There are even evaluators ready to say those who don't follow their guidelines commit malpractice (Campbell, 1995; Gardner, 1992). It does not serve children, their families, the professions involved in these evaluations, or the courts to have a battle of the experts.

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[3] Items included in the scale were confirming characteristics in the child's statements, medical evidence, police evidence, conviction, confession, confirming evidence from another professional, and confirming information from a caretaker.

Accordingly in this article, guidelines will be offered but with an acknowledgment that, as Corwin and colleagues (Corwin, Berliner, Goodman, Goodwin, & White, 1987) pointed out, there are "no easy answers", and that there may be many appropriate strategies for undertaking assessments of allegations of abuse in divorce. Moreover, in may cases what is optimal may be infeasible. Optimal practice may be too expensive or not timely, parties may refuse it, or the decision-makers may not accept it.

The following topics will be covered in this section: 1. sources of bias, 2.the evaluator's employer, 3. Legal representation for the child, and 4. a multidisicplinary approach.

Beware of bias

In all situations where there are allegations of abuse, especially sexual abuse, there is the risk of evaluator bias. Typical sources of bias are gender, class, professional experience, personal experience, and values.

Cases involving child abuse allegations and divorce may bring with them biases in addition to the customary risks. The evaluator may be very ready to dismiss an allegation because it occurs in the context of divorce or may be very ready to defend and rescue the child and the concerned parent because often they are left with no recourse[4]. The research related to abuse allegations in divorce can ground evaluators and thereby counteract bias.

Evaluators also run the risk of being polarized by a parent on one side or the other. Parental emotions run very high in these cases; evaluators can be infected by these emotions. Evaluators also need to appreciate that they may be more persuaded by the parent whose perspective they obtain first. They may then evaluate information from the other parent and other sources through the lens of the parent seen first.

Moreover, public resources for funding custody evaluations when there is divorce is not as available as in Child Protective Services cases. In divorce cases, one party may be paying for the evaluation. The evaluator may feel the pull to be sympathetic to that side, sometimes to assure payment, other times because of wanting to "please the customer", or irrationally not to "betray" the parent who is paying. Practical strategies for avoiding bias for fear of non-payment include asking for payment or partial payment before the evaluation is undertaken or requiring payment before the report is released.

Finally, as lawsuits increase in association with findings of sexual abuse (or perhaps in the future lack of findings), the evaluator may feel threatened by this possibility from one or both parents. This can immobilize the evaluator and lead to a "inconclusive" finding or result in biased findings.

Who should evaluators work for?

Frequently evaluators are faced with difficult decisions related to how and for whom they work in cases involving allegations of abuse and a divorce action. In this section, I will discuss optimal arrangements and strategies that might be used if the optimal is infeasible, and finally attendant professional dilemmas.

Evaluators want the court to hear what they have to say and to take their findings seriously. The best strategy for effecting this is by becoming the court's expert. This also allows the evaluator to communicate directly with the court and not have to rely on the parents' lawyers for communication with the court. Court appointment can come about in a variety of ways. The judge can make the decision, or both parents' attorneys can agree on a specific evaluator and ask the court to appoint that person.

What if this isn't possible? Then the evaluator can refuse to be involved. Or the evaluator can agree to work on the case provided he/she has access to all information needed to make a determination of the likelihood of abuse. This usually means having an opportunity to interview the child and both parents, and perhaps others, such as new partners of the parents or relatives. In cases where the evaluator isn't the court's expert, but has access to all relevant information, the other side may well have his/her own expert. Thus, there is more than one expert. It is not uncommon for experts to disagree. In such cases, the court may ultimately appoint its own expert. This is a difficult situation for parents, but especially for children, who must be evaluated at least three times.

What if access to all information isn't possible? Specifically the evaluator will not be allowed to see the accused or the child. The evaluator can refuse to be involved. Alternatively the evaluator can conduct a limited assessment based upon information available and make recommendations to the court about additional intervention. There also may be good reason for evaluating a child when not having access to the accused parent. Concerns about abuse may be unfounded, and abuse can be ruled out by merely seeing the child. In such an instance, the evaluator can reassure the concerned parent and perhaps make recommendations for treatment. On the other hand, there is consensus in the field that sexual abuse cannot be ruled out by an interview and/or testing of the accused. The fact that the accused does not reveal characteristics associated in some cases with child abuse behavior does not mean the accused is not one. There is no single profile of a child abuser, and the accused may fail to share information he/she thinks will be incriminating.

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[4] Because of the lack of desired responsiveness of professionals and important decision-makers like the courts, some parents take their children and enter the Underground, which is described as a network of committed individuals who will harbor "protective parents" and their children and assist them in establishing new identities and new lives. Other parents violate court orders, and some go to jail and/or lose custody because of these actions.

Finally what if obstacles arise in the evaluation process, such as the withholding of information or the failure of persons, who are supposed to be interviewed, to present themselves? The evaluator can refuse to go forward with the evaluation. In some instances, an option will be to seek a court order to assure cooperation. But what if the latter is not possible? The evaluator may want to provide a report based upon the information available, noting the shortcomings of the evaluation process.

All of these decisions raise ethical and professional dilemmas. These are of two sorts. Failure to be involved except on the evaluator's conditions may result in an allegation not being investigated and children being left in danger. It can also result in an unresolved suspicion hanging over a parent's head indefinitely.

On the other hand, when the evaluator has access to only part of the information, he/she runs the risk of forming a biased or uninformed opinion. In addition, depending upon the evaluator's profession, his/she may be violating professional guidelines. Specifically the American Psychological Association's Guidelines on Child Custody Evaluations in Divorce Proceedings (1995) state a psychologist should not form an opinion about the psychological functioning of an individual without evaluating him/her. In addition, the APA document, *Potential Problems for Psychologists Working with the Area of Interpersonal Violence* (1996) cites as a problem, making a child custody recommendation without evaluating all parties. Similarly, the American Academy of Child and Adolescent Psychiatry *Guidelines for Clinical Evaluation of Child and Adolescent Sexual Abuse* advise seeing both parents in cases of intrafamilial sexual abuse. In contrast the Guidelines of the American Professional Society on the Abuse of Children, a multidisciplinary group, state specifically that an evaluator need not interview an alleged offender in order to form an opinion about sexual abuse.

If an evaluator feels compelled to become involved in an assessment where he/she is not allowed to review all the information and perhaps is prohibited from seeing all relevant parties, it is advisable to take these limitations into account in forming an opinion and making recommendations. The evaluator should specify in any written report the evaluation procedure, including what documents were reviewed and who was interviewed. It may be useful to limit recommendations to measures that assure protection of the child and further steps in evaluation in cases where access to desired information was not possible.

Legal representation for the child

The evaluator should consider whether legal representation for the child could be helpful. In a child protection legal proceeding, the child is afforded legal representation by federal statute, but not in divorce cases when custody and visitation are contested. In most states, appointment of an attorney for the child is at the judge's discretion and therefore does not routinely occur (Barr & Jerabek, 1993)[5]. Consequently in the majority of divorce proceedings, children have no official voice in court. This increases the child's vulnerability to being treated like parental property.

The evaluator can seek legal representation for the child by sending a letter to the court, by recommending counsel in her/his report, or by asking either the mother's or father's attorney to make this request of the judge. However, having legal representation is not a panacea. The choice of attorney will be crucial. Moreover, someone must pay the attorney, and this is usually the parents. Lack of funds may preclude an appointment, or the attorney may not be truly independent of the parents because they are paying.

A multidisciplinary approach

Given the complexity of these cases, collaboration is important. Evaluation by more than one person, involving more than a single discipline, and using professionals with a spectrum of expertise will be discussed in this section.

Use of a team: Conducting evaluations of this sort single-handedly is extremely burdensome. Making decisions is likewise sometimes overwhelming. The solo clinician may feel battered by both sides or caught between them. The evaluator may be fearful of professional or personal consequences of his/her decisions. Evaluators "burn out" under these circumstances. In addition, when a single evaluator is responsible, this may increase the risk of individual bias.

A possible solution to these problems is the use of a team of evaluators rather than a single evaluator. The problem of feeling overwhelmed is reduced by a sharing of the burden. Team members can share their concerns, questions, and frustrations among themselves. There may be safety against lawsuits and other professional and personal threats in numbers. A team may also be less prone to bias.

Some programs assign one evaluator to the child and the concerned parent and another evaluator to the accused. This reduces logistic problems since the child is usually residing with the concerned parent. Although this assures that each parent has an evaluator who hears the case from his or her perspective, this may not be the optimal model in cases where the parents are polarized against one another. The family polarization may be recreated within the team. A better division of labor may be to assign one evaluator to the child and a second to both parents.

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[5] This attorney is *guardian ad litem* who represents the child's best interest, as opposed to the child's wishes.

If possible, it is good to have a team of both males and females. Having both male and female team members can mediate the impact of gender bias. Although costly, in some cases male female teams to interview the parents may be very useful. This means that each parent is seen by two people, one male and the other female.

Use of more than a single discipline: As a rule, interview data, especially the child's statements and behavior in sexual abuse cases, are the most important findings for a decision about the likelihood of abuse. However, children may not be forthcoming in interviews, or they may be too young to accurately communicate. In addition, both parents will be highly aware that everything they say can have an impact on the decision of the evaluator. Not only will they likely be "putting the best foot forward" but they may dissemble and distort.

Therefore it may be useful to have psychological test data from both parents and children. These data can often provide useful insights into overall functioning and specific information about parent and child characteristics. For example test findings from the accused parent may reveal a lack of impulse control. The absence of impulse control does not prove abuse, but it may buttress other findings. Similarly, evidence of trauma may be apparent in the child's test findings. Again this does not prove abuse because the trauma could derive from other sources, but it may be consistent with other findings supportive of child abuse.

Of course, the context of the testing (divorce and sexual abuse allegations) can influence responses to testing. In addition, parents may dissemble in testing as well as in interviews, particularly in their responses to objective tests. And of course not all abuse results in traumatic or other impacts that might be reflected in test findings.

Evaluators should not overlook the possibility of medical findings. Medical findings are more important in cases of physical abuse and physical neglect. However, they may also be found in some sexual abuse cases. Like other findings, medical evidence may not be conclusive, but suggestive findings may correlate with data from other sources, for example the child's statement.

Use of professionals with a range of expertise: Not only may the inclusion of team members from different disciplines be advantageous, but it may be advisable to include professionals with different specializations. In recent years the relationship of child maltreatment to other problems in functioning has become better understood. Families may manifest more than one type of child maltreatment, or they may have problems like domestic violence, substance abuse, and mental illness, which may increase the risk for child maltreatment. Furthermore, living with parents who are violent toward partners, who abuse drugs or alcohol, or who are mentally ill, even without additional maltreatment, is detrimental to children.

Investigating these problems requires particular expertise. These assessments can be accomplished parsimoniously by having team members with relevant expertise. This is preferable to having to request separate substance abuse, domestic violence, or mental disorder assessments and then integrating the results with information related to child maltreatment.

EVALUATION PROCESS

In this section strategies that can enhance the accuracy and utility of an assessment will be described. These strategies are covered under the following headings: review of background information, data collection from others working with the family, involving parents' current partners and all children, child interviews, interview with the concerned parent, interview with the accused parent, and the use of parent-child interaction in decision-making.

Review background information

Mental health evaluators appreciate they are seeing a family at a particular point it time. So they obtain information in the evaluation about current individual or family functioning, but information gathered at evaluation time needs to be put in the context of the individual or family's history. Families generally come to an evaluation in a state of crisis. Certainly this is the case when couples are divorcing and when allegations of abuse arise.

Because of this, it is important for evaluators to review past mental health and other professional records. It is also important for evaluators to gather historical information about the parents and the children from them, although evaluators are aware that the reporting may be biased by the current crises and the fact participants are under scrutiny.

There are additional reasons in cases of divorce and abuse allegations to gather these background data. First, the evaluator may be surprised to find that the allegations have already been investigated, and the parent or lawyer is not satisfied with the results. The results may be conclusions either for or against abuse. The parent or lawyer may argue that he/she does not want the current evaluator to be biased by prior findings. Indeed the findings may be biased, but nevertheless the evaluator should have access to them. There is nothing more useless than an evaluator operating in the dark. Even if the lack of past history does not result in actual inaccuracy in findings, it will result in the evaluator's efforts being given less weight and perhaps being totally discredited because the evaluator did not consider all of the history.

Second, the prior assessments or investigations may have taken place closer to the alleged abuse. A review of these documents may give the evaluator a more accurate view of the abuse allegation. What was the source of the initial concern, child statements or behavior, parental observations and report, or questions raised by a professional or

disinterested party? Memories fade over time and accounts may become contaminated. The best information may have been collected closer to the event.

Third, especially with young children with immature communication skills, there may be a series of reports of ongoing abuse that are unsubstantiated or inconclusive. For example the child may initially have physical signs but be unable to say anything, or the child may engage in sexualized behavior but not provide any interview findings. In may be useful to integrate these earlier concerns with the current concern.

Fourth, it can be instructive to note the occurrence of the abuse allegations in relationship to other events in the family, marital dissolution, and post-divorce relationships and contact. Have the allegations arisen when the concerned parent was at a disadvantage of some sort in the marriage or divorce action? Is there a history of escalation in the reports of bad behavior on the part of the accused parent? How might that history be variously interpreted? Have reports been associated with periods of unsupervised access to the child by the accused? Have there been allegations and counter allegations.

Collect data from others professionals working with the family

Related to the necessity of gathering background information is the importance of accessing data from others currently involved with the family. These people may be physicians, therapists, school personnel, child protection workers, law enforcement personnel, or others. Some of them, for example teachers and therapists, may have much longer relationships with family members than the evaluators. Others may have information about the family in other contexts. Child protection workers typically go to the home. Evaluators usually do not. Police and child protection workers respond to crises and may have more immediate findings than evaluators. There may be professionals who have made observations about parent-child relationship. If the accused parent has supervised visits, information from supervisors may be valuable.

Involvement of all parties and significant others

As noted above, because of the widely divergent perspectives divorcing parents bring to an abuse allegation, it is useful to interview not only the child and the concerned parent, but also the accused parent. These are, of course, the three core individuals to be evaluated. Although there will be some cases in which a single child interview is sufficient, for example with a very forthcoming, non-stressed child, generally two or more interviews will be required. Parent interviews will usually take between an hour and a half and five hours. The length of time needed depends upon the complexity of the case, the communicativeness of the parent, and whether the evaluator has to address the parent's agenda as well as his/her own. Examples of agendas are as follows. Some parents will be overwhelmed with anxiety that result in a veritable verbal flood of concerns. It is advisable to allow the parent to vent. Other parents may feel the need to control the interview, and thus it takes the interviewer more time to cover the topics on the evaluator's agenda.

If the parents have new partners, it is advisable to see them. Moreover, if there are other children of the parents (for whom there are no concerns of abuse), they should be interviewed as well. There may be children from new or other relationships of the accused who should be interviewed. The purposes of these interviews are several. First of all, they give the evaluator other perspectives on the allegations and the people involved. Second, heir information may directly support or refute concerns about abuse. Third, additional victims may be discovered in these interviews. These interviews need not be as long or as thorough as those of the primary parties. As a rule, the purpose of these interviews is to collect information relevant to the allegations, not to evaluate these other persons. However, the evaluator will want to make some assessment of the reliability of the information these individuals provide. This is done by making an assessment of its accuracy, by determining any vested interest the interviewee might have in lying or distorting, and by an assessment of the interviewee's overall functioning.

Child interviews

As in other situations in which abuse is alleged, the child interview(s) is the centerpiece of the evaluation[6]. It is an opportunity to directly inquire about possible abuse, to assess the child's overall functioning, and to assess for any effects of abuse. It is also a context for gathering information about the quality of relationships between the child and parents and for assessing the impact of divorce on the child.

As in other allegations of abuse, the evaluator will want to interview the child in a circumstance as free from parental influence as possible. However, the influence of concern may be different in divorce cases. In situations of possible maltreatment in intact families, the concern is the parent may, intentionally or unintentionally, inhibit the child's disclosure of actual abuse. In divorce cases, the evaluator will often have the additional concern that the concerned parent may foster, either intentionally or unintentionally, a false allegation of abuse.

It is difficult to devise strategies to free the child from parental pressures. Even removing the child from the home and placing the child with a neutral relative or a foster family may backfire. The child feel may punished and deprived by such a placement and may respond in interviews in ways to convince the evaluator to recommend a return home.

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[6] The author disagrees with Gardner (1995) and Blush and Ross (1986), who hold a minority view that the child interview is the "poorest source of information" (Gardner ,1995, p.29).

However, one reason for assigning a separate evaluator for the child is to provide the child with someone she/he does not have to share with the either parent. This may decrease the sense of obligation the child feels to say what one or both parents wishes. In addition, if the child's evaluator sees him/her several times, the relationship they develop may also increase the child's freedom to be candid.

Sometimes it is helpful to have the child brought to the evaluation by someone other than a parent or someone, who is supportive of the child, but neutral regarding the divorce. This person may be a child protection worker, an old family friend, the child's therapist, or a school counselor. However, especially if the child must be seen several times, arranging for this may be difficult logistically.

There are also strategies the child's evaluator can use in the interview that may enhance honest communication. First, the evaluator can increase the child's sense of trust and control in several ways. The evaluator may tell the child that "kids are in charge here. This is a place where kids can say what they really think or feel." Similarly, the evaluator can describe the agency or program as a place where "we really care about kids and what happens to them. We want you to tell us what you are thinking and feeling. We also want you to tell us if any things have happened to you that you didn't like or made you feel bad." Often the child's revelations to these sorts of invitations have nothing to do with abuse allegations. They nevertheless are very useful to the evaluator in determining what issues and problems are salient for the child. The evaluator can also attempt to give children a sense of control by telling them they do not have to do anything they really don't want to do.

Second, the evaluator can begin the interview or the abuse specific inquiry with some general guidelines, such as "I'll be asking you lots of questions. If you don't know the answer, tell me you don't know. If you don't understand the question, tell me that, too. I will try to ask it in a better way. Remember only tell me what you really remember. And also only tell me what really happened."

Third, there are strategies the evaluator can choose when children do describe abuse, but the evaluator has doubts, to check the veracity of the child's disclosures. These strategies can even be used in cases where he/she has no doubts, but decides for legal reasons it is a good idea to check. The child can be asked if this "really happened". The evaluator may also ask if anyone talked to the child about "coming here" or about "what to say". If the child provides an affirmative response, the evaluator can ask what the child was told or what the child was supposed to talk about. It may be advisable to wait till after a disclosure rather than to ply the child with these questions before abuse focused inquiry. There are some who write that "the truth" is a codeword for a false allegation (Gardner, 1992, 1995). Where this opinion comes from is not stated. There is no research that supports this assertion.

Finally, children are highly variable in their reactions to abuse, especially sexual abuse. Their responses will usually depend upon the child's functioning, the abuser's relationship with the child, the type of abuse, its frequency and duration, what strategies the offender used to involve the child and any admonitions to prevent disclosure, and what happened when the child disclosed. Therefore using child's emotional state when reporting abuse and his/her responses to disclosure (e.g. hesitancy vs eagerness to disclose) is a questionable strategy for determining likelihood. At very least, it is important to appreciate that children's affect in cases in which they are believed, supported, and receive treatment, when they report abuse, may be quite different from the affect of children who have been blamed, disbelieved, and punished when they report abuse.

Interview(s) with the concerned parent

In some respects, the second most important source of data about the likelihood of abuse is the parent who raises the concern. The evaluator will be interested in the source of the concerns about abuse and in the personality of this parent.

With regard to the source of concerns, there are several factors the evaluator should explore. The first is whether these concerns come solely from the parent or also from other people. If there are others concerned, are they professionals? If they are professionals, what are their roles and reputations? If the others are non-professionals, who are they and what are their relationships with the child and the parents? In most cases, the evaluator will want more than the parent's report of other people's concerns. The evaluator will want to review any reports of professionals and perhaps speak directly with them. For non-professionals, the evaluator may ask for notes, for example those made by a grandparent or a baby-sitter, or for an opportunity to talk with them.

Second, the evaluator will want to know the precise statements or observations that made the parent concerned. When these are the child's statements, were these vague or explicit? For example, did the child return from a visit and say "Daddy hurt me," or did the child say, "Daddy made me suck his wiener." A related question is whether the source of concern is specific to abuse or could it relate to something else? For example, if the child is reported to have said, "Daddy was swinging his big thing," this might be a description of physical or sexual abuse, but it also could refer to something entirely different, like a baseball bat. Yet another related question is whether the reported behavior is benign activity misconstrued. The most common type of benign behavior that is mistakenly considered abuse is child care. It may require touching the child's genitals or anus, for example to assist the child in wiping or to apply medication.

The evaluator will want to consider comparable explanations for behaviors the concerned parent describes. Are these general or specific to abuse? It is common for children caught between two parents in divorce to resist going for visits and returning from them. While these reactions may be caused by abuse when in one or the other

parents' care, they may merely reflect the child's dilemma. The child may already feel very insecure because of the divorce and fear showing loyalty to one parent in the presence of the other will lead to abandonment by the observing parent. Similarly, behavior the parent might construe as indicative of abuse may be normal, for example masturbation or aggression. Even with more explicit sexualized behavior, evaluator should rule out more benign sources, such as viewing sexually explicit magazines or observing sexual activity. Finally even when it is established that the child's activity indicating possible abuse derives from, say, sexual contact, the evaluator should query why the concerned parent thinks it is the other parent. For example, children of divorce often call their parents' new partners "mom" or "dad".

In addition to assessing the source of the parents' concerns, the evaluator will be interested in certain characteristics of the parent. How accurate generally is the parent in his/her reports of events in his/her experience. Does the parent exaggerate? Making this determination may be possible by comparing information from the parent to information from other sources. How easily does the parent become distressed? Does distress result in distortions? If problems are found in the parent's accuracy and vulnerability under stress, then reports related to possible abuse should probably be given less weight. Of course, the evaluator should appreciate that he/she is seeing the parent in a very stressful circumstance, and therefore some distress should be anticipated.

If the evaluator is concerned about a calculated false allegation, the evaluator should be alert for other examples of manipulation of people and anti-social behavior. However, the fact that the parent is defensive or hostile to the evaluator should not presume this sort of deviancy. A parent who is genuinely concerned about abuse of his/her child but is meeting skepticism and counter-accusations is likely to be angry and resistant when an evaluator probes regarding what they experience a legitimate concerns.

Interview(s) of the accused parent

As with the concerned parent, the evaluator will be quite interested in the accused parent's view of the abuse allegations and with the personality of the parent. More so in allegations in divorce than in other cases, there may be a perfectly benign explanation for the concerns. An accident may be misconstrued as abuse. Illustrative is a case in which a four year old boy was accidentally injured in the genitals when his father flung the bat during a baseball game, accidentally hitting his son in the groin. Physical discipline can be overinterpreted as abuse. There is increased risk for misinterpretations in divorce because of the communication breakdown between parents. Sleeping arrangements may be unorthodox, for example with the child sleeping with the parent or in the parent's room, either for lack of space or because the child does not want to sleep alone. And, as already mentioned, child care behaviors such as bathing wiping, and applying medication can be misinterpreted as abuse. If the accused parent does not offer any such explanations for the allegations, the evaluator should query generally about child care, discipline, and sleeping arrangements.

On the other hand, the loss of structure that occurs for both custodial and non-custodial parent in divorce may increase risk and opportunity for abuse. Prior to marital dissolution, the parent's behavior with the children is subject to intermittent supervision by the other parent. This provides some external control for parental behavior. Divorce generally ends this. Other aspects of family structure may disappear as well. Especially when the child is with the non-custodial parent, there may be no set bedtime, sleeping arrangements, mealtimes, or even rules regarding behavior. The general atmosphere created by the loss of structure may increase risk for abuse. In addition, the loss of structure and the fact that often both the custodial and non-custodial parents must function as single caretakers may increase risk for neglect.

As with other situations of possible abuse, personality characteristics such as impulse control and empathy will be of interest to the evaluator. The evaluator will also be interested in the accused parent's relationship with and investment in the child, particularly the adult's capacity to see the child as a separate person, with needs of his/her own.

However, parents whose abusive behavior comes to professional attention in the context of divorce include those who have engaged in ongoing abuse and those whose abusive behavior is precipitated by the marital dissolution. Some parents whose sexually abusive behavior appears precipitated by the loss of family structure and emotional turmoil of divorce do not evidence marked deviancy prior to the abuse. Often they are parents with intense investment in their children that becomes sexualized during a period of great emotional distress and loss. Or they look to their children to meet needs previously met by the spouse, including sexual needs. The sense of loss and anger at the abandoning spouse can also increase risk for physical abuse, especially if the child is of the same sex as the ex-partner and/or reminds the parent of the ex-partner.

Observation of parent child interaction

Social scientists and mental health professionals have used observation of parent-child interactions to make determinations about the quality of those relationships. This practice derives from the study of normal infant-mother relationships in middle class families. Researchers observed the progressive development of an attachment between child and mother and the presence of certain types of behaviors when this bond was present. These insights have been applied to both the child maltreatment and the divorce fields.

In the 1980s, especially when making determinations about maltreatment with preverbal children, such as infants with failure to thrive or unexplained injuries, clinicians relied on observations of the parent-child relationship

as one source of information about the etiology of the child's condition. They also used this information to predict the potential impact on attachment of removing the child from the parent's care and to decide whether or not to try to preserve the child's relationship with a maltreating parent.

In the divorce field, observations of the parent-child relationship have been employed by mental health professionals to make recommendations about custody and visitation. They have used information about the quality of the relationship as a strategy to cut through all of the accusations and counter-accusations in custody/visitation disputes with no abuse allegations. Specifically many have felt the relative strength of the child's relationship with the each parent should determine who gets custody. In addition, a good or adequate parent-child relationship, even with a deficient parent, should be supported (through visitation).

However, there are both practical and ethical dilemmas to relying on observations of parent-child interaction to make determinations of abuse in divorce cases (Faller, Froning, & Lipovsky, 1991).

Practical problems: Most evaluators appreciate the inherent limitations in information they obtain about parent-child relationships, particularly when gathered from short observations in the evaluator's office. For example, the parent is likely to be on his/her good behavior during the observation. The parent is very unlikely to physically or sexually abuse the child during the observed interaction. Only a very inadequate parent will not be able to sustain appropriate interaction with the child for an hour. Information gathered from these observations may not be a good predictor of how the parent behaves with the child when there is no observer, or when having to deal with the child along with other exigencies.

Children may behave and feel quite differently during an observed interaction than when alone with the parent. They may feel safe and therefore not display anxiety or fear. They may also test parents in the observer's presence by behaving provocatively. Alternatively, there may be good qualities to the relationship, and these may be apparent during the parent-child interaction, rather than the problematic ones. And there will be situations in which the child does not experience the parent's abusive behavior as inappropriate and therefore will not show signs of problems in the relationship. Finally, children may dissociate so that any fear they have is not evident in their behavior.

On the other hand, difficulties noted in the parent-child interaction may not relate to abuse, especially in situations of divorce. The child may be hostile to the parent because the child feels abandoned, because of the divorce, or because the other parent is angry at the accused parent. The child may have heard many negative things about the accused, such as failure to pay child support, and may be reacting to these. Finally when a parent is accused of abuse, contact with the child is often stopped. The observed parent-child interaction may be the first contact for quite some time. As a consequence it may reflect the results of the absence of contact rather than the quality of the relationship.

In the absence of overt signs of abuse during the parent-child interaction, some clinicians have chosen to interpret more subtle information as either indicative of abuse or not (Haynes-Seman & Baumgarten, 1994). For example, a father taking his child to the toilet may be interpreted as overinvestment in the child's genitals and therefore supportive of sexual abuse. Similarly, the fact that the parent can get down on the floor and play with the child may be considered indicative of no abuse. There is no empirical support for these opinions.

Ethical considerations: Evaluators should also consider the impact on the child of a parent-child interaction. It may be experienced as a confrontation with an abuser. Children abused by adults have already learned that adults cannot be trusted. If the child reveals abuse and then is faced with the abuser, this encounter is likely to exacerbate the child's problems with trust. Especially problematic are parent-child interactions in which the evaluator allows the accused parent to confront the child, requires the child to repeat the allegations to the accused parent, or repeats the child's allegations to the accused parent. Abused children, who have not disclosed, will be reinforced for keeping the secret when they are required to participate in a parent-child interaction.

What about ethical considerations related to parent-child interactions in false accusations? In some of these instances, it is not the child who is making the accusation, but someone else. In these cases, a parent-child session may not be detrimental. In others, the children make or support the accusation, but often do so because they feel compelled to, or because they have accepted an interpretation of a non-abusive behavior as abusive. In the latter instances, they actually feel they have been abused. For children in these types of false accusations, such confrontations likely add to children's sense of impotence and betrayal.

Conclusion: Some evaluators have argued in favor of assessing the parent-child interaction to make a determination of likelihood of abuse. An apparently good interaction does not rule out abuse. It just informs the evaluator that the parent can behave appropriately. If abuse occurs while the evaluator is watching, this finding is compelling, but even that does not conclusively prove prior abuse. The practical problems and potential detrimental impact of conducting parent-child interactions argue against their routine use in determining the likelihood of abuse. However, they may be useful as one method of assessing parent-child relationship, after abuse has been ruled out. They also may be appropriate in select cases when abuse is indeterminate. In instances where they are used, the child should indicate he/she wants to see the parent, and provisions should be made to assure the child feels safe and comfortable.

DECISION-MAKING

The evaluator begins the assessment process with a series of competing hypotheses. These general categories and specific hypotheses for physical and sexual abuse are as follows:

1. Child was abused; offender the accused
2. Child was abused; another offender
    a. different daddy
    b. advanced sexual knowledge from other abuse
3. Child was not abused
    a. accident
    b. acceptable discipline
    c. child care behavior
    d. sexual knowledge from another source
    e. misinterpretation of information from the child
    f. poor interview technique by prior interviewer contaminated child's account
    g. programming by caretaker
    h. misinterpretation by caretaker
    i. consciously made false allegation
        1. by caretaker
        2. by child
        3. by both

The process of decision-making is best described as a process of ruling out hypotheses. The goal is to arrive at one or more most likely explanations for the concerns about abuse. To form these conclusions, the evaluator considers the following classes of information.

I. INFORMATION FROM THE CHILD INTERVIEW(S)

A. The behavior described by the child

1. Types of abusive acts
2. Frequency/duration of the abuse
3. Verbal description
    a. Behavior described from a child's viewpoint.
    b. Explicit accounts of abusive acts.
4. Demonstrations
    a. Medium (e.g., dolls, drawings)
    b. Explicit demonstrations
5. For sexual abuse, sexual knowledge beyond what would be expected for the child's developmental stage.

B. Context of the abuse.

1. Specifics about where it happened.
2. Specifics about when it happened.
3. For sexual abuse, grooming or use of inducements.
4. For physical abuse, precipitating event(s).
5. Whereabouts of other people
6. Specifics about the child's clothing.
7. Specifics about the alleged offender's clothing.
8. Description of an idiosyncratic event.
9. Child's recollections of emotional state.
10. Offender's emotional state.
11. Strategies to discourage disclosure.
12. Disclosures by the child.
13. Reactions of persons child has told.
14. Other (specify).

C. The child's affect in responding to direct inquiry and/or disclosure 1. Level of reluctance (explain; e.g. hesitant, no hesitance, minimizing, exaggerating)

2. Other affects (explain; e.g. fear, shame, anger, anxiety, disgust, sexual arousal, embarrassment)

II. INFORMATION FROM OTHER SOURCES

A. Medical findings

B. Explanation of the accused parent

C. Any witnesses/other victims
D. Child's statements to others
E. Observations by concerned parent(s)
F. Information from other family members
G. Information from other professionals/reports
H. Additional relevant observations by others
I. Psychological test data
J. Other information

The evaluator catalogues all of the findings and usually assigns relative importance to the available information. In making a decision about abuse, it is important to appreciate usually it will not be possible to form a conclusion, either in support or against the accusation, with 100 percent certainty. In divorce cases, there is generally less likelihood of an adult witness than in other abuse cases, and the offender is less likely to admit than in other intrafamilial cases (Faller, 1990), meaning conclusions will be less certain. However even without complete certainty, the evaluator can make recommendations that are in the child's best interest.

CONCLUSION

Cases involving divorce and abuse accusations are particularly difficult to evaluate. Because of this, a multidisciplinary, multimodal approach may be useful. Evaluators should focus first on determining the likelihood of abuse and second on making recommendations regarding custody and visitation. Even though the evaluator may feel buffeted by both parents, he/she should remain steadfast in the pursuit of the child's best interest.

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CASE MANAGEMENT CONSIDERATIONS WHEN ALLEGATIONS OF CHILD ABUSE OCCUR IN THE CONTEXT OF DIVORCE

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I. DYNAMIC CONSIDERATIONS
- A. UNLIKE OTHER INTRAFAMILIAL ABUSE CASES, PARENTS MAY BE PREDISPOSED OR MOTIVATED TO SEE OR PORTRAY THE OTHER PARENT IN A NEGATIVE LIGHT, FOR EXAMPLE AS AN ABUSER
  1. MISINTERPRETATIONS
  2. EXAGGERATIONS
  3. DELIBERATE LIES
  4. FUSED FALSE ALLEGATIONS
- B. SOME PARENTS DO THE RIGHT THING
  1. UPON DISCOVERY OF SEXUAL ABUSE, THEY PUT THE CHILDREN'S INTERESTS FIRST AND CHOOSE TO DISSOLVE THE MARRIAGE
- C. PRIOR SEXUAL ABUSE MAY BE REVEALED DURING DIVORCE
  1. CHILD MAY FINALLY TELL
  2. PARENT MAY ATTEND TO EVIDENCE
- D. SEXUAL OR PHYSICAL ABUSE MAY BE PRECIPITATED BY DIVORCE
  1. LOSS OF FAMILY STRUCTURE MAY INCREASE RISK
  2. EMOTIONS ASSOCIATED WITH DIVORCE MAY SERVE AS DISINHIBITORS

II. PROCEDURAL CONSIDERATIONS
- A. MUST RESOLVE THE ABUSE ALLEGATION BEFORE DEALING WITH ISSUE OF CUSTODY AND VISITATION
- B. STRUCTURE OF THE EVALUATION MAY DIFFER FROM THOSE WITH NO DIVORCE
  1. IT IS ADVISABLE TO INSIST OF SEEING ALL PARTIES INVOLVED
  2. CHILD INTERVIEW STILL THE MOST IMPORTANT
     - A. IT MAY BE USEFUL TO HAVE CHILD BROUGHT BY A NEUTRAL PARTY
     - B. CAN BE HELPFUL TO TEST FOR PROMPTING OR PROGRAMMING
     - C. SUPPORTED CHILDREN MAY BEHAVE DIFFERENTLY THAN NOT SUPPORTED
  3. NEXT MOST IMPORTANT INTERVIEW IS WITH THE NON-ACCUSED PARENT
     - A. IMPORTANT TO PROBE FOR CAUSE FOR CONCERN ABOUT SEXUAL ABUSE
     - B. ASSESS FOR MOTIVATION OF REPORT
     - C. ASSESS PERSONALITY
  4. INTERVIEW OF ACCUSED IS IMPORTANT
     - A. HE/SHE MAY HAVE AN ALTERNATIVE EXPLANATION FOR ALLEGED ABUSE
     - B. PERSONS WHO SEXUALLY ABUSE IN THE CONTEXT OF MARITAL DISSOLUTION MAY NOT HAVE CHRONIC HISTORIES OF SEXUAL AND OTHER DYSFUNCTION
  5. PSYCHOLOGICAL TESTING AS WELL AS INTERVIEWS WITH PARENTS HELPFUL
  6. OBSERVATIONS OF PARENT-CHILD INTERACTION TO DETERMINE ABUSE
     - A. ETHICAL PROBLEMS

B. PRACTICAL PROBLEMS

7. VERY IMPORTANT TO REVIEW BACKGROUND MATERIAL, PARTICULARLY PRIOR EVALUATIONS

8. IMPORTANT TO COMMUNICATE WITH OTHERS INVOLVED WITH THE FAMILY

A. NON-PROFESSIONALS

B. PROFESSIONALS

III. DECISION-MAKING

A. EVALUATOR WILL RARELY BE 100% CERTAIN

B. PROCESS OF RULING OUT COMPETING EXPLANATIONS

C. POSSIBLE EXPLANATIONS

1. CHILD WAS SEXUALLY ABUSED; OFFENDER THE ACCUSED

2. CHILD WAS SEXUALLY ABUSED; ANOTHER OFFENDER

A. DIFFERENT DADDY

B. SOMEONE LESS LOVED OR FEARED

3. ADVANCED SEXUAL KNOWLEDGE FROM OTHER ABUSE

4. CHILD WAS NOT ABUSED

A. ACCIDENT

B. ACCEPTABLE DISCIPLINE

C. CHILD CARE BEHAVIOR

5. SEXUAL KNOWLEDGE FROM ANOTHER SOURCE

6. MISINTERPRETATION OF DATA FROM THE CHILD

7. POOR INTERVIEW TECHNIQUE BY PRIOR INTERVIEWER

8. PROGRAMMING BY CARETAKER

9. MISINTERPRETATION BY CARETAKER

10. CONSCIOUSLY MADE FALSE ALLEGATION

A. BY CARETAKER

B. BY CHILD

C. BY BOTH

IV. WHAT IF YOU CAN'T DECIDE?

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LITERATURE REVIEW

Research on False Allegations of Sexual Abuse in Divorce

—by Kathleen Coulborn Faller, David L. Corwin, and Erna Olafson

The statement, "There is an epidemic of false allegations of sexual abuse in divorce cases," is regarded by some as a truism. The argument is that women seeking to win custody of their children, to cut off the father's visitation, or to wreak vengeance on former spouses, falsely accuse them of child sexual abuse (Mantell, 1988; Renshaw, 1985; 1986). Such is the assertion of accused fathers, their attorneys (Gordon, 1985), and their expert witnesses (Blush & Ross, 1986; Gardner, 1989). Moreover, the media have supported and broadcast these views, and many professionals with mandated responsibility for these cases, including child protection workers, law enforcement personnel, and, most importantly, judges, have come to believe that abuse allegations during divorce are likely to be false.

Are there any empirical findings that lend credibility to the view that most allegations of child abuse in divorce are false? In this article, literature addressing this issue will be critically reviewed, looking specifically at data cited, sample size, any sample biases, and the criteria employed to determine the veracity of the allegation.

Studies providing no data

Writers holding the most extreme positions and promulgating new "syndromes" provide no data to support their statements (Blush & Ross, 1986; Gardner, 1987).

Blush and Ross have propounded the Sexual Allegations in Divorce (SAID) Syndrome, the overwhelming majority of which they assert are false. These false allegations are fostered by mothers, whom Blush and Ross label psychotic or hysterical (dominated, dominating, or "justified vindicators"). They advise that almost no weight should be given to any statement made by the child, and in practice they may not even interview the child. However, Blush and Ross maintain, great weight should be given to the fact that these allegations are made by mothers who wish to restrict their ex-partners' access to their children (Ross, 1988). Blush and Ross find fathers much less likely to make false allegations, and describe those who do as rigid and hypercritical of their estranged wives. Falsely accused men are also described as inadequate, dependent, and passive, descriptors the authors also apply to incest perpetrators.

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Literature Review

-Kathleen Coulborn Faller, David L. Corwin, and Erna Olafson

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Since no data are provided, there is no way to evaluate the SAID Syndrome, other than to note that the admonition to put little weight on children's accounts is contrary to general practice (see Conte et al., 1991).

Perhaps even stronger views are held by Gardner (1987; 1989; 1991; 1992), who has defined the Parental Alienation Syndrome (PAS), which is manifest in children who "view one parent as all good and the other as all bad." These children have been "programmed by their mothers to hate their father and to subject him to a campaign of denigration" (Gardner, 1992, p. 160). Among the material the mother sometimes also programs the child to believe is that the father has sexually abused him/her. When an allegation arises after a dispute over custody, Gardner believes it possesses a "high likelihood of being false" (Gardner, 1991, p. 4).

There is no way to evaluate authors' opinions not supported by data. Thus all that can be said about the SAID Syndrome and the Parental Alienation Syndrome is that they express the authors' opinions.

A companion to the PAS is the Sexual Abuse Legitimacy Scale (SALS, Gardner, 1987). The present version (1992) contains 84 differentiating criteria, 24 of which apply to the alleged offender, 30 to the child, and 30 to the mother. Many of these criteria relate specifically to allegations of abuse in divorce. For example, if one finds, in examining the mother, "the presence of a child custody dispute and/or litigation," "enlistment of the services of a 'hired gun' attorney or mental health professional," or "history of attempts to destroy, humiliate, or wreak vengeance on the accused," her allegations are less likely to be true, according to Gardner.

Gardner presents no data to validate either the PAS or the SALS. Therefore, the utility of the scales cannot be evaluated. Most of Gardner's writing on these topics is not peer reviewed and is published through his own press.

Studies involving small samples

The first and oft-cited clinical study of false allegations of sexual abuse in divorce involved a single case and reference to a second one (Kaplan & Kaplan, 1981). In the case, described in detail, an 11-year-old boy and his 5-year-old sister made allegations against their father and paternal grandparents. Both children had testified numerous times in court about the abuse and persisted in their accusations when challenged. Indeed, the Kaplans describe one particularly stormy session in which the boy is confronted simultaneously by the paternal grandparents and one of the Drs. Kaplan. Because, during this session, the boy partially recanted and said he had only been anally penetrated once instead of numerous times, the Kaplans conclude that his allegation is false. His partial recantation also led them to doubt the sister's account even though, in addition to her statements, she had a number of behavioral and emotional symptoms of sexual victimization. The Kaplans propose the possible dynamic of folie á deux as an explanation for the children's allegations, despite the fact there was no delusional thinking diagnosed in either child, the mother, or the maternal grandparents, who were supportive of the allegations, and despite the fact that the allegations originated with the children rather than a dominant adult.

Another frequently quoted study is that of Schuman (1986), who cites seven cases determined to be false on the basis of "psychodynamic formulation" and court determinations, out of an unknown number seen in his practice of probate and family court cases. Six of these were sexual abuse allegations against a father or stepfather; the seventh was a physical abuse case. The psychodynamic explanation for the false allegations was regression by the child and the accusing adult; in addition, in some instances (Schuman does not say how many) this adult retracted the allegation. This study is limited by its small sample size and by the lack of an empirical basis for the criteria Schuman uses to determine that allegations are false.

A study that has excited quite a lot of controversy is one reported by Green (1986) involving 11 cases from his practice, four of which (36%) he believed to be false. From these four cases, he generates criteria indicative of a false allegation, including easy disclosure, no evidence of negative affect, use of adult sexual terminology, checking with the accusing parent (mother) during the interview, and an ability to confront the father with the accusation. Falsely accusing mothers are described as hysterical and paranoid.

Green's conclusions were challenged because of the size and bias of his sample, and because one of his "false" cases was deemed possibly valid by two other experts in child sexual abuse (which would reduce his rate of false cases to 27%). His paper occasioned a rebuttal article (Corwin, Berliner, Goodman, Goodwin & White, 1987) as well as a letter to the editor of the journal that published the original article, challenging its findings (Hanson et al., 1988). Among other things, Corwin and colleagues point out that there is a difference between a false (no abuse) and an unsubstantiated case (a null finding). In addition, they note that marital dissolution may increase the risk of sexual abuse and increase the likelihood of disclosure of pre-existing incest.

Benedek and Schetky (1985) also present findings from their private practices. They were interested in studying the characteristics of false allegations in divorce, and Benedek (1987) reports screening at intake to include suspected false cases and to exclude ones that appeared to be true. Fourteen of the 18 cases they assessed involved custody or visitation disputes in the context of divorce (four involved other issues related to custody). The authors thought that 10 of their cases were false (71% of 14 and 56% of 18). Not surprisingly, since they screened for false cases, this i

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the highest false allegation rate reported by any author presenting case data. All but one of the allegedly false allegations were made by mothers. It is not clear what criteria Benedek and Schetky used to determine that allegations were false; among the explanatory factors they cited were that the mother suffered from psychiatric disturbance ("paranoia" was the diagnosis most frequently mentioned by the authors), or wished to exclude their ex-spouses from their lives, were being vindictive, or were "crying wolf."

A much larger study (576 cases) of sexual abuse cases referred to child protective services provided findings relevant to the issue of sexual abuse and divorce (Jones & McGraw, 1987). Criteria employed in classifying the cases as likely true or likely false consisted of source of report, vindictiveness of parties, emotional disturbance in the accuser or the accused, abnormal parent/child relationships, timing of report, child's emotional state, physical evidence, confessions, polygraph results, and court role. Of the 5% of cases which a team of sexual abuse experts determined were "fictitious" allegations by adults, a large proportion involved contested custody or visitation. These findings suggest that false accusations are very rare generally, but may be more common in the context of custody disputes.

In a subsequent study by Jones and Seig (1988), 20 divorce cases involving accusations of sexual abuse from the Kempe Center were evaluated using the Jones and McGraw (1987) criteria to ascertain the rate of fictitious allegations. Four cases (20%) were determined to be fictitious, 14 (70%) reliable, and 2 (10%) uncertain. In this study, the authors observed that factors thought to be characteristic of false allegations were noted in the reliable cases, and characteristics expected in reliable cases were noted in the fictitious ones.

"There is a fair amount of disagreement among writers about characteristics of false allegations. Indeed, one professional's indicator of a false allegation may be another's indicator of a true one. In addition, some criteria lend themselves to a variety of interpretations, either in the context of a single case, or depending upon the case."

Using the criteria developed by Jones and McGraw (1987) and used by Jones and Seig (1988), McGraw and Smith (1992) re-examined 18 cases referred to Boulder County Protective Services involving sexual abuse allegations in the context of divorce, all but one of which had been unfounded after CPS investigation. The results of this re-examination were that eight cases (44.4%) were founded, seven cases (39%) had insufficient information or unsubstantiated suspicion, and three (16.5%) were fictitious (one from a child and two from adults). The authors admonish investigators and clinicians to keep an open mind when investigating such cases, rather than assuming that they will be false.

Studies comparing divorce cases to other sexual abuse cases

Two studies compare results from divorce and non divorce cases. Paradise, Rostain, and Nathanson (1988) examined 31 cases, (25 from Children's Hospital of Philadelphia and six from the first author's private practice), 12 of which involved divorce. Those cases involving divorce were significantly less likely to be substantiated: 67% substantiation rate in divorce cases vs. 95% substantiation rate in cases not involving divorce. In addition, children in the divorce group were significantly younger (5.4 years vs. 7.8); this age difference may have affected substantiation rates, since cases involving younger children may be generally more difficult to substantiate (Thoennes & Tjaden, 1990).

Hlady and Gunter (1990) examined the records of 370 children seen at the Child Protection Service Unit at British Columbia Children's Hospital. One hundred seventeen children were primarily referred for alleged physical abuse, and 253 for alleged sexual abuse. Forty-one children were the objects of custody disputes. Surprisingly, children involved in custody disputes were more likely to exhibit physical findings (71% had findings of physical abuse, 17.6% had findings of sexual abuse) than were children not involved in custody disputes (43.6% showing findings of physical abuse, 15% of sexual abuse). Generalizations from these data must be cautious, since the number of custody cases with allegations of physical abuse was small, and the difference on sexual abuse cases was not significant. However, these data suggest that sexual abuse allegations made in the context of divorce are at least as likely to have the corroboration of medical findings.

More studies comparing commonly evaluated characteristics of sexual abuse cases in divorce and other contexts would be very useful.

Studies involving larger samples

To date, there are two pieces of research with samples larger than 100 cases. Faller (1990) studied 136 cases involving divorce that were referred to the University of Michigan Interdisciplinary Project on Child Abuse and Neglect, which includes a tertiary care program for evaluation of child maltreatment cases. Using criteria derived from a study of confessed cases, Faller determined the likelihood of sexual abuse in her sample. These criteria included (1) description of the sexual abuse; (2) details about the context; and (3) affect congruent with allegations and circumstance. Faller categorized these cases into six groups: cases in which disclosure of apparently true abuse leads to divorce (N=11; 8.1%); cases in which divorce leads to disclosure of apparently true abuse by the child or belief by the parent (N=26; 19.1%); cases in which divorce leads to sexual abuse (N=52; 38.2%); cases in which apparently false allegations arise in an atmosphere of acrimony surrounding the divorce

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(N=19; 14%); cases in which false allegations may have been made (N=12; 8.8%); and cases in which other dynamics were at work (N=16; 11.8%). Of the 19 cases involving apparently false allegations, three appeared to be consciously made; two of these three intentionally false allegations were made by fathers.

By far the most important study to date is that conducted by the Association of Family and Conciliation Courts Research Unit (Thoennes, Pearson, & Tjaden, 1988; Thoennes & Tjaden, 1990). The researchers surveyed 9,000 divorce cases involving custody/visitation disputes from 12 domestic relations courts to determine how many such disputes involve allegations of sexual abuse. The researchers found allegations of child sexual abuse in less than two percent (169) of these cases. In 129 cases, the question of sexual abuse was addressed by the domestic relations court. Accusations were made by mothers (67%), fathers (28%), and third parties (11%). Fewer than half of cases involved mothers making accusations against the fathers of children.

On the basis of the research that has been conducted so far, it is difficult to support an assertion that there are high rates of false allegations of sexual abuse consciously made by mothers in divorce situations.

Using the Child Protective Services determination and/or the report of a court-appointed mental health evaluator as the criteria for substantiation, the researchers found that 50% of cases were likely, 33% were unlikely, and 17% were uncertain (which included cases in which two evaluators held different opinions). They also attempted to discern the motivation for unlikely reports and found 58 cases in which the case material addressed that issue. In eight cases, child protective service workers thought the allegation was maliciously made. Factors associated with cases being classified as unlikely or uncertain were younger age of the child, a single incident alleged, non-intrusive sexual behavior, a single report, a report less than two years since the filing for divorce, and animosity between the parents.

Conclusions

On the basis of the research that has been conducted so far, it is difficult to support an assertion that there are high rates of false allegations of sexual abuse consciously made by mothers in divorce situations.

There is no way to evaluate authors' opinions not supported by data. Thus all that can be said about the SAID Syndrome and the Parental Alienation Syndrome is that they express the authors' opinions. Moreover, the language used in both suggests a bias against mothers concerned about sexual abuse of their children.

The remainder of the research can be evaluated regarding possible sample biases, sample size, and criteria used to determine that the allegation is false.

With the exception of the research supported by the Association of Family and Conciliation Courts (Thoennes & Tjaden, 1988; Thoennes & Tjaden, 1990) and that by Paradise and colleagues (1988), all of the studies cited rely on cases from a single source. A single site or source may introduce biases based upon geography, the authors' selection criteria, and the reputation of the clinician or the site. Selection criteria include such factors as Benedek's screening for cases she thought might be false, or Faller's taking cases referred by another agency. Payment source for the service may also determine the sorts of cases seen at a particular site. In addition, cases seen in private practices are likely to differ from those seen at an agency or at a hospital.

Sample size is also very important in weighing the utility and potential validity of findings. It is very difficult to draw any conclusions from samples smaller than 20 cases. Particularly problematic is the situation in which the writer draws conclusions about characteristics of false allegations from a subset of a small sample, as does Green (1986).

The most difficult problem in evaluating research on allegations of child sexual abuse is evaluating the criteria researchers use to assess the veracity of allegations. To test these criteria, researchers need to see if they are in fact reflected in a sample of cases proven false or true by some independent measure (for example, that the offender never had access to the victim, or, alternatively, that the offender gave a complete, detailed confession). Since such samples are hard to find and indeed may be unrepresentative, research on the veracity of child sexual abuse allegations cannot draw upon them. Most writers use their clinical judgment, the consensus of several clinicians or experts, or a legally supported decision, such as the disposition of the child protection agency, the conclusion of a court-appointed expert, or a judge's opinion. All of these have limitations. Jones' and Seig's (1988) determination that cases thought to be reliable had characteristics of false reports and vice versa is illustrative. So is the Association of Family and Conciliation Courts' classification of cases as "uncertain" when two opinions disagreed.

Moreover, there is a fair amount of disagreement among writers about characteristics of false allegations. Indeed, one professional's indicator of a false allegation may be another's indicator of a true one. In addition, some criteria lend themselves to a variety of interpretations, either in the context of a single case, or depending upon the case.

When the research is examined critically, the strongest study is that conducted by the Association of Family and Conciliation Courts, because of its large sample, its use of multiple sites, and the fact that cases are fairly representative of the total population of divorce cases with disputes over custody and visitation. Its findings indicate that sexual abuse allegations do occur in the context of divorce, but the overwhelm-

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ing majority (98%) of disputed custody cases do not involve sexual abuse accusations. Moreover, although the majority of charges are brought by mothers, by no means all are. The predominance of women as accusers and men as accused is consistent with the finding that the majority of offenders are men. This study and that of Faller contradict the assertion by others that most adults who make false reports do so knowingly (e.g. Benedek & Schetky, 1985; Blush & Ross, 1986; Gardner, 1987; Renshaw, 1986).

Where the Association of Family and Conciliation Courts may be weaker than other studies is in the criteria it used to judge the veracity of an allegation: the child protective services determination or a court- appointed mental health professional's opinion. Perhaps criteria such as those based on a consensus of experts or a collaborative decision (Jones & McGraw, 1987; Jones & Seig, 1988; McGraw & Smith, 1992) or derived indirectly from cases substantiated by confession (Faller, 1990) are more accurate. Interestingly, substantiation rates tend to be higher in such studies and uncertainty rates lower.

Perhaps the likelihood of a parent making a false allegation in a divorce has increased because of greater awareness of sexual abuse and of the potential power of an allegation. Conversely, adults cognizant of the recent outcomes in such cases may be less likely to raise a legitimate concern about sexual abuse because the legal consequences may further traumatize a child and family without stopping the abuse.

Altogether 11 data-based articles about sexual abuse allegations in divorce are cited here. This number is too small to draw more than tentative conclusions. Moreover, characteristics of allegations in divorce may be influenced by increased public education and experience regarding sexual abuse, so that samples that are just five years old may not reflect current caseloads. Perhaps the likelihood of a parent making a false allegation in a divorce has increased because of greater awareness of sexual abuse and of the potential power of an allegation. Conversely, adults may be cognizant of the recent outcomes in such cases. These include disbelief by the court or refusal to hear evidence of sexual abuse, incarceration of the parent who refuses visitation, loss of custody by the parent alleging sexual abuse, and negative experiences of parents, who with their children may go so far as to enter the "underground" to avoid court decisions. This knowledge may result in parents becoming less likely to raise a legitimate concern about sexual abuse because the legal consequences may further traumatize a child and family without stopping the abuse.

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Overcoming Obstacles

to Accurate

Communication with Children

Presented by

Anne Graffam Walker, PhD

CHECKLIST FOR INTERVIEWING/QUESTIONING CHILDREN
Revised September 1995

Developed by
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I. Framing the Event

1. Did I tell the child my name and what my job is -- in non-technical words?

2. Did I help the child become familiar with the surroundings of the interview?

3. Did I tell the child the purpose of our talk, and why it is important, and what will happen afterward?

4. Did I give the child a chance to ask me questions about this talk? Did I try to establish a common vocabulary for the things we talk about? Was I listening to the kind of words and sentences that the child used?

II. Using Clear Language

5. Did I use easy words instead of hard ones? (Do I know what a "hard" word is?)

6. Did I avoid legal words and phrases?

7. Did I use words that mean one thing in everyday life, but another thing in law (like "court"?)

8. Did I assume that because a child uses a word, he or she understands the concept it represents?

9. Was I as redundant as possible? That is, did I use specific names and places instead of pronouns (like "he" and "we") and vague referents (like "it", "that", and "there")?

III. Asking the Questions

10. Did I keep my questions and sentences simple? Did I try for one main (new) thought per utterance?

11. Did I avoid asking "DUR-X" questions? [Questions that begin, "Do you remember", followed by one or more full propositions. Ex. with propositions underlined: Do you remember telling me that somebody hurt you?]

12. When I shifted topics, and when I moved from the present to the past or vice versa, did I alert the child that I was going to do so?

13. Did I give the child the necessary help in organizing his or her story?

14. Did I avoid asking the child about abstract concepts, like, "What is the difference between truth and lies?" Did I choose instead to give the child everyday, concrete examples and let him or her demonstrate, rather than articulate knowledge of truth and lies, right and wrong?

15. Did I use as few negatives as possible in the questions I asked?

IV. Listening to the Answers

16. Were the child's RESPONSES to my questions, ANSWERS to my questions? Am I sure?

17. If the child's answers were inconsistent, did I ask myself if:
    a. I, or someone else, had asked the same question repeatedly?
    b. I had changed the wording of a question I had asked before?
    c. I was forgetting that children can be very literal in their interpretation of language?
    d. The child's processing of language might not be as mature as mine?

V. Global Checks

18. Did I stay in the child's world by framing my questions in terms of the child's experience?

19. Did I take the child's understanding of language for granted?

20. Was I listening to my OWN language, my OWN questions?

21. Did I ask myself before I began: Am I gathering information, or doing therapy?

A FEW FACTS ABOUT CHILDREN'S LANGUAGE SKILLS

Revised September 1994

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In general:

By the age of 3, average children use language of a grammatical complexity similar to an adult's everyday language. Their vocabulary can range from about 500 to 3,000 words. They can identify over five parts of their own bodies.

By age 5-6, the basic language structures of most children are well established, although not yet fully mature. They can define SOME simple words. They can accurately name 3-4 colors. With a vocabulary generally estimated at around 14,000 words, their language sounds on the surface much like an adult's.

This misleading surface similarity of language does not mean, however, that these children have achieved mastery of their language. Late acquisitions include (but are not limited to) the ability to handle 1) complex sentences containing relative (e.g., who, which, that) or adverbial (e.g., when, before, after, while) clauses; 2) some critical verb structures like passives; 3) complex negation, and 4) complex structural distinctions such as those between ask and tell, know and think, easy to (see/please/etc) and eager to (see, etc) and some syntactic aspects of the verb "promise" -- that is, the way we use the word (not the concept of) "promise" in a sentence.

Nor does the apparent similarity mean that children this age have mastered all those concepts expressed in language, such as abstractions (What is truth?) or relations of age, time, speed, size, and duration: (How old is she? When did it happen?, How fast was the car going?, How big was the knife?, How many times did that happen to you?) They do not fully understand the family relationships expressed by kinship terms such as parents, aunt, grandfather, etc.

By age 10-11, most children have acquired the ability to use most of these relational words in an adult fashion.

Specific lexical skills:

Feature	Age*
Adjectives	
Comparatives (e.g., more, bigger)	4 - 5
Superlatives (e.g., most, biggest)	3 - 6
Ability to make complex comparisons in response to Q's (e.g., Which box is taller than it is fat?)	6+

Feature	Age*
Adverbs	
Distinction between before/after	7+
'Frontwards', 'sidewards', 'backwards'	about 7
Articles	
Full mastery of contrast between 'the' and 'a'	8
Prepositions	
In, on (first two acquired)	1-1/2 to 2
Off, out (of), away (from)	2 to 3
Toward, up, down	.3 to 3-1/2
In front of, next to, around	3-1/2 to 4
Beside	4 to 4-1/2
Ahead of, behind	4-1/2 to 5-1/2
Pronouns	
Possessives:	
My, your, their, mine, his	by age 3-1/2
Her(s), his, its, our(s)	3 - 5
Deictic ("Pointing") pronouns "this" v. "that" (when no fixed referent is available)	7+
Accurate matching of pronouns to prior or following noun	about 10
Verb contrast between come-go; bring-take	7 - 8+
tell-ask	8 - 10
WH questions (WHat, WHere, WHo, WHy, How, WHen)	
Appear in child's speech (in approximately above order)	from 2-1/2 to 4-1/2
Appropriate grammatical response to WH Q's acquired	by age 5-1/2
Appropriate cognitive response to WHy, How, WHen	by about age 10
Syntactic Skills:	
Passives: with action verbs (e.g., hit, push)	5+
with all verbs, including non-action (e.g., like)	7 - 13+
(earliest form of passive is the agentless "Get" passives (e.g., I got hit)	
"Tag" questions (e.g., Xxx, isn't it? tag underlined, produced at about age	4+
but when combined with negatives, (That's not what she said; isn't that so?) can be confusing on into adulthood	

Feature	Age*
Conversational skills:	
Understanding turn-taking	before age 2
Asking contingent questions: (Contingent questions relate to the immediately prior utterance; e.g., questions which indicate that something just said is not fully understood, such as "What did you say?")	by age 3
Ability to report typical events (such as what happens at a birthday party	3
Ability to describe, narrate, and inform in adult-satisfactory way	May still be developing in Jr and Sr High School years

*The ages given here represent approximations of the time when each feature is fully and reliably acquired – meaning that the child can both comprehend and produce the feature. Children reach different stages, of course, at individual times that can vary widely.

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A FEW ABBREVIATED SUGGESTIONS FOR QUESTIONING CHILDREN

Revised October 1997

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General precepts:

1. Reduce the processing load that children must carry: aim for simplicity and clarity in your questions. If the child uses simple words and short sentences, so should you.

2. Be alert for possible miscommunication. If a child's answer seems inconsistent with prior answers, or doesn't make sense to you, check out the possibility that there is some problem 1) with the way the question was phrased or ordered, 2) with a literal interpretation on the part of the child, or 3) with assumptions the question makes about the child's linguistic/cognitive development or knowledge of the adult world.

Some specifics:

1. Break long sentences/questions into shorter ones that have one main idea each.

2. Choose easy words over hard ones: use Anglo-Saxon expressions like "show," "tell me about," or "said" instead of the Latinate words "depict," "describe," or "indicated."

3. Avoid legal jargon, and "frozels" (my term for frozen legalisms) like "What if anything," "Did there come a time."

4. It is important that you and the children use words to mean the same thing, so run a check now and then on what a word means to each child. Although children generally are not good at definitions, you can still ask something like, "Tell me what you think a ____ is," or "What do you do with a ___/What does a ___ do?" Don't expect an adult-like answer, however, even if the word is well-known. The inability to define, for example, "wind" does not mean that the person does not know what the wind is. Definitions require a linguistic skill.

5. Avoid asking children directly about abstract concepts like what constitutes truth or what the difference is between the truth and a lie. In seeking to judge a young (under 9 or 10) child's knowledge of truth and lies, ask simple, concrete questions that make use of a child's experience. Ex: I forgot: how old are you? (Pause) So if someone said you are ___, is that the truth, or a lie? [Young children equate truth with fact, lies with non-fact.]

6. Avoid the question of belief entirely (Do you believe that to be true?).

7. Avoid using the word "story." (Tell me your story in your own words.) "Story" means both "narrative account of a happening" and "fiction." Adults listening to adults take both meanings into consideration. Adults listening to children, however, might well hear "story" as only the latter. "Story" is not only an ambiguous concept, it can be prejudicial.

8. With children, redundancy in questions is a useful thing. Repeat names and places often instead of using strings of (often ambiguous) pronouns. Avoid unanchored "that"'s, and "there"'s. Give verbs all of their appropriate nouns (subjects and objects), as in "[I want you to] Promise ME that YOU will tell ME the truth," instead of "Promise me to tell the truth."

9. Watch your pronouns carefully (including "that"). Be sure they refer either to something you can physically point at, or to something in the very immediate (spoken) past, such as in the same sentence, or in the last few seconds.

10. In a related caution, be very careful about words whose meanings depend on their relation to the speaker and the immediate situation, such as personal pronouns (I, you, we), locatives (here, there), objects (this, that), and verbs of motion (come/go; bring/take).

11. Avoid tag questions (e.g., "You did it, didn't you?"). They are confusing to children. Avoid, too, Yes/No questions that are packed with lots of propositions. (Example of a bad simple-sounding question, with propositions numbered: "[1] Do you remember [2] when Mary asked you [3] if you knew [4] what color Mark's shirt was, and [5] you said, [6] 'Blue'?" What would a "Yes" or "No" answer tell you here?) It does not help the factfinder to rely on an answer if it's not clear what the question was.

12. See that the child stays firmly grounded in the appropriate questioning situation. If you are asking about the past, be sure the child understands that. If you shift to the present, make that clear too. If it's necessary to have the child recall a specific time/date/place in which an event occurred, keep reminding the child of the context of the questions. And don't use phrases like, "Let me direct your attention to." Try instead, "I want you to think back to...," or "Make a picture in your mind ...," or "I'm going to ask you some questions about...."

13. Explain to children why they are being asked the same questions more than once by more than one person. Repeated questioning is often interpreted (by adults as well as by children) to mean that the first answer was regarded as a lie, or wasn't the answer that was desired.

14. Be alert to the tendency of young children to be very literal and concrete in their language. "Did you have your clothes on?" might get a "No" answer; "Did you have your p.j.'s on?" might get a "Yes."

15. Don't expect children under about age 9 or 10 to give "reliable" estimates of time, speed, distance, size, height, weight, color, or to have mastered any relational concept, including kinship. (Adults' ability to give many of these estimates is vastly overrated.)

16. Do not tell a child, "Just answer my question(s) yes or no." With their literal view of language, children can interpret this to mean that only a Yes or a No answer (or even "Yes or No"!) is permitted -- period, whether or not such answers are appropriate. Under such an interpretation, children might think that answers like "I don't know/remember," and lawfully permitted explanations would be forbidden.

Some Basic Sentence-Building Principles
For Talking to Children

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1. Vocabulary

- Use words that are short (1-2 syllables) and common.
  ex: "house", instead of "residence"
- Translate difficult words into easy phrases.
  ex: "what happened to you" instead of "what you experienced"
- Use proper names and places instead of pronouns.
  ex: "what did Marcy" do? instead of "what did she do?"; "in the house" instead of "in there"
- Use concrete, visualizable nouns (back yard) instead of abstract ones (area).
- Use verbs that are action-oriented.
  ex: "point to", "tell me about," instead of "describe"
- Substitute simple, short verb forms for multi-word phrases.
  ex: "walked", instead of "was walking"
- Use active voice for verbs instead of the passive.
  ex: "Did you see a doctor?" instead of "Were you seen by a doctor?"
  [Note: One exception: the passive "get" ("Did you get hurt?"), which children acquire very early, and is easier to process than "Were you hurt?"]

2. Putting the words together

- Aim for one main idea per question/sentence.
- When combining ideas, introduce no more than one new idea at a time.
- Avoid interrupting an idea with a descriptive phrase. Put the phrase (known as relative clauses) at the end of the idea instead.
  ex: "Please tell me about the man who wore the red hat."
  instead of "The man who wore the red hat is the one I'd like you to tell me about."
- Avoid difficult-to-process connectives like "while" and "during".
- Avoid negatives whenever possible.
- Avoid questions that give a child only 2 choices. Add an open-end choice at the end.
  ex: Was the hat red or blue, or some other color?

BOTTOM LINE: SHORT AND SIMPLE IS GOOD.

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Handouts for Overcoming Obstacles to Accurate Communication with Children
Three sessions: Wed. 3/18 @ 1:15; 3/18 @ 3:00; and Thur. 3/19 @ 8:00 a.m.

1. THREE VERY USEFUL STATEMENTS
when interviewing children of any age

1. I wasn't there, so ...
2. Even if you think I know it, tell me anyway.
3. Even if you think it doesn't matter, tell me anyway.

2. EXAMPLES OF INDEXICALS: WORDS THAT "POINT"

Personal pronouns: I, you, him, we, they ...
here / there
IT
this / **THAT**
come / go
bring / take

3. AVOIDING PROBLEMS WITH PRONOUNS AND OTHER POINTING WORDS

When YOU speak:

1. Be specific:
   Put the nouns back in.
   Be sure the meaning of "it" and "that" are clear.
2. Repeat proper names and places — a LOT.
3. Repeat phrases from earlier questions or statements you or the child has made.

When the CHILD speaks:

4. Be very careful about taking the meaning of the child's pronouns for granted.

4. **COMPREHENSION OF QUANTIFIERS:***
WORDS USED TO TALK ABOUT SETS OF THINGS
Children ages 4-7

Choosing among 4 things:	Success Rate with Two tasks: easy and harder
All	100%
Another	49% and 51%
Either	46%
Choosing between 2 things:	
Both	100%
None	87% and 89%
Neither	31% and 43%
Each	31% and 3%

*Adapted from Camille Hanlon, in F. Kessel, 1988

THE MISMATCH BETWEEN LINGUISTIC AND COGNITIVE SKILLS

5. The example below illustrates the difficulty children have 1) in providing a clear description — a necessary component of stories, and 2) accommodating to the lack of understanding on the part of a listener. Child is 5 years old, the primary witness for the State in the three trials for the murder of a child by three children. She is under cross-examination.

Q. Do you remember telling them on that date that Mark was white and Jim was black?
A. And Chuck was mixed.
Q. Oh, I see, Chuck was mixed. What do you mean by "mixed"? Is that --
A. White and black --
Q. Okay.
A. -- is mixed.
Q. And it isn't -- It isn't like this, like if you took a line and put it in the middle, half white and then half black on this side, is it?
A. No.
Q. It means somebody who's lighter colored?
A. His whole face is mixed.
Q. Okay. I'm not quite sure I understand "mixed." Do you mean -- Do you mean light -- a lighter color, closer to mine but still darker than me?
A. Mixed.
Q. Mixed up on their face?
A. No.
Q. Okay. Tell me what you mean. I'm not -- I'm sorry.
A. I -- I mean how people's face is. They're mixed.

The following two examples (size, and time) illustrate both difficulties that children have in matching words to concepts, and that we have in understanding just what the problem is.

6. SIZE

Cross-examination of a same 5-year-old girl as above.

Q. How tall is Jim? Is he -- Well, let me look. Is he taller than me?
A. Yeah.
Q. Okay.
A. About taller than you, above your head.

6. SIZE: cont'd.

Q. Like about this high?
A. Yeah.
COUNSEL: I think the record -- oh --
A. He's big.
Q. Real big?
A. Big.
Q. Bigger than this?
A. He's that big.
Q. That big.
COUNSEL: I'm about five eleven, Judge. I guess that's about a foot above my head.
Could the record reflect that?

7. TIME: Dates

Voir dire by the judge of a 5-year-old child, taken from the same trial as above.

Q. Okay. Do you know what your birth date is? I bet you know that?
A. No.
Q. When were you 5 years old?
A. I am 5.
Q. You are 5?
A. (Witness nods).
Q. Okay, when will you be 6?
A. When my birthday comes.
Q. Ask a silly question, get a silly answer -- or get a straight answer. Okay. How long ago did you have your birthday?
A. I didn't HAVE my birthday.

8. TRUTH AND LIES

SUGGESTIONS FOR ASSESSING CHILDREN'S T/L COMPETENCY

Problematic:
Asking child to identify a SHORT hypothetical Q YOU ask ["If I said..."].

Better:
Asking short hypothetical Q made by someone other than you or the child. ["If this puppet/Susie/your sister said"].

Best:
Use drawings prepared by Saywitz and Lyon or similar ones.

THE WAY WE STRING OUR WORDS TOGETHER

9. FOUR MAJOR COMPLICATING FACTORS IN SENTENCES/QUESTIONS

1. Vocabulary

2. Number of ideas

3. How the ideas are strung together

4. Amount of cognitive power required

10. NEGATION

1. Negation takes longer to process.
2. The more kinds of negation, the tougher the processing.
3. Three kinds of negation are:

Syntactic:	NOT, NO (as in "no more")
Morphological:	Unhappy, impolite, irresponsible
Semantic:	Forget, Deny, Miserable, Disappointed

4. The hardest kind to process seems (surprisingly?) to be Syntactic: Not, and No. This fact can lead to children misprocessing a negative question as if it were a positive one.

11. DO YOU REMEMBER (X) QUESTIONS

Structure of a "DUR/X" question:

Do you remember [X]
saying [Y]
(that) J had the knife [Z]
when D got hurt?

12. CURE FOR COMPLEX QUESTIONS

CHECK: on the child's language

Think **AULM**:

Ask: short WH and "tell me about" questions.
Use: simple home-type ("kitchen") words.
Listen: to the child's responses to what you ask/say.
Match: the length and complexity of your questions to the child's language.

THINK SIMPLE:

- ONE main (new) idea at a time is good.
- if COMBINING old and new ideas, try putting the NEW idea first.
- USE simple tenses: present and past is good.
- DROP unnecessary words.
- AVOID negatives, when possible.

The Rules of Evidence and the Courts:

Using Them to Win Your Case

Presented by

Steven K. Aldridge, JD

The Rules of Evidence:
A Legal Review

By
Steven R. Aldridge
Assistant District Attorney

Right now, you're probably thinking . . . *"Why me? Why should I worry about the rules of evidence? That's not my job!! I just do my investigations, and leave all the legal stuff to my DA!"*

I know that's what you're thinking because I've felt the same way myself . . . about your job! But, the truth is, we can't afford to think that way any longer. What we do is just too important. Ask your clients. And just as we have gotten better at our jobs . . . and we have! . . . so have the defense attorneys and skeptics who challenge us every day.

So, now more than ever, it's up to all of us to do everything we can to make sure that not only do we conduct a thorough, professional investigation, but that our findings will be admissible in court as well. Only then can we truly say that we are really doing everything we can for our clients . . . the abused children we meet who have no one else to depend on.

So, that's why the rules of evidence are important . . . to all of us! Or, as the old saying goes . . . If you're gonna play the game, you gotta know the rules! And, as "evidenced" by your choice of a career, you have most definitely chosen to play the game . . . a game always played in a adversarial setting, governed by a strict set of legal rules, where the other team always has the "home-court" advantage! So, learn the rules and use them to your advantage. The stakes are just too high to do anything less!

Finally, I can think of one more good reason to learn the rules . . . your DA wants you to! I know because I'm a DA, too! And I know it helps me do a better job when you know what I need to present a successful case in curt and what I can and can't do in trial. Or, as someone else said . . . "Trust me . . . I'm a lawyer!"

Convinced yet? Good! Then let's get started!

The Rules of Evidence: A Legal Review

By: Steven K. Aldridge, Assistant District AttorneyK

I. **Learning to "Play The Game"**

A. A change in perspective is all that's required!.

1. If it helps, think of the law - judges, courts, and lawyers - as a club, a very "secret" club!
   a. Historical precedence - historically, the use of Latin; Star Chamber proceedings, and charging "by the word" created an aura of secrecy.
   b. Today - LSAT's, bar exams, legalese, and the role of law-makers in our society help continue this perception.
2. Ask yourself, what are the characteristics of a "secret" club?
   a. Limited membership?
   b. A "secret clubhouse" where only a few may enter?
   c. A mysterious leader?
   d. Rituals?
   e. A secret language?
   f. Uniforms?
3. Now, ask yourself, what do lawyers use?
   a. Limited membership? Sure, the LSAT, the 1/3-cut policy, and the bar exam insure this part.
   b. A "secret clubhouse"? Yes, the courtroom!
   c. A mysterious leader? Yes, again . . a leader who sits up over everyone else in the clubhouse dressed in a sinister black robe!
   d. Rituals? . . . That's right, lawyers call them "motions" and "pleadings".
   e. A secret language? Right again! "legalese" flavored with a heavy dose of Latin; and
   f. Uniforms? Of course - either a dark suit or blue blazer, Khaki pants, blue button-down Oxford pin-point shirt, red tie, and loafers.
4. Now, doesn't it seem a little easier?
   a. The idea? Learn the "rules" of the club, and then;
   b. Join the club . . . or, at lease learn the rules and level out the playing field to your own advantage.
5. How?
   a. It's easy!
   b. There's no "magic".
   c. Just some basic rules that, for the most part, are based on "common" sense.
   d. You don't believe me? Then here, look at this!

II. **The Origins of Our Law**

A. First, you need to know where our rules of law come from?

1. Ecclesiastical law - from the Heavens!
   a. Holy men . . . like Moses, Buddha, and Allah.
   b. Holy books . . . like the Koran, the Torah, and the Bible.
   c. The "rules" were divinely inspired - You either followed them or suffered the consequences in the afterlife!
2. From the mind of a man!
   a. The "codes of old".
   b. Hammurabi, Draco, Justin, and the great state of Louisiana via Napoleon.
   c. The problem with a code? People and times change . . . but codes don't!
3. And finally, from the hearts of men!
   a. The "common law" for the "common man".
   b. A long slow history and development in England.
   c. The role of Blackstone - making the law accessible to every man and promoting uniformity.

d. The development of the doctrine of *stare decisis* and its' importance today . . . making the law fit the facts!
e. The role of the "reasonable man" . . . the most important person in the law!
f. The status of the "common law" today? A trend toward more codes?
g. Where will we be tomorrow?
- in our laws?
- in our courts?
- in our corrections systems?
- impact on sex offenders/sex abuse cases?
h. And now, (finally!!) some of the more important "rules of law" we need to be comfortable with:

III. Legal "*Presumptions*"

A. A legal "starting point"! . . . Only!!
1. Rebuttal v. non-rebuttable - I dare you - name one that isn't!
2. What's the most well-known, most important presumption in the law? - even it's rebuttable!

IV. The Importance of the Spoken Word - *Testimony*

A. Even in the age of the Internet, nothing, absolutely nothing will be admissible in court without some form of testimony preceeding it.
1. Testimony includes descriptions of what you saw, heard, felt, smelled, or experienced in any sense (including OJ's dreams?); and
2. What you found at the "scene of the crime"; and
3. Evidence left on/in the victim's body; and
4. Everything else - absolutely everything!

B. Tips for testifying effectively

C. "Chain of Custody" - Especially effective testimony
1. The traditional rule - if one link in the chain is broken, the evidence is irretrievably lost . . . why?
2. The Alabama rule - a "common-sense" modification.
a. Not so much a chain, but more of a rope with different strands entwined to "hold" the evidence, even if one or two unravel. The question is,
b. How many strands can you unravel before you lose the evidence?

V. There Are Two "*Types*" of Evidence

A. Direct
1. . . . "of which the witness has first-hand knowledge . . ."
2. What <u>you</u> personally saw, felt, heard, smelled or otherwise personally experienced; and

B. Circumstantial
1. Depends on reasonable "inferences" for its' relationship to the proposition to be proven or which is in issue.
2. Evidence of one fact (collateral or subsidiary) from which another fact may be reasonably drawn . . . "it snowed last night . . ."
3. Can you have convictions based entirely on circumstantial evidence? YES! . . .but <u>only</u> if the facts relied on and necessary to support the conviction lead to no other reasonable conclusion.
4. The importance of this rule to you? Expand your investigations, gather all the "collateral" facts . . .your DA can often use them to win!

VI. The Three "*Forms*" of Evidence . . . What Kind of "Packages" Can Evidence Come In?

A. Testimonial
   1. Again, you tell the jury what you saw, heard, felt, smelled, experienced, etc.
   2. Or, what you said about what you experienced,
   3. Or, sometimes, what someone else said about it! (Here, I'm talking about "hearsay", or learning to use the rules to use someone else's words to your advantage!)
   4. The "rule" for giving testimony - it must be given by a witness who is competent, under oath or solemn affirmation, from the witness stand or by way of a pre-trial deposition.

B. Tangible
   1. Here, I'm referring to exhibits - "things" for the jury to consider, to hold, touch, look at, etc. There are two types:
      a. "Real" - The real thing at issue in the trial, e.g., the actual gun used to commit the murders, the actual electrical cord used to beat the child, the actual curling iron used to burn the baby, etc.; and
      b. Demonstrative - not the actual gun, cord, or curling iron, but an identical substitute, e.g., a 32" Louisville Slugger just like the actual one used on the victim, etc.
      c. Think how you can "develop" demonstrative evidence and use it in court? The impact on the jury is amazing!

C. Tangible - Testimonial Evidence
   1. A hybrid - testimonial in nature and tangible in form, e.g., a transcript from a prior hearing.
   2. The importance to you of this rule? Be Careful! What you say in related civil and administrative hearings can come back to haunt you during a later criminal trial!

D. Finally - compare all this with "Judicial Notice"
   1. A "fact" that doesn't have to be "proved" in the traditional sense because it is common knowledge and universally accepted as true. (e.g., the sun rises in the East; HPD has been officially accredited by the International Chiefs of Police Association, etc.)
   2. Once "judicially noticed," a fact can't be "argued," i.e., no evidence to the contrary may be submitted to the jury.
   3. How can you use this? Get the judge to "judicially notice" things about you or your organization that strengthen your case, e.g., certifications, accreditation's, etc.

VII. There Are Three *Tests* for Determining the Admissibility of Evidence

A. Why should you know the tests?
   1. Now that you know about the importance of testimony, the different types and forms of evidence recognized by the law, and how evidence gets to the jury, it's important to know **when** it will be admissible. This will help you gather evidence that your DA can use, and help you understand **why** your DA often can't use everything you discover during your investigations!

B. Admissibility is determined by a 3-prong test
   1. Is the proffered evidence **relevant**; and
   2. Is it **material**; or
   3. Is it **barred** by some other rule of evidence?

C. What does "relevant" mean?
   1. Simply, if it reasonably and logically tends to prove or disprove any proposition, then it is relevant to that proposition.
   2. Examples?
      a. A man admits to having a long-term interest in viewing and collecting child pornography . . . is this relevant to the proposition that he robbed a U-Totem?
      b. . . . to the proposition that he enticed a child to his home and molested the child and then took pornographic photographs of the child?
      c. . . . to the proposition that he enticed a child walking home from school to get into his car and then exposed himself to the child while trying to fondle the child?
      d. Why is this rule important to you? Because it helps you understand what kinds of information your DA needs, and what can and can't be used in court!

D. What is the meaning of "material"?
   1. Just as proffered evidence must be relevant (i.e., tending to reasonably prove or disprove the proposition for which it is offered), it must also be material, i.e., that same proposition must also be properly **in issue** in the case; or
   2. Another way of saying this is that a proffered fact is material only if the proposition for which it is being offered to prove is "within the range of allowable controversy".
   3. So, always think of "relevance" and "materiality" together and first ask . . . "is this information relevant to the case (does it tend to prove or disprove a proposition?), and, if it does, then ask . . . and is it material (is that proposition really in issue/in controversy?) in this case?
   4. Examples of "material"?
      a. suppose a man is charged with having sex with his 11-year old step-daughter and he admits to you he had been masturbating excessively . . is this relevant . . . and . . . material?
      b. Same charge and the man tells you that is step-daughter was extremely promiscuous - in fact, he knows she is having sex with her 15-year old boyfriend?
      c. Same as above, and the man tells you that his step-daughter always runs around the house in her underwear, she's got a great body, and once when she was sitting in his lap in only her underwear he kissed her deeply and got an erection?
      d. He tells you he has sex with other minor females?

E. Is this evidence barred by any other rule of evidence?
   1. Now, assuming the information you gathered during your investigation and want your DA to present to the jury is both relevant and material, you then have to determine if it is barred from trial by any other rules of evidence?
   2. Unfortunately, this may not be so easy . . . the rules are numerous, but they really aren't all that complicated . . . some of the more important ones include:
      a. Competency . . . will this witness be allowed to testify?
      b. Is its probative value outweighed by its prejudicial effect? . . .will it unfairly inflame the jury?
      c. Is it protected by some recognized privilege? . . . There are some relationships deemed so important to the functioning of a peaceful, ordered society that we don't risk destroying them by forcing one person to testify against another, and
      d. Is it "hearsay"? . . . If so, it may not be trustworthy!
      e. Is there a legal foundation to support the evidence?
   3. These are the main rules all of us need to be familiar, and comfortable, with. Everything else, you can pretty much leave to your DA to worry about!

VIII. *Competency*

A. Importance to your? By now, you know that without testimony to support it, absolutely no evidence will ever get to the jury for consideration. Therefore, it's important to you to know **who** can testify in our courts and who can't!

B. To testify, a witness must be judicially-deemed "competent".
   1. Definition - "competency" refers to a court's willingness to hear testimony from a particular person.
   2. Historically, at common law, certain persons were arbitrarily deemed incompetent to testify. These included:
      a. Infants/minors . . . too young to trust!
      b. Idiots . . . can't believe them either!
      c. Husbands and wives . . . love is blind!
      d. Atheists . . . not afraid of burning in Hell so not afraid to lie!
      e. Certain races, creeds, and religions . . . getting to the truth was obviously secondary to other concerns!
      f. Convicted felons . . .The right to testify was just one of many civil liberties forfeited!

C. Today, the rules are more relaxed.
   1. Now, more than ever, our courts are concerned with "getting to the truth" (called "the search for justice"), so
   2. Almost anyone is now deemed competent to testify, subject to certain mental and physical qualifications. But, remember that
   3. This "search for justice" must always be weighed against another legal consideration that always takes precedence, i.e., the defendant's right (as embodied in the Fifth Amendment of the Constitution) to a "fair trial". With this in mind, let's look now at specific issues regarding competency to testify in our courts today:

D. Physical Requirements
   1. Obviously, witnesses must be capable of somehow expressing themselves so as to be understood by the jury.
   2. Our courts go to great lengths to accommodate persons with any problems or handicaps that limit their ability to communicate effectively what they know about the case to the jury, including
      a. Hiring interpreters, signers, etc., or
      b. Allowing some witnesses to testify outside the presence of the jury and the accused (despite what the Sixth Amendment guarantees)
   3. But, if a person for whatever reasons simply cannot somehow convey to the jury what they know and be cross-examined on the same, then that person will not be allowed to give the jury the benefit of their knowledge about the case (i.e., they will be deemed "incompetent" to testify).
      a. Karen Ann Quinlan - ? - obviously could not testify, but what about:
      b. A young child "paralyzed" by fear of the courtroom? In Alabama we make special provisions for this as well under the 1989 Child Sexual Abuse Victim Protection Act, if the court, in its' discretion, agrees.
      c. Among other things, this Act permits certain individuals in certain situations to testify for a child who is physically or emotionally unable to testify for themselves.
      d. This Act raises many issues, including: Constitutionality? How frequently should it be used?

E. "Mental" Requirements for "Competency"
   1. A witness (other than a technical expert) must have personal knowledge of the matters they intend to testify about, and
   2. A witness must be able to understand and appreciate the significance of an oath or affirmation to tell the truth.
      a. This is especially true with respect to minor children.
      b. In Alabama, historically any child under the age of six was deemed conclusively not to be able to take/understand such an oath - thus, children under six years of age could not give testimony in criminal trials.
      c. Now, Alabama courts recognize a presumption that any child - not matter what age - is capable of taking an oath and "presume" every child is competent until proven otherwise, i.e., until the presumption is effectively rebutted . . . usually the judge makes this determination.
      d. Some other states, however, presume otherwise and do not allow young children to testify . . . with potentially devastating results (for example, a child may be forced to return to an abusive environment if unable to testify, and there is no other evidence to rely on; and
      e. Children may be prohibited from giving testimony in other equally important trials (like People v. Jeffrey McDonald).
      f. Generally, however, if a child can demonstrate to a judge that they have the ability to observe, recollect, and communicate accurately to a jury what they experienced, they will be permitted to testify, and
   3. A witness needs to be competent only at the time of their anticipated testimony - not immediately before or after.

F. Special Cases
   1. Children (already discussed)
   2. Idiots/mental incompetents - same rules apply as to children . . . mental incapacities do, however, raise the issue of "lucid intervals".
      a. "Lucid intervals" are defined as periods of time during which an otherwise incompetent (to testify) person may be able to recollect what they observed, communicate effectively and truthfully to the jury, and understand the significance of an oath or affirmation, and thus, during that period of time, be allowed to testify.
      b. Importance to you? Obviously, with proper court preparation, such a witness could save an otherwise hopeless case.
      c. The problem, however, is: what if on Monday "Witness X", a resident of the State Mental Hospital, testifies for the State during a lucid interval but, on Tuesday, before being cross-examined, they lose their lucidity and cannot be questioned by the accuser's attorney? The results can be drastic, so proceed cautiously if you find yourself in this situation!
   3. Atheists - no longer sufficient legal grounds for disqualification.
   4. Husbands and wives - may be permitted to testify in certain situations (when the "marital privilege" is waived), then their relationship affects only what <u>weight</u> a jury may give their testimony, not their competency to testify.
   5. Alcohol and drug addicts - treated like husbands and wives . . . goes to the weight the jury may choose to give the testimony, not to competency.
   6. People of a certain race, creed, religion, etc. - no longer may be used to disqualify an otherwise competent witness.
   7. Prior convicted felons? Not a disqualification to testifying, but if their conviction was for a crime of moral turpitude, the conviction may be used to **impeach** their testimony, thus affecting again the weight the jury may assign to such testimony.

G. What About the Judge, the Prosecutor, the Defense Attorney, or a Juror as a Witness?
   1. Historically, our courts routinely allowed this . . . the judge, a lawyer, or a juror would just get up at a certain point during the trial, sit in the witness chair, swear to "tell the truth", etc., and then testify either for or against the defendant, then return to their seat.
   2. Today, this practice is frowned upon and generally an objection from either side will be enough to preclude it from happening.
   3. Importance to you? Make sure your DA knows about <u>all</u> potential witnesses, however unlikely they may be . . . otherwise, a mistrial will most likely result if suddenly the judge or a juror is needed as a witness!

IX. Expert Testimony - Or - You Are So Much Smarter Than You Thought You Were!

A. The General Rule - "Just The Facts, Mam . . ."
   1. Historically, the courts have not embraced "experts" or their opinions.
      a. In England, well into he 19th Century, "opinions" were admissible only if based on first-hand knowledge . . . you can imagine how rare this was, since it is highly unlikely that, for instance, an expert on shipbuilding would survive a sinking and be around to testify about it later!
      b. American courts were even stricter, insisting that all cases be decided just "on the facts", and excluded all opinions, inferences, and conclusions.
   2. Today, our courts' determination to "search for the truth" has resulted in a complete reversal, and now opinions are admitted on almost any topic, including scientific issues (like DNA) and even traditionally less reliable subjects like the existence or non-existence of syndromes, trauma, and "identification with" your attacker.

B. The Current Rule
   1. Our courts still adhere to the rule that, unless properly qualified first and after a sufficient foundation is established, a witness may testify only regarding matters about which they have direct, first-hand knowledge.
   2. As we shall see, qualifications and foundations may be easily established, and it is often difficult to differentiate between "facts" and "opinions."

C. Who May Give an Opinion?
   1. To answer this, it is helpful to first identify what the opinion will relate to:
      a. If it concerns a scientific, technical matter generally beyond the "ken" (understanding) of the average juror, then only a properly qualified traditional "expert" may state an opinion on the subject, but;
      b. If it concerns a matter about which most of us are familiar with - including the average juror - then almost anybody, including me and you! may qualify as an "expert."

D. Technical and Scientific Matters
   1. Generally, to give an opinion on these, the "expert" must first prove (through testimony) his or her **training, education, and experience** . . . once this is done, your DA can then ask the court to "judicially recognize" the witness as an "expert" in their particular area of expertise . . . then
   2. It is necessary to lay a proper legal foundation to demonstrate what it is the expert is basing the opinion on . . . for example . . . examination of the "thing" in issue (a body?), or reliance upon research personally conducted or the work of others also recognized as experts in the field . . .
   3. Then, the witness is generally allowed to state an opinion about what happened, etc., generally by answering a carefully prepared and worded **hypothetical question** asked by the lawyer;
   4. Such experts will generally be cross-examined by the other side in an effort to discredit them or their opinion . . .
   5. Cross-examination may focus on issues like bias, conflicting testimony in the past (e.g., Barry Scheck), conflicting opinions shared by other experts, conflicting opinions found in "learned treatises," etc.
   6. How is this important to you? You can help your DA! For instance, if a suspected child molester hires an "expert" to testify that his child victim has been programmed, coached, or is experiencing false memory syndrome, you can assist your DA in locating other experts or materials to **rebut** the damaging testimony . . . This can often be the turning point in a close case!

E. Lay Persons as "Experts"
   1. Alabama law is very broad . . . it allows anyone who can aid the jury in understanding the issues to testify as an expert if it is first shown that there exists a proper basis (foundation) for the opinion.
   2. To allow a lay person to give his or her opinion about something at issue in a trial, your DA must first show:
      a. That the witness's opinion is "rationally based on the perception of the witness" . . . which means only that the witness personally observed whatever it is they will testify about; and
      b. That the subject matter of the opinion is something about which the witness is familiar; and
      c. The witness's opinion is needed to assist the jury reach a clear understanding of the facts.
   3. Once this is established, a lay person is generally allowed to give an opinion on matters like:
      a. Taste, smell and appearance . . . "he smelled like he'd been drinking" . . . or "it looked like blood to me" . . .; and
      b. Mental condition . . . "scared" . . "nervous" . . . "clearly upset"; and
      c. Physical condition . . . "he was intoxicated" . . ."she looked younger than 16" . . ."the baby was in pain"; and
      d. Distances, dimensions, time, etc., . . . "it was a stick, about 18" long and 1/2" thick, that the child was stuck with" . . .and issues like size, speed, color, quantity as well; and
      e. Handwriting . . . if sufficiently familiarity is established.

4. Once the witness gives their opinion, they will e subject to cross-examination . . . usually this will focus on issues like bias ("you get paid to find sex abuse, don't you!") or . . . ability to observe accurately ("you didn't spend much time looking at the injuries, did you!") . . . or . . . ability to recall (how can you be so sure; it's been a long time, hasn't it!") . . . so . . . discuss this with your DA and be prepared to respond in a calm, objective, and professional manner.
5. Sciscoe v. State allows certain persons to go one step further and testify that, in their opinion, a particular child was sexually abused. Obviously, the impact of such testimony can be tremendous. Why is this important to you? Because, with the proper training and experience, you can be that person. So, discuss this with your DA, and see what would be necessary in your jurisdiction to use this testimony and then make it happen!

X. The Rule Against Hearsay

A. Historical Basis
1. The constitution guarantees each individual the right to "confront" the witnesses against them (Sixth Amendment).
2. Literally, this means the right to look them in the eye while they are testifying and then cross-examine them about what they said . This is one of the most important of our constitutional rights!
3. Obviously, you can't "face" your accuser and cross-examine them with respect to something they said in the past outside the courtroom. These type statements are called "hearsay".

B. Rationale
1. Underlying the rule are serious concerns about the trustworthiness of such statements. This is true since such statements:
   a. Are not given under oath, and
   b. Are not subject to cross-examination about the declarants ability perceive what the statement concerned, their recall of the event, their ability to articulate what they claim to have seen or heard, or any motives they might have to lie, exaggerate, etc.
2. Unless these concerns are adequately addressed, courts will generally not allow hearsay evidence to be presented to the jury.

C. The Importance of the Rule Today
1. Briefly, the rule prohibits testimony that reveals any statement out of court that is offered as proof of the matter asserted.
2. The importance of this rule today is not in what it prohibits, but instead in what it allows by way of numerous recognized **exceptions** to the rule which, by their nature, are deemed to address and satisfy the concerns historically associated with hearsay. As you will notice, there is something about each exception which makes it "trustworthy."

D. Exceptions
1. Admissions . . . statements by a party that is inconsistent with their position in court . . . e.g., . . . defendant pleads "not guilty," DHR worker may testify that he told her "I'm sorry I did it" . . .
   a. Obviously, this closely parallels confessions to police officers, but Miranda warnings are not required unless the person to whom the statement is made
      i. Is a law enforcement officer who has placed the suspect in custody, or
      ii. The person to whom the statement is made is acting either at the request of the police or directly for the benefit of the police . . . So, be careful!
   b. Wide latitude is allowed in determining what constitutes an admission . . . e.g., . . . suspect (while being interviewed) says "my daughter wouldn't lie about this," or "I know I need help," "I have a problem," etc.
2. Dying declarations . . . It is believed that most people do not want to meet their maker with a lie on their lips, so such statements are believed to be trustworthy . . . must show that the declarant had a sense of impending, imminent death.
3. Excited utterances . . . deemed trustworthy if made **spontaneously** and contemporaneously with or immediately after some **startling** event . . . little boy walks in on little sister crying as daddy is raping her and screams "stop it, you're hurting her!," or . . . "mommy, hurry, he's trying to drown her!"

4. Declarations of physical condition . . . may be used when a person's physical condition at a certain time becomes an issue . . . e.g., . . . "I heard her screaming 'please stop, daddy, it hurts too bad.'" Rationale? People don't lie about what's hurting them because they want the pain to stop.
5. Declarations of mental condition at the time in question . . . e.g., . . . "She said 'now everybody will think I'm dirty'". . .
6. Statements made as part of medical diagnosis . . . e.g., . . . Doctor asks little girl "who hurt you down there" may testify that she answered "my daddy did" . . . etc.

E. Others
1. These are not all of the recognized exceptions to the rule against hearsay. In fact, Alabama currently recognizes over 20, including a "catch-all" that will allow evidence of any out-of-court statements possessing "particularized guarantees of trustworthiness" in the trial judge's discretion.
2. Importance to you? Make sure the reports you prepare for your DA about your investigation are complete and contain all statements by all parties with any bearing on the case. You never know which one might make the difference between a conviction or an acquittal!

XI. Privilege

A. Definition
1. "Privilege" is the name for a rule of law that, in order to protect a certain relationship or interest, either permits a witness to refrain from testifying about something they otherwise would be required to reveal or which permits someone (like a defendant) to prevent someone else from testifying or revealing certain information about them.
2. Obviously, the assertion of a privilege against testifying can be a very serious consequence in child abuse cases where often there is no physical evidence to rely on.
3. Importance to you? Be sure that, prior to trial, your DA is aware of the various relationships that exist between the various parties in a case (e.g., common-law marriages, etc.).

B. Rationale - "to Ensure an Orderly Society. . . "
1. The law recognizes privileges to protect certain relationships that are believed to be so fundamentally necessary and important to our society so as to protect them from the damage that could be expected to result if statements made out of a sense of confidence in that relationship were suddenly revealed in open court.
2. For a privilege to apply, the statement must have been made "in confidence," i.e., with the expectation that it would not be divulged. The presumption, however, is that <u>any</u> statement made pursuant to such a relationship was made in confidence. Importance to you: Remember, presumptions are rebuttable, so investigate thoroughly to see if the circumstances surrounding your case indicate that a privilege should not protect it!
   a. e.g., . . . husband says to wife very quietly, privately, "I'm sorry, I swear I'll never touch her again." Does this indicate confidentiality was presumed:

      v.

   b. in emergency room, husband looks at wife who is standing next to ER doctor trying to stop the bleeding from their daughter's torn vagina and says "Oh God, I'm sorry, I didn't mean to hurt her!"

C. Recognized Privileges
1. The most historic, widely accepted privilege in American Jurisprudence is that between **husband and wife**. Courts traditionally tread lightly when the sanctity and security of a marriage is at risk. In today's world, where inter-familial child abuse is common, this rule may seem outdated. Until it is changed, however, we must try to work around it. Alabama does recognize some very limited exceptions in this area when a child's safety or well-being is at risk, so work closely with your DA to make sure the law is used to your advantage whenever possible.

2. The second most sacred privilege in the law is that between **attorney and client**. For the justice system to function effectively, clients must be assured that whatever they tell their attorney will remain confidential. Before you get too upset, however, I should point out that even lawyers must violate their clients' confidence if they reasonably believe someone's health or safety is at risk if they don't . . . remember "A Time to Kill?"
3. Other important privileges include: that between **doctor and patient** . . . "I think she may have given me gonorrhea . . ."; and
4. Between priest and penitent . . . "Father, I have sinned by having sex with my daughter" . . . extended to include the clergy in all denominations; and
5. **Psychotherapist - patient . . .** recognized to promote full disclosure and facilitate effective treatment . . . extends to all participants in group counseling . . . does not protect realistic threats to harm others.

Now . . . you know the rules, go forth and enjoy the court process!

PREPARING FOR COURT: POINTS TO CONSIDER

By
Steven K. Aldridge
Assistant District Attorney

Be Prepared!

Document all aspects of your investigation and then review those documents thoroughly!

Go Over Your Role in the Case!

Discuss with your DA what role you play in the over-all prosecution. He or she will tell you what they need from you, what you can and can't say, and what to look out for! Understanding your part in the big picture will help you prepare and should relieve any anxiety you may experience about testifying!

Look and Act Like the Professional You Are!

Don't be fooled. From the moment you enter the courtroom, you too are "on trial." Make an impression on the jury with your professional appearance and demeanor. If you do, you've won half the battle!

Control Your Emotions!

With few exceptions, anger, sorrow, and laughter are inappropriate during a trial. It may be difficult to stop yourself from laughing, smirking, or arguing, but remember that the jury is always watching your every move!

Demonstrate Your Objectivity!

Personally, I feel this is the most important tip I can give you. Think about it . . . in the typical child abuse case, there usually is little or no real (physical) evidence to corroborate what our child-victims' say happened. Most of the time, you don't have a fingerprint or a matched bullet or a videotape to carry with you to the witness stand. All you have is your personal credibility. In the final analysis, you are asking the jury to believe you instead of the accused. It boils down to credibility. Nothing will cause a jury to doubt you quicker than an effort on your part to do anything other than report the facts in a full, fair, and impartial manner. The jury decides guilt or innocence - your job is to relay information to them. If you come across as prejudiced, vindictive, angry, or a "winged, caped crusader for justice," you forfeit your credibility, pure and simple! Just keep your testimony and demeanor "professional" at all times, and you'll do just fine!

Prevention Education Curricula

Overview and Guidelines for

Program Planning

Presented by

Shannon M. Dammann, PsyD and
Pamela Brown, MEd

Prevention Education Curricula Overview and Guidelines for Program Planning

GCCA
Georgia Council on Child Abuse, Inc.
Working to end child abuse
1375 Peachtree St., NE, Suite 200
Atlanta, GA 30309
(404) 870-6565, or
Toll-free (800) 532-3208

Shannon M. Dammann, Psy.D.
Pamela B. Brown, M.Ed., LPC

School systems and community organizations have become increasingly interested and active in prevention-oriented education of children on the topics of child abuse awareness, personal safety, empathy building, and anger management. Based on both research and practice, this workshop will:

- **Present an overview of numerous prevention education curricula and resources available**
- **Offer guidance in the identification and selection of appropriate materials based on age and maturity level of children to be served**
- **Address implementation strategies, including challenges to implementation**
- **Discuss strengths and weaknesses of available resources in reference to context, content, and target audiences**
- **Provide workshop participants with a written Guide to Prevention Education Curricula, developed by the Georgia Council on Child Abuse Prevention Education Services.**

The Georgia Council on Child Abuse Prevention Education Services provides training, consultation and technical assistance to communities, agencies, organizations, and individuals. For more information, please contact:

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General Assumptions About Child Abuse Prevention Education

A. Prevention education is a critical part of a community's response to child abuse and violence.

B. Every family should have access to prevention information.

C. Schools and other child serving organizations are ideal settings for reaching adults and children with prevention programs because of their consistent and longitudinal contact with children and families.

D. All prevention efforts should be well planned, age appropriate, delivered by trained persons, evaluated, and culturally relevant.

E. All prevention education should begin at an early age and continue with adaptations appropriate for the child's developmental and cognitive growth.

F. Prevention education should focus on adults, such as teachers, parents, and caregivers, as well as children. Parents and caregivers cannot teach or reinforce information presented in other contexts if they are not familiar with the information themselves. Often parents need tips on how to teach their children prevention information, even if they are familiar with the material.

G. All activities that teach empathy, assertiveness, anger management, and problem solving skills, as well as those that help build self-esteem, contribute to empowering children to protect themselves better and grow into non-abusive adults.

APPROACHES AND FORMATS OF PREVENTION EDUCATION PROGRAMS

I. Primary Focus

A) To teach children about different forms of abuse, including what they are and how to recognize them.

B) To teach children certain concepts and skills that can help them avoid abuse, including neglectful, emotional, physical and sexual abuse by trusted adults as well as by strangers.

C) With growing evidence that many sexual offenders begin abusing children in their adolescent years, some newer programs for adolescents may include prevention messages for potential perpetrators.

D) While most prevention programs are directed toward children, an effective program will include prevention training for teachers and parents. This is a critical component, especially for programs targeted to younger children.

E) Some programs focus on teaching prevention skills to special populations at high risk for abuse, such as handicapped and mentally retarded youth.

II. Presentation Format

A) Single session programs (30 minutes to 4 hours in length)

B) Multi-session curricula with each session lasting 30 minutes to a full day per session

C) Extended programs covering an entire semester or school year that are presented weekly

D) "Booster shots" or "Follow-up sessions"

III. Prevention Concepts Taught

A) Most common concepts

1. Body ownership
2. Secrets (appropriate vs. inappropriate/harmful)
3. Intuition (Trust your feelings)
4. Say "NO"
5. Get away
6. Tell someone (support systems, adults that can help)
7. It's not your fault if someone abuses you
8. Personal body safety rules
9. Touch continuum (discriminating between safe and unsafe touches)
10. Abuse can come from people you know, love or trust as well as from strangers

B) Other Important Concepts that may be taught

1. Definition of terms (i.e. sexual abuse, perpetrator, etc...)
2. Anatomical terms for body parts
3. How to report
4. Helping a friend (how to handle disclosure of abuse)
5. Problem solving
6. Assertiveness
7. Empathy
8. Self-defense
9. Offender characteristics
10. Preventing abduction
11. Witness preparation
12. Perpetrator prevention
13. Sex education
14. Sexual decision making
15. Communication skills
16. Violence prevention skills
17. Anger management and impulse control
18. Difference between discipline and abuse

IV. Teaching Materials and Activities

A) Curricula tailored for specific ages that include:

1. Personal safety
2. Abuse prevention
3. Stranger danger
4. Non-violence
5. Decision making
6. Assertivenss skills
7. Conflict resolution

B) Live performances including plays or puppet shows

C) Stories or vignettes followed by an outlined discussion

D) Coloring books, activity books, story books or comic books

E) Audio visual presentations: films, videos, audio tapes, records

F) Songs and games

G) Pamphlets, brochures, booklets

H) Public service announcements

I) Interactive activities such as roleplays or outlined discussions

J) Resources to aid adults in talking to children about prevention concepts

GUIDELINES FOR PREVENTION EDUCATION PROGRAM SELECTION

1. **Prevention programs should take into account the overall developmental needs and cultural differences of children.** Programs that fail to do this risk being an isolated response to a specific problem, using concepts or beliefs that make sense to adults only but may be misunderstood by children, and making children more fearful.

2. **Prevention education resources and curricula address many different concepts and issues including: sexual abuse, violence, assertiveness training, communication skills, building positive self-image, development of basic life skills, and other skills that help children feel safe and act in a way that keeps them safer.** You may want to review several different resources or programs in order to select one that is appropriate to your program needs and target population.

3. **Prevention programs should address abuse of children by people that they know as well as abuse by strangers.** Programs that focus only on "stranger danger" fail to recognize that most abuse of children occurs in the home and involves a parent or someone the child knows and trusts.

3. **Selection of people to teach prevention programs is a s important as the selection of the program itself.** Prevention educators should have adequate teaching skills to communicate with the target population.

4. **Be sure that adequate training is provided for people who are selected to teach prevention programs.** Prevention educators should have an adequate understanding of the basics aspects of positive, effective prevention concepts. They should also be familiar and comfortable with the concepts and learning objectives of the program they are teaching.

5. **There are particular groups of children that have needs that are not adequately addressed by most prevention programs.** These include: children who demonstrate on post-tests or in role plays that they are not understanding or learning the concepts presented; children known to be at risk or children who have already been victimized; children with very low self-esteem. These children need follow-up and additional support services.

6. **Adaptations of tested programs may alter the desired effect as they frequently involve modifying or shortening the format.**

7. **Program evaluation is critical to minimizing unanticipated negative effects and increasing knowledge about what is effective.** Prevention education program facilitators should have a plan for determining if children are receiving and retaining the intended messages and skills.

CONCEPTUAL DILEMMAS

Following are some conceptual dilemmas that often arise as a result of efforts to translate the complicated phenomenon of abuse into concepts that make sense to children in various developmental stages.

CONCEPT: "Good Touch" vs. "Bad Touch"

***DILEMMA*: Can children of various developmental stages learn and understand the "good" vs. "bad" touch concept well enough to appropriately identify dangerous or abusive situations and types of touch that may be "confusing"?**

a) sexual abuse often involves touches or attention that feel good and then later lead to touch that feels "bad" or "confusing"

b) children often have trouble reconciling "bad" touch coming from "good" people who they love and trust

c) some touch may feel bad but be good (i.e. a shot from the doctor)

d) young children may overgeneralize from discussions of "bad" touch and become fearful or uncomfortable about appropriate touches

e) although abuse prevention education programs do not directly address sexuality, children may generalize the idea that all sexual touching is "bad" when presented with the concept that it is "bad" for other people to touch the private parts of their body.

CONCEPTS: "It's not your fault" and "Say 'no' and tell'

***DILEMMA*: How can prevention programs minimize the guilt often felt by already victimized children who did not tell and avoid imposing additional guilt on future victims who may be unable to effectively utilize prevention skills?**

a) it is difficult to balance the empowering idea that "you can keep yourself safe" with "it's not your fault" if you weren't able to keep yourself safe

b) it may be helpful to teach the concept of "inherent power differentials" in abusive situations and that abuse always involves an "abuse of power"

CONCEPTS: Assertiveness and Self-Defense Skills

***DILEMMA**: How do you teach self-protective skills without teaching children to be aggressive? How much self-defense training is necessary for children of different ages to protect themselves?*

a) with a little self-defense knowledge, children may feel more powerful than they really are and endanger themselves further

b) children may be tempted to use aggressive self-defense skills in inappropriate situations

CONCEPTS: Sexual Content and Anatomical Terms

***DILEMMA**: Does the exclusion of sexual content and language significantly limit children's ability to understand important concepts in sexual abuse prevention? Does the inclusion of such content increase the possibility of negative consequences or reactions for children introduced to such information?*

a) some parents or people in the community may be uncomfortable with sex education and direct sexual content

b) children may not understand what sexual abuse is without direct sexual definitions and language

c) children are inhibited from telling about abuse because they do not have a vocabulary to discuss sex related matters

d) when sexual content is avoided, children may again get the message from adults that it is not okay to talk about sexual abuse and their bodies.

e) when adults talk to children only about avoiding coercive forms of sexuality, children may get the message that sex is primarily a negative experience

CONCEPT: Specific Information About Sexual Abuse

***DILEMMA**: Is it necessary to talk about sexual abuse to teach prevention skills? If specific information about sexual abuse is not taught, will children know what they need to know to protect themselves?*

a) education is a necessary part of prevention and prevention occurs before abuse happens

b) teaching basic safety skills *(such as how to recognize danger by trusting one's instincts and paying attention to signs in the environment, how to react to danger by protecting oneself and/or removing oneself from a dangerous situation, and how to report danger to an adult that can help)* may help to teach decision making skills that can apply to all potentially harmful situations.

c) teaching certain specifics may be necessary in order to help children recognize various situations that are threatening before the danger becomes obviously apparent and thus more difficult to respond to in a preventative manner.

****

WHAT DOES THE RESEARCH SAY ABOUT ABUSE PREVENTION EDUCATION PROGRAMS?

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Supervision of CSA Forensic Interviewers

Presented by

Lori Holmes, MA, LISW and
Judy Weigman, MA, LICSW

SUPERVISON OF CHILD SEXUAL ABUSE FORENSIC INTERVIEWERS

Handouts

- RICE Model of Supervision
- Supervision Content Areas
- CornerHouse 5 Stage Interview Process
- Feedback Information For Use With the VIA
- VIA (Videotaped Interview Assessment) Tool
- IPR (Interpersonal Process Recall) Mapping Chart
- Additional IPR Information

RICE MODEL

1. **Recognition and Support**
   - Fostering the expectation of interviewers sharing their own responses to interviews.
   - Providing praise and encouragement.
   - Providing a means for interviewers to support each other.
   - Encouraging self-care.
   - Developing professional growth opportunities.

2. **Immediacy**
   - Providing feedback as soon as possible after an interview. (This is especially true in the initial stages of supervising a new interviewer)
   - Viewing videotapes of interviews with the interviewer.
   - Teaching interviewers how to review their own interviews.

3. **Consistency**
   - Providing regular supervision and follow-up on problems/issues discussed both formally and informally.
   - Utilizing a consistent model for the skills to being discussed.

4. **Excellence**
   - Creating an atmosphere that fosters excellence in interviewing through:
     research discussions
     in-service training
     peer review and support and
     case follow-up.

Supervision Content Areas

1. **The Interview Process/Protocol Utilized**
   - Make sure that the feedback you give covers all the areas of the interview process.
   - It's most helpful if you can review the interview with the interviewer.
   - Feedback can be both verbal and written. In a few minutes we will give you a tool we have developed to do this.

2. **Report Writing**
   - If your interviewers write reports, it's necessary that they receive feedback about them.
   - Depending on the purpose of the report content and style may be critical.

3. **Review of professional research; conference material; and "hot" issues.**
   - It's imperative that interviewers stay current with the research.
   - Interviewers need to have opportunities to attend conferences.
   - If there is media coverage about a case, there should be a forum for discussion.

4. **Court Testimony**
   - Review the interview with the interviewer.
   - Help make notes about what questions were asked and what the child said (especially important if you don't also write a summary of your interview)
   - Anticipate areas that are likely to be attacked by the defense.
   - Discuss strategies to respond to defense issues.

5. **Contact With Parents**
   - Discuss what information should/shouldn't be discussed with parents.
   - Assist with any confrontations that may arise.

6. **Team Facilitation**
   - Teach interviewer how to facilitate team meetings.
   - Problem-solve conflicts that may present themselves.

Five Stage Interview Process
(RATAC)

1. **RAPPORT**
   The Purpose is to Establish the Child's:
   - comfort
   - communication, and
   - competence (child's developmental/cognitive ability)

2. **ANATOMY IDENTIFICATION**
   The Purpose is to:
   - arrive at a common language regarding names for body parts, and
   - determine child's understanding of gender (boy vs. girl)

3. **TOUCH INQUIRY**
   The Purpose is to:
   - assess the child's ability to understand and communicate about touch

4. **ABUSE SCENARIO**
   The Purpose it to:
   - allow the child to tell details of his/her abuse experience

5. **CLOSURE**
   The Purpose is to:
   - educate the child regarding personal safety, and
   - explore safety options with the child

** Since this is a semi-structured process, one or more of these stages may be modified or eliminated, allowing for the developmental considerations of each child.*

TYPES OF FEEDBACK

MOTIVATIONAL FEEDBACK

Purpose: To encourage the interviewer and reinforce skilled behavior

- It tells the person what s/he did well
- It rewards the person for good performance

FORMATIVE FEEDBACK

Purpose: To help the interviewer identify how s/he could do a better job

- It tells the person what needs to be done better
- It provides information about how to do the task better

CornerHouse Videotaped Interview Assessment (VIA) Tool

To be completed by Interviewer:		To be completed by Reviewer:
Name: _____	Child's name/ID: _____	Reviewer Name: _____
Total number of interviews I have conducted using the CornerHouse model: _____	Child's Age/DOB: _____	Date of Review: _____
Of these interviews, what number is this interview? _____	Date of Interview: _____	

A high degree of competence is necessary for mastery of interviewing. This interview assessment tool is used to evaluate the skill outcomes required of an effective interviewer and provide suggestions for further skill development. The rating scale indicates the degree to which skills are mastered as demonstrated by this videotaped interview. Because this is a limited sample, the assessment may or may not reflect the full range of the interviewer's skills The rating scale below and on the following page uses these values: 1 = problematic; 2 = needs improvement; 3 = satisfactory; 4 = good; 5 = excellent; NA= not applicable

INTERVIEW PROCESS	RATING SCALE:	OBSERVATIONS/COMMENTS:
Rapport		
•Established child's: Comfort	1 2 3 4 5 NA	
Communication	1 2 3 4 5 NA	
Competence	1 2 3 4 5 NA	
•Demonstrated cultural sensitivity	1 2 3 4 5 NA	
Anatomy Identification		
•Established child's names for body parts	1 2 3 4 5 NA	
•Established child's ability to differentiate gender	1 2 3 4 5 NA	
Touch Inquiry		
•Established child's ability to understand & communicate about touch	1 2 3 4 5 NA	
•Addressed both liked & not-liked kinds of touch	1 2 3 4 5 NA	
Abuse Scenario		
•Asked questions regarding details of abuse consistent with child's affect & ability	1 2 3 4 5 NA	
Closure		
•Educated the child about personal safety	1 2 3 4 5 NA	
•Explored safety options with the child	1 2 3 4 5 NA	
•Thanked child and ended interview	1 2 3 4 5 NA	

CornerHouse Videotaped Interview Assessment Tool - Page 2

INTERVIEWING TECHNIQUES	RATING SCALE:	OBSERVATIONS/COMMENTS:
Use of drawings & diagrams		
•Age appropriate	1 2 3 4 5 NA	
•Added information as child disclosed	1 2 3 4 5 NA	
•Use of timeline	1 2 3 4 5 NA	
•Culturally appropriate	1 2 3 4 5 NA	
Use of dolls		
•Est. child's ability to make representational shift	1 2 3 4 5 NA	
•Used for purpose of demonstration, i.e., lang. clarification	1 2 3 4 5 NA	
•Culturally appropriate	1 2 3 4 5 NA	
Timing		
•Appropriate use of silence	1 2 3 4 5 NA	
•Utilized opportunities	1 2 3 4 5 NA	
•Appropriate length of interview	1 2 3 4 5 NA	
•Appropriate pacing during the interview	1 2 3 4 5 NA	
•Culturally sensitive	1 2 3 4 5 NA	
Empathy		
•Gave appropriate reassurance	1 2 3 4 5 NA	
•Adequately addressed blocks	1 2 3 4 5 NA	
•Culturally sensitive	1 2 3 4 5 NA	
Engagement		
•Used child's name	1 2 3 4 5 NA	
•Invited child's participation	1 2 3 4 5 NA	
•Culturally sensitive	1 2 3 4 5 NA	
Age-appropriateness		
•Used questions appropriately	1 2 3 4 5 NA	
•Used appropriate language and sentence structure	1 2 3 4 5 NA	
•Effectively used escalation of inquiry	1 2 3 4 5 NA	
Adaptability		
•Effectively dealt with control issues	1 2 3 4 5 NA	
•Responded to child's needs throughout interview	1 2 3 4 5 NA	

INTERVIEWING TECHNIQUES	RATING SCALE:	OBSERVATIONS/COMMENTS:
Reliability and credibility issues		
•Established contextual factors	1 2 3 4 5 NA	
•Explored alternative hypothesis	1 2 3 4 5 NA	
•Clarified child's responses	1 2 3 4 5 NA	
Suggestibility		
•Avoided misleading questions	1 2 3 4 5 NA	
•Avoided leading behaviors	1 2 3 4 5 NA	
•Avoided inappropriate reinforcement	1 2 3 4 5 NA	
•Allowed child to say "I don't know", & to correct or disagree with interviewer	1 2 3 4 5 NA	

Summary Comments: _____

_____

_____

_____

Suggestions for Further Development: _____

_____

_____

_____

Interagency Child Abuse Evaluation Center
2502 Tenth Avenue South
Minneapolis, MN 55404

Phone: 612-872-6225
Fax: 612-872-1230

Thank you for the opportunity to assist
in the continued development of your interviewing skills!

INTERPERSONAL PROCESS RECALL (IPR)
SITUATION MAPPING CHART

MINE	THE OTHER PERSON'S (e.g., Child or Colleague)
Observations	Observations
Thoughts	Thoughts
Feelings	Feelings
Goals	Goals

My alternative response/s

INTERPERSONAL PROCESS RECALL (IPR)

HELPFUL INTERPERSONAL PROCESS RECALL QUESTIONS

When a child being interviewed makes a statement that throws you off and you don't know how to respond, or when the interview is not going the way you think it should, ask yourself the following questions. Use the *Situation Mapping Chart*, if desired, to jot down your answers.

1. When did I first start to feel uncomfortable with how the child was responding to me?

2. When did I feel at a loss for what to do?

3. What was I thinking?

4. What was I feeling?

5. What was I trying to accomplish (i.e., what were my goals)?

6. What do I think the child was thinking, feeling and trying to accomplish?

Now take what you are thinking, feeling and wanting to do and use it to phrase an alternative response to the child.

Some additional questions that may also be useful:

1. Do I have a history with this child that would make her/him respond to me that way?

2. Have I seen the child respond that way to someone else? If so, what did I see happening (feeling, thinking, doing)?

3. What is it about me that would make the child respond that way to me?

Child Sexual Abuse:

Findings Specific for Abuse

Presented by

David Muram, MD

Most children can be fully evaluated in an office properly equipped to examine young children. In rare instances, often following penile penetration of the vagina, a significant degree of trauma is present, and a properly equipped operating room and general anesthesia are required for a thorough evaluation and repair. However, with most children the physical findings are less dramatic, or absent altogether. Some forms of abuse do not cause injury and an examination is not expected to detect any physical evidence of abuse. Even when injured, many of these children may not be seen for weeks, months, or even years after the incident occurred. The delay allows for semen and debris to wash away and for most, if not all injuries, to heal. When they are present, physical findings vary with the degree of trauma sustained by the victim. Minimal trauma results in minor injuries, which heal in a short time and leave no permanent scars. Deep lacerations take longer to heal, and often leave scars, which can be seen even after a relatively long time period. (McCann & al. 1992)

Based upon the experience drawn from the Pediatric Gynecology Clinic at the University of Tennessee, Memphis, a simplified classification of the physical findings observed in prepubertal girls has been developed. (Muram 1988). This classification distinguishes non-specific findings from those, which are highly suggestive or definitively related to abuse, and has proved useful in subsequent legal proceedings. All physical findings are classified into one of four categories:

1. **Category 1.** Normal appearing genitalia

2. **Category 2.** Non-specific findings - Abnormalities of the genitalia that could have been caused by sexual abuse, but also often seen in girls who are not victims of sexual abuse, e.g., inflammation and scratching. These findings may be the sequelae of poor perineal hygiene or non--specific infection. Included in this category are: redness of the external genitalia, increased

vascular pattern of the vestibular and labial mucosa, presence of purulent discharge from the vagina, small skin fissures or lacerations in the area of the posterior fourchette, and agglutination of the labia minora.

3. **Category 3.** Specific findings - The presence of one or more abnormalities strongly suggesting sexual abuse. Such findings include recent or healed lacerations of the hymen and vaginal mucosa, enlarged hymeneal opening of 1 or more centimeters, procto-episiotomy (a laceration of the vaginal mucosa extending to the rectal mucosa), and indentations in the skin indicating teeth marks (bite marks). The category also includes patients with laboratory confirmation of a venereal disease.

4. **Category 4.** Definitive findings - Any presence of sperm.

Other investigators made similar attempts at classification. (Adams, Harper, & Knudson, 1992), (Adams, Harper, Knudson, & Revilla, 1994). The American Professional Society on the Abuse of Children (APSAC) has appointed a committee to develop guidelines for the interpretation of anogenital findings in child victims of sexual abuse. Until such guidelines are established, each examiner should describe the abnormalities in detail to allow for correct interpretation in the future. (Vandeven & Emans, 1995).

Abnormal Physical Findings Specific for Abuse

It has been shown that even in girls where sexual abuse has been confirmed, the medical evaluation fails to document specific findings in up to 70% of victims. (Bays & Chadwick (1993), Muram (1989a), Adams & al. (1994).

In a large prospective study, 205 prepubertal girls who were determined to be victims of sexual abuse by Child Protective Services were evaluated. (Muram, 1989a) Ninety-five (45%) had abnormalities considered specific for sexual abuse. Hymenal-vaginal lacerations were detected in 68 of these young girls. In three, the examination revealed extensive lacerations through the posterior vaginal wall with extension into the rectum. Two patients were found to have motile sperm in the vaginal fluid or on the vulvar skin. Venereal disease was noted in 31, and in the majority of these girls (25), there were no other signs of genital injury.

However, the absence of physical findings should not be construed to suggest that the history obtained from the child is incorrect. A recent study correlated the physical findings and the history obtained from the victim with a confession obtained from the perpetrator. The study has documented the reliability of history obtained from the children. In only 6 instances the assailant did not confirm the child's story. But even in these instances, the assailant admitted to sexually assaulting the children and confirmed penile contact although penetration was denied. All the patients in that study were confirmed victims of sexual abuse by the perpetrator's admission, however, the medical examination failed to detect abnormalities in 29% of the patients. Of all abnormal findings, hymeneal vaginal tear (HVT) was the most common finding observed in girls who described penile or digital penetration. Of the 18 girls in whom vaginal penetration was described, only 11 were found to have HVT. (Muram 1989b).

Another study evaluated the case files and colposcopic photographs of 236 children where the perpetrator was convicted for sexual abuse. The mean age of the patients was 9.0 years (range 8 months to 17 years, 11 months). The genital examination findings were suspicious or abnormal in

25% of the cases. Abnormalities were more likely to be present when the children were seen soon after the assault, or when they have reported to experience bleeding following the attack. The authors concluded that abnormal genital findings were not common in their series of sexually abused girls. (Adams & al. 1994).

Accidental injuries rarely affect the hymen. A prospective multicenter study, evaluated 56 prepubertal girls who presented to the emergency department with acute perineal injury. All injuries were witnessed, or there was knowledge of the girl's engagement in a risky activity (eg, biking or climbing monkey bars) immediately before the injury. Most injuries were minor. The labia minora was the most frequent site of injury. There was only one girl who sustained an injury that involved the hymen. (Bond & al. 1995).

Penetrating sharp injuries of the hymen have a typical appearance which is significantly different than that caused by blunt penetrating trauma. Penetration by a sharp object, whether accidental or intentional, may cause hymeneal, or even vaginal injury, with minimal or no disruption of the hymeneal edge. One series described four patients who sustained a sharp penetrating injury to the hymen (Hostetler & al. 1994). In all patients, the hymeneal injury was left to heal by secondary intention, although a vaginal laceration was repaired surgically in one patient. In the three patients in whom the injury was surrounded entirely by hymeneal tissue, fenestration of the hymen was seen following the healing process. In the fourth patient, who required surgical repair of an accompanying vaginal laceration, the hymeneal defect was no longer visible, possibly as a result of the surgical repair.

Hymeneal injuries are often seen in girls who are victims of sexual abuse. In sexually abused girls, tearing of the hymen occurs as a blunt object enters the vagina, e.g., digital or penile penetration. As the unestrogenized hymen has only limited elasticity, the shearing force causes the hymen to tear. The tear may then extend to the vaginal walls or to the perineum.

Genital injuries heal quite well. McCann & al. followed 3 children who were injured as a result of sexual assault. (McCann, Voris, & Simon, 1992) Acute injuries disappeared rapidly, and the wounds healed without complications. Even the injuries to the posterior fourchette healed with minimal scar tissue. The changes created by the trauma remained relatively stable throughout the prepubertal years. Disruption of the hymen exposed underlying longitudinal intravaginal ridges, creating hymeneal mounds or projections. Hymeneal edges remain narrow and irregular at the point of the injury. With the onset of puberty, hymeneal hypertrophy obscured the site of injury, which could still be seen when the hymeneal folds were separated with a Q-tip. (McCann & al., 1992)

The genital findings in girls assaulted as adolescents are less dramatic. Adams & Knudson (1996) examined 204 girls; aged 9 to 17 years (mean age 13), who reported a penile-vaginal penetration. Abnormal genital findings were documented in 32% of patients overall but were more common when the girls had reported bleeding at the time of the assault, or when the examination occurred within 72 hours of the last episode of abuse. Transections of the hymen were observed in only 15 (7%) girls. Other investigators observed similar findings. (Muram 1995).

Anal and Perianal Findings

Anal abuse is a common form of sexual assault against children, especially in male victims. While genital injuries are often recognized as possible signs of abuse, anal and perianal injuries are sometimes dismissed by physicians as being associated with common bowel disorders e.g., constipation or diarrhea. Recently, numerous studies have examined the issue of perianal abnormalities caused by sexual assault.

Recent papers address anal and perianal abnormalities seen in child victims of sexual abuse. Wynn and Hobbs reviewed a large series of sexually abused children in Leeds, England. (Hobbs & Wynne, 1986) (Hobbs & Wynne, 1989) The patients included a spectrum of certainty ranging from complete proof (statement by child, admission by abuser with corroborative physical and forensic evidence) to lesser degrees of certainty (e.g., disturbed family relationships or behavior disorders in child). In the 143 children, the following abnormalities were observed: fissures or tears (n=53), redness and other minor skin changes (n=53), reflex anal dilatation (n=42), laxity of the sphincter (n=38), venous congestion (n=-24), scars or skin tags (n=8) and HPV lesions (n=4). Thirty-eight boys and 49 girls had anal signs consistent with sexual abuse. Of these, 86% showed anal dilatation, 61% fissures, 25% venous congestion, 16% scarring, funneling, 7% laxity, and 32% other signs (redness, edema, skin tags, and warts).

Another study described the anal and perianal findings in 310 prepubertal children who were determined to be victims of sexual abuse. (Muram, 1989c) 206 (66%) had perinea which appeared normal. Abnormal findings were present in 104 children (34%): anal gapping in 61 children; skin tags in 44; rectal tears in 33; sphincter tears in 15; HPV lesions in 4; perineal scarring in 2; and

bite marks in 1. Normally appearing perianal and anal regions were noted in 150 of 175 children (85%) who denied anal assault, and in 11 of 70 (16%) who described such assault. In comparison, anal and perianal; abnormalities were observed in 59 of the 70 children (84%) who gave a clear history of anal assault, but in only 25 of 175 (15%) who denied such abuse.

In another study, McCann & al. attempted to collect normative data of the anogenital anatomy from a representative sample of non-abused prepubertal children. (McCann, Voris, Simon, & Wells, 1989) Perianal erythema was found in 68 of 168 (41%) of the children, increased perianal pigmentation was found in 74 of 251 (30, venous congestion of the perianal tissues was present in many children and was more noticable the longer the child remained in a knee-chest position. This venous congestion may be caused by an increase in the intra-abdominal pressure created by the knee-chest position. Smooth areas on or near the anal verge were found in the midline, at either the 6 o'clock or the 12 o'clock positions. In 47% (8 of 17) of the children with this finding, the smooth area was associated with a depression. Anal skin tags/folds were all found in the midline. In all but one of the 18 children, the tags were located anterior to anal orifice. Perianal scars were found in 4 of the 240 children evaluated for this entity. Three of these lesions were located in the midline at the 12 o'clock position posterior to the rectum, while the other one was at the 2 o'clock location. No fissures, abrasions, lacerations or hematomas were found in any of the subjects. (McCann, et al., 1989)

Anal sphincter dilatation occurred in 130 of 267 (49%) of the children. The anal orifice had a symmetrical oval configuration in 89% of the children whose anus dilated. The antero-posterior diameter of the orifice, as measured in the midline, varied from less than 0.1 cm to 2.5 cm with a mean of 1.0 cm. In 91% of the subjects with anal dilatation, the A-P diameter was less than 2 cm.

The percentage of children with anal dilatation of 2 cm or greater without the presence of stool in the rectal ampulla was 1.2%. The horizontal diameters of the anal orifice ranged from less than 0.1 cm to 2 cm with a mean of 0.57 cm. The loss of the slightly "puckered" anal verge and the flattening or smoothing out of the folds was related to the relaxation of the anal sphincter muscles with subsequent dilatation of the anus. The authors concluded that the relatively high incidence of perianal soft tissue changes found in this study does not imply that these findings cannot be caused by sexual abuse. When unexplained perianal findings are encountered, other etiologic factors must be considered before the specter of abuse is raised. If a reasonable explanation is not forthcoming, a more thorough investigation must be initiated if children are to be protected from further exploitation. (McCann, et al., 1989). Another study evaluated 89 girls 18 months of age or younger. (Berenson & al. 1993) They observed non specific findings e.g., redness, in afew patients. However, skin tags were observed in only 3 patients and a fissure in one infant only. These findings are similar to those observed by other investigators (Lazar & Muram , 1989).

Longitudinal follow-up of anal injuries allowed investigators to conclude that complete healing is to be expected. (Hobbs & Wynne, 1989) This may take from weeks to years, with some anal appearances remaining permanently abnormal with scarring. Swelling of the anal margin largely disappears within 7-10 days. Anal dilatation commonly disappears in 1-6 weeks, deep fissures may take months to heal, and distended veins are one of the last signs to disappear. Anal dilatation in some children remained many months after abuse has ceased. Other investigators reported similar observations. (McCann & Voris, 1993) They followed four children with perianal injuries as a result of sexual assault. Subjects were followed for up to 14 months and were examined in both supine and prone positions. Acutely, the findings included erythema, edema, venous engorgement, dilation, and lacerations. Superficial lacerations healed in 1-11 days. The

deeper lacerations healed within 1-5 weeks, leaving narrow bands of scar tissue. Signs of these lacerations including one that was surgically repaired virtually disappeared in 12-14 months. The skin tag that formed at the site of tissue avulsion became less obvious over time. (McCann & Voris, 1993)

Finally, McCann & al (1996) examined the post mortem appearance of the perianal area in 65 subjects, ranging in age from birth to 17 years. They found some dilation of the anal sphincter in 48 subjects (74%). The anal canal was seen in 21children (32%), and the pectinate line was exposed in another 21 (32%). Other non-specific findings, e.g., venous pooling, were observed as well. However, no fissures, lacerations, hemorrhoids, or scars were found in any of the children. The authors concluded that anal dilatation alone cannot be used a marker for prior sexual abuse and the exposure of the pectinate line should not be confused with tears or fissures of the anal verge.

Interpretation of Anal Findings

Altough anal abuse is a common form of assault; there is no consensus as to which perianal or anal abnormalities are the result of sexual abuse, and which have other causes, e.g., constipation with passage of large, hard stools. Such determination may not be easy because the anal sphincter and anal canal allow some room for dilatation. Other disorders may cause perianal abnormalities similar to the ones observed in this series. Perianal abnormalities are often seen in children suffering from Crohn's disease or Hirschsprung's disease. In children with significant constipation the anal canal gapes when the buttocks are gently drawn apart. This is a normal anorectal reflex initiated by the distended rectum. Usually, stool may be seen in the anal canal. The diagnosis of

venereal disease affecting the anal canal is often delayed or even missed, because such infections are often asymptomatic. Thus, it is often difficult to observe anal abnormalities that are specific enough to establish the diagnosis of sexual abuse.

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Overview of the

CAC Model

Presented by

Nancy O'Leary, MSW and
Anne Lynn, MSW, MLSP

COMMON ELEMENTS AND UNIQUE OPTIONS

I. Designated Child-Friendly Facility & Staff

A. Located in a variety of settings:

1. Warm, comfortable and child-friendly
2. With the specialized equipment needed to provide intervention services

B. Options

1. Free-standing, renovated houses
2. Office building or suites
3. Hospital
4. Agency sponsored
5. Satellite sites

C. Staffing

1. Specialized training
2. Sensitivity to children
3. Administrative skills

D. Staff can be:

1. Employees of the CAC
2. On-loan from partner agencies
3. All based on-site
4. Participating agencies use CAC as needed

II. Multi-disciplinary Teaming and Multi-agency Commitment

A. Team comprised of:

1. Law enforcement
2. Child protective services
3. Prosecution
4. Mental Health
5. Medical Services

B. Team activities include:

1. Protocol development
2. Information sharing
3. Service provision
4. Team decision-making regarding child abuse cases

C. Options:

1. A core team may handle all cases
2. The team may vary with each case

D. Commitment

1. Formalized through written cooperative agreements and protocols

   a. agreements may be brief statements of philosophical commitment
   b. agreements may spell out roles and responsibilities in greater detail

III. Agency Affiliated or Independent Nonprofit

A. Organizational infrastructure supports the delivery of services.

1. Agency Affiliated

   a. can sometimes "get off the ground" more quickly
   b. enjoy relatively greater budget stability
      BUT
   c. more vulnerable to changes in financial position of the host agency
   d. may be perceived as controlled by sponsoring agency

2. Independent Nonprofit

   a. can minimize turf issues
   b. maximize a sense of equal agency "ownership"
   c. allow for greater ease in fund raising
      BUT
   d. operating budgets must be raised each year which adds to staff workload and stress

3. Options:

    a. sponsorship by any one of the participating agencies
    b. affiliation with other appropriate agency (i.e. rape crisis)
    c. independent nonprofit with strong involvement by agencies

IV. Joint Investigative Interviews

A. *Door* to the CAC

B. First become engaged with the CAC through the investigative process

C. Law enforcement and child protective services are usually involved in the interview process

D. Options:

1. Representatives from both agencies interview the child together
2. One investigator takes the lead
3. A child interview specialist conducts the interview, while others observe

V. Medical Exams & Evaluation and Mental Health Treatment

A. Need specialized medical and mental health services

1. Provide on-site at the CAC or through referrals
2. Medical exams may be provided by trained physicians, nurse practitioners, sexual assault nurse examiners or physicians assistants

VI. Prosecution, Case Review & Tracking

A. Involvement of prosecutor during interview process or afterwards through review of investigative reports

B. Team review (or staffing) of all cases or as needed on complex cases

C. Computerized case tracking systems

VII. Other CAC Services and Activities

A. CACs can provide support to victims and non-offending parents

1. Victims advocates to assist child with the court process
2. "Court school" to prepare children for court
3. Court Appointed Special Advocate (CASA) programs
4. Non-offending parent support or counseling groups

B. CACs also

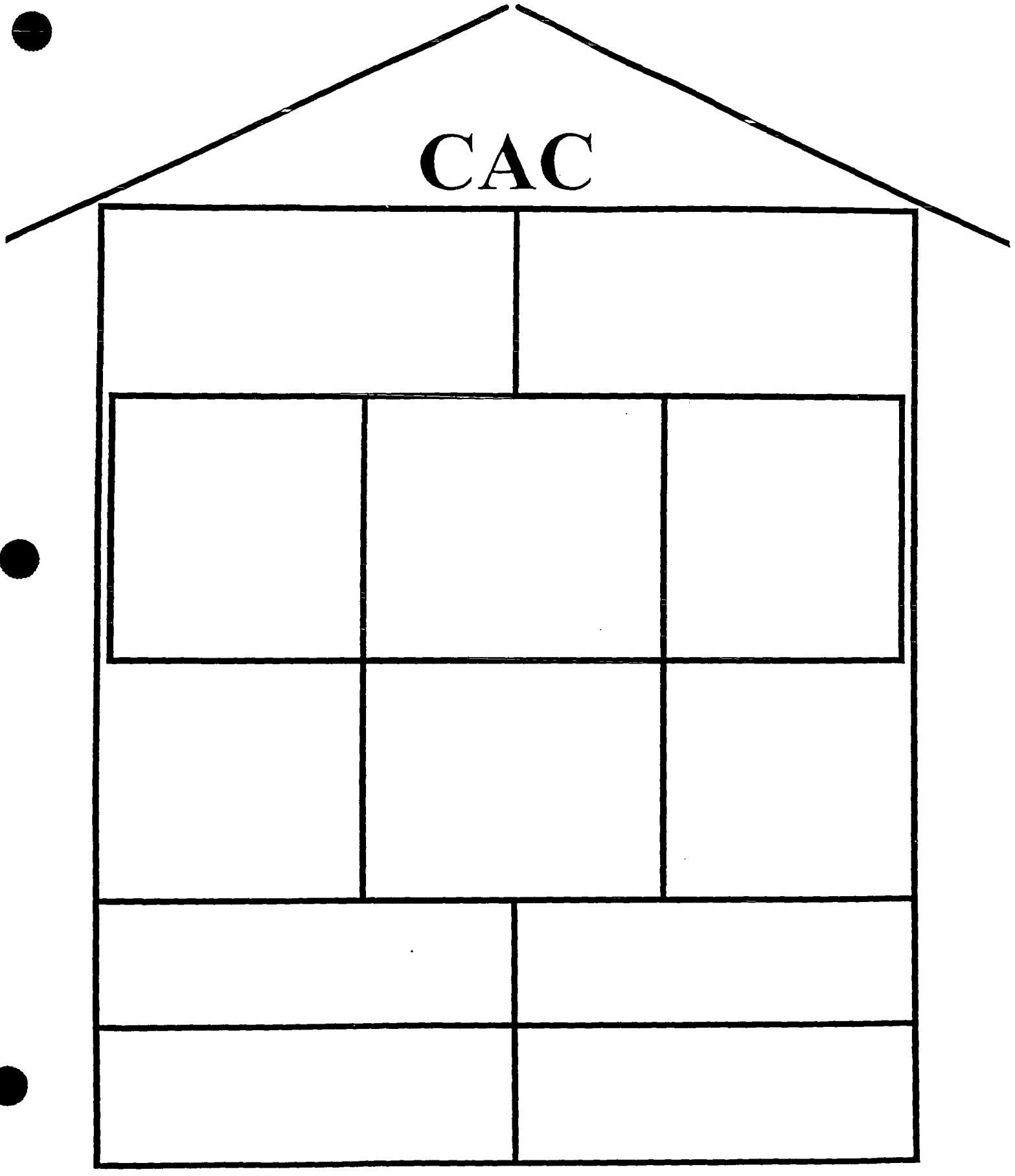
1. Provide education, training, and prevention programs regarding child abuse
2. Need to ensure that the professionals providing services through the CAC are well-trained

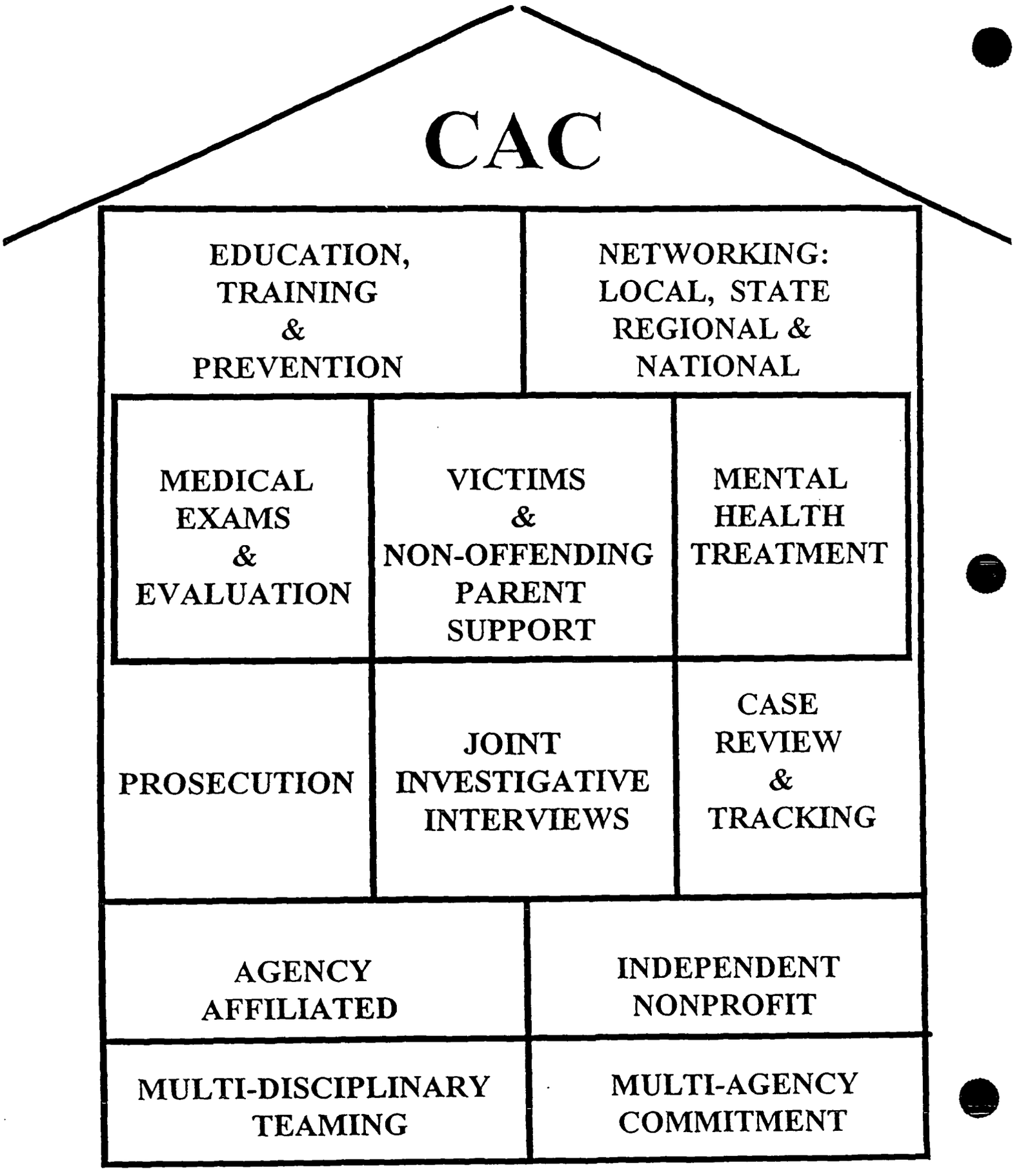
    a. hosting specialized training for professionals
    b. sending multi-disciplinary teams to training conferences
    c. providing training of "mandated reporters"
    d. education and outreach to civic and youth groups
    e. multi-media prevention education campaigns
    f. support for prevention programs for high risk families

C. Networking is important

1. Partnerships with other local organizations & businesses
2. Development of state networks or NNCAC chapters
3. Membership in the NNCAC (i.e. support, associate for full members)

VIII. Video - *Changing the System*


CAC


CAC
EDUCATION, TRAINING & PREVENTION
NETWORKING: LOCAL, STATE REGIONAL & NATIONAL
MEDICAL EXAMS & EVALUATION
VICTIMS & NON-OFFENDING PARENT SUPPORT
MENTAL HEALTH TREATMENT
PROSECUTION
JOINT INVESTIGATIVE INTERVIEWS
CASE REVIEW & TRACKING
AGENCY AFFILIATED
INDEPENDENT NONPROFIT
MULTI-DISCIPLINARY TEAMING
MULTI-AGENCY COMMITMENT

Keeping Expert Testimony on Children's Suggestibility Out of Court

Presented by

Brian K. Holmgren, JD

LIMITATIONS ON FORENSIC APPLICATION OF CHILDREN'S MEMORY AND SUGGESTIBILITY RESEARCH: A CRIMINAL JUSTICE PERSPECTIVE

Presented by Brian K. Holmgren
APRI's National Center for Prosecution of Child Abuse
(703) 739-0321

"When you have no basis for an argument, abuse the plaintiff."

Marcus Tullius Cicero

Know Your Role As An Interviewer

- To find the truth
- Establish absence and presence of crime
- Open mind - neutral posture
  - Willingness to accept allegations
  - Consider alternative hypotheses
  - Low frequency of false allegations
- Not therapist
- Gather information not dispense it
- Ask questions and listen to answers

State v. Michaels

625 A.2d 489 (N.J. Super. 1993)

642 A.2d 1372 (N.J. 1994)

State v. Michaels

642 A.2d 1372 (N.J. 1994)

Interviews of children were so coercive and "suggestive" that the children's testimony was facially unreliable--state has to prove reliability before re-trying the case.

State v. Michaels,
642 A.2d 1372 (N.J. 1994)

"We therefore determine that a sufficient consensus exists within the academic, professional, and law enforcement communities, confirmed in varying degrees by courts, to warrant the conclusion that the use of coercive, or highly suggestive interrogation techniques can..."

State v. Michaels,
642 A.2d 1372 (N.J. 1994)

"... create a significant risk that the interrogation itself will distort the child's recollection of events, thereby undermining the reliability of the statements and subsequent testimony concerning such events."

State v. Michaels,
642 A.2d 1372 (N.J. 1994)

"We thus agree with the Appellate Division that the interviews of the children were highly improper and employed coercive and unduly suggestive methods. As a result, a substantial likelihood exists that the children's recollection of past events was both stimulated and materially influenced by that course of questioning."

State v. Michaels,
642 A.2d 1372 (N.J. 1994)

"Accordingly, we conclude that a hearing must be held to determine whether those clearly improper interrogations so infected the ability of the children to recall the alleged abusive events that their pre-trial statements and in-court testimony based on that recollection are unreliable and should not be admitted into evidence."

TAINT HEARINGS FOR CHILD WITNESSES? A STEP IN THE WRONG DIRECTION

John E.B. Myers

46 *Baylor Law Review* 873 (1994)

Factors Which Influence Suggestibility in Interviews

- Interviewer's mental set - preconceived ideas, lack of objectivity
- Stereotypes about the subject of inquiry
- Erroneous suggestions
- Delay between the event and interview
- Intimidating environment including the status of the interviewer
- Repeated questions & multiple interviews

Factors Which Influence Suggestibility in Interviews

- The form of the question (open ended, focused, leading, suggestive, coercive)
- Positive and negative reinforcements to provide information (threats, bribing, cajoling, praise, rewarding)
- Inducements to keep secret or lie
- Exposure to outside information (disclosures by other victims, independent questioning by parents)

Multiple Interviews Or Not?

Multiple Interviews Or Not ? Risks

- May traumatize some children
- Children frequently inconsistent over multiple interviews
- Increases likelihood interviewers will use improper forms of questioning
- May reinforce suggested information from prior interview

Multiple Interviews Or Not ? Benefits

- May assist child in preparation for court
- Research reveals children frequently recall more information during subsequent interviews
- Reinforces information recalled during prior interview

Reasons For Use Of Leading and Focused Questions

1. False Denials
2. Psychological dynamics of sexual abuse
3. Developmental considerations (cognitive, linguistic, emotional)
4. Other avenues exhausted
5. Protective concerns

False Allegations and False Denials in Child Sexual Abuse.

Tom Lyon,

1(2) Psychology, Public Policy and Law, 429-437 (1995).

False Negatives in Sexual Abuse Disclosure Interviews: Incidence and Influence of Caretaker's Belief in Abuse in Cases of Accidental Abuse Discovery by Diagnosis of STD.

Louanne Lawson & Mark Chaffin, 7(4) Journal of Interpersonal Violence 532-542 (1992).

False Negatives in Sexual Abuse Disclosure Interviews

- 28 children ages 3 to menarche presenting to hospital with STD's
- No known prior disclosure or suspicion of sexual abuse
- Only 43% provided any verbal confirmation of sexual contact
- 57% were false negatives

False Negatives in Sexual Abuse Disclosure Interviews

- Caretaker attitude & support was critical variable in the child's disclosure process - children with supportive caretakers disclosed at a rate almost 3.5 times as great as those whose caretakers denied any possibility of abuse
- Aside from the STD many of the abused children presented free from any "suspicious" abuse symptoms, suggesting single interviews and red flags won't identify many hidden victims

The Diagnosis of Child Sexual Abuse. **Dubowitz, Black & Harrington, 146 American Journal of Diseases of Children 688-693 (1992).**

- 28 children with abnormal medical findings indicative of sexual abuse
- 25% provided no verbal information re sexual abuse even to skilled interviewers

Sexual Abuse Evaluations in the Emergency Department: Is the History Reliable?

Stacy Gordon & Paula Jaudes, 20(4) Child Abuse & Neglect 315-322 (1996).

- 141 kids screened in ER for SA by MDT
- 54% abnormal exams; 10% had STD
- 27% made no ID of perp
- 15% no ID of perp during first interview; 83% of these kids had abnormal exam
- 12% recanted ID after interview
- 30% refused to speak with ER physician; adult had to act as the historian
- The mean ages of the kids recanting or failing to ID perp were significantly lower

How Children Tell: The Process of Disclosure in Child Sexual Abuse.

Teena Sorenson & Barbara Snow, 70 Child Welfare 3-15 (1991).

- 116 cases of confirmed sexual abuse by plea (80%), conviction (14%) or medical evidence (6%)
- 74% of initial disclosures were accidental
- 72% initially denied abuse
- 78% moved on to tentative disclosures defined as the child's partial, vague or vacillating acknowledgment of abuse
- 70% gave further information over time
- 22% of kids recanted; 92% reaffirmed

Children's Memories of Physical Examinations Involving Genital Touch: Implications for Reports of Child Sexual Abuse.

Saywitz, Goodman, Nicholas & Moan, 59 Journal of Consulting and Clinical Psychology 682-691 (1991).

- 72 girls, half 5-year-olds, half 7-year-olds
- Girls given physical exam, half included genital examination
- 1/2 interviewed week later, 1/2 after a month
- Children were interviewed using free recall, direct questions, misleading questions, and asked to provide a demonstration of the exam using anatomically correct dolls

- For the genital condition, 78% of the girls failed to disclose vaginal touching in free recall, and 83% failed to show genital touching in the demonstration
- Children who disclosed were younger
- 86% disclosed genital touch for direct question's
- For misleading questions, older children performed better than younger but error rates for all children were low

- Children in the genital condition answered abuse like questions less accurately than children in the non-genital touch condition. However, errors made were more likely to be omissions rather than false assertions

Reasons For Use Of Leading & Focused Questions

Psychological & Sociological Dynamics Of Sexual Abuse

Psychological and Sociological Dynamics of Sexual Abuse

- Adult's abuse of power and control
- Violation of trust
- Delayed and piecemeal disclosure process; inconsistent disclosures
- Threats to silence - fear and secrecy
- Emotional attachment to abuser

Psychological and Sociological Dynamics of Sexual Abuse

- Loss of control and autonomy
- Guilt & shame - repression, denial, avoidance, embarrassment & humiliation
- Isolation, abandonment and specialized treatment

Psychological and Sociological Dynamics of Sexual Abuse

- Disruption of the family, family disfunction, covariance of family violence
- Lack of support and acceptance prior to and subsequent of disclosure
- Trauma from victimization
- Cognitive appreciation for wrongfulness of behavior

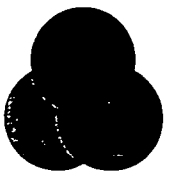
The Effect of Threats on Children's Disclosure of Sexual Abuse.

Thomas Lyon, 9(3) APSAC Advisor 9 (1996).

Reasons For Use Of Leading & Focused Questions

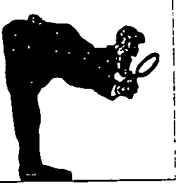
Developmental Capacities Of Children

- ➢ Ability to provide information using free recall vs. recognition
- ➢ Language skills
- ➢ Memory retrieval mechanisms



Focused and leading questions vary in the degree of their suggestiveness.

What is *leading* and what is *suggestive* are largely in the eye of the beholder.



A Continuum of Types of Questions

Greater Certainty ——————>Less Certainty

General (Open Ended)

Leading——>Suggestive——>
Coercive

Kathleen Coulborn Faller, M.S.W., Ph.D

KIDS IN COURT

What you really need to know about memory

Three *Phases*

❶ Acquisition

❷ Storage

❸ Retrieval

KIDS IN COURT

What you really need to know about memory

Acquisition

- ✦ Children have more difficulty than adults with complex issues
- ✦ Ability increases till age twelve
- ✦ Young children remember familiar things well

KIDS IN COURT

What you really need to know about memory

Storage

Ability does not increase with age

KIDS IN COURT

What you really need to know about memory

Retrieval

Event *reporting* affected by

- ✦ Cognitive development
- ✦ Language acquisition
- ✦ Delay between event & interview
- ✦ Secrecy inducement

KIDS IN COURT

What you really need to know about memory

Retrieval

Memory & Reporting affected by

- ✦ Stress
- ✦ Both a help & hindrance

KIDS IN COURT

What you really need to know about memory

Three *tasks*

❶ Recognition

❷ Reconstruction

❸ Free recall

What You Really Need To Know About Memory

Recognition

- Simplest & earliest memory task
- Young children can recognize familiar items as well as adults but have more difficulty with complex stimuli.
- Questions employing recognition allow kids to perform more like adults, but questions are often considered leading or suggestive.
- Multiple choice format for recognition type questions can reduce suggestibility

What You Really Need To Know About Memory

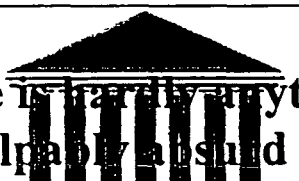
Reconstruction

- Involves reinstating the context in which the original event occurred.

What You Really Need To Know About Memory

Free Recall

- Memory strategy most strongly related to age and development.
- Requires memory search for event and descriptive narrative response.
- Questions employ free narrative formats with open ended questions
- Information provided is the most reliable.
- With younger children this format produces quantitatively less information.



"There is hardly anything not palpably absurd on its face that cannot now be proved by some so-called expert."

Chaulk v. Volkswagen of Am. Inc.., 808 F.2d 639, 644 (7th Cir.. 1986)

Federal Rules of Evidence

Rule 702

If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue a person qualified by knowledge, skill, experience, training or education, may testify thereto in the form of an opinion or otherwise.

Federal Rules of Evidence

Rule 703

The facts or data in the particular case upon which an expert bases an opinion or inference may be those ***perceived*** by or ***made known*** to him at or before the hearing. If of a type ***reasonably relied upon by experts*** in the particular field in forming opinions or inferences upon the subject, the ***facts or data need not be admissible in evidence.***

Federal Rules of Evidence

Rule 704

Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.

Federal Rules of Evidence

Rule 705

The expert may testify in terms of ***opinion*** or ***inference*** and give his reasons therefor ***without prior disclosure*** of the ***underlying facts or data, unless the court requires otherwise.*** The expert may in any event be required to ***disclose*** the underlying facts or data on ***cross-examination.***

Federal Rules of Evidence

Rule 803(18) LEARNED TREATISES

To the extent called to the attention of an expert witness upon *cross-examination* or relied upon by him in *direct examination*, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, *established as reliable authority* by *testimony* or *admission* of the witness or by other *expert testimony* or by *judicial notice*. If admitted, the statements may be *read* into evidence but may *not be received as exhibits*.

Scientific and expert testimony with their aura of special reliability and trustworthiness... courts the danger that the triers of fact will abdicate (their) role of critical assessment and surrender... their own common sense in weighing testimony

State v. Batangan

799 P.2d 48 (Hawaii 1990)

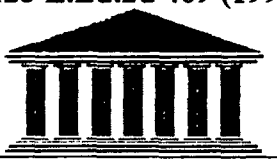
Frye Test

Basis for testimony must be sufficiently established to have gained general acceptance in the relevant scientific community

EXPERT WITNESS TESTIMONY

DAUBERT v. MERRELL DOW PHARMACEUTICALS INC.

___ U.S. ___ , 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993)



The subject of an expert's testimony must be "scientific...knowledge." The adjective "scientific" implies a grounding in the methods and procedures of science. Similarly, the word "knowledge" connotes more than subjective belief or unsupported speculation.

Daubert v. Merrell Dow Pharmaceuticals

An additional consideration under Rule 702 - and another aspect of relevancy - is whether expert testimony proffered in the case is sufficiently tied to the facts of the case that it will aid the jury in resolving a factual dispute. ...whether that reasoning or methodology properly can be applied to the facts in issue.

Daubert v. Merrell Dow Pharmaceuticals

Rule 702's "helpfulness" standard requires a valid scientific connection to the pertinent inquiry as a precondition to admissibility.

...scientific validity for one purpose is not necessarily scientific validity for other, unrelated purposes.

Daubert v. Merrell Dow Pharmaceuticals

The inquiry envisioned by Rule 702 is, ... a flexible one. It's overarching subject is the scientific validity - and thus the evidentiary relevance and reliability - of the principles that underlie a proposed submission. The focus,... must be solely on principles and methodology, not on the conclusions they generate.

Daubert v. Merrell Dow Pharmaceuticals

CRITERIA UNDER *DAUBERT*

1. **Whether the theory or technique can be or has been tested.**
2. **Whether the theory or technique has been subjected to peer review or published.**
3. **Whether the theory or technique has a known or potential rate of error and what it is.**
4. **The existence and maintenance of standards controlling the technique's operation.**
5. **Whether the theory or technique is generally accepted in the relevant scientific community.**

Research Issues

Analog Studies

- ✪ General issues of memory
- ✪ No direct parallel to CSA

Example: staged event studies

Research Issues

Ecological Validity Studies

- ✪ Tries to recreate aspects of CSA
- ✪ Can isolate one or a few aspects

Example: medical exam study

KIDS IN COURT

Suggestibility

"Suggestibility concerns the degree to which children's encoding, storage, retrieval, and/or reporting of events can be influenced by a range of internal and external factors." Ceci 1993

"Suggestibility is an extremely complex, multiply determined phenomenon. Situational factors such as the interview context, the nature of the questions used, and the strength of one's memory of the event in question interact with personality variables to influence the suggestibility of both children and adults."

Reed, D.L. (1996). Findings from Research on Children's Suggestibility and Implications for Conducting Child Interviews. 1(2) Child Maltreatment 105-120.

"Therefore, the same individual may be highly susceptible to being misled in one situation, yet highly resistant to being misled in a different situation."

Reed, D.L. (1996). Findings from Research on Children's Suggestibility and Implications for Conducting Child Interviews. 1(2) Child Maltreatment 105-120.

Factors That Vary Across Studies

- → Type of recalled event (observations vs. personal experience)
- → Form of remembering task (Free recall, recognition)
- → Length of delay between event and recall
- → Single vs. multiple interviews
- → Setting
- → Age of children
- → Type of questions posed to child

Limits of Research

- Cannot replicate circumstances of abuse
- Cannot replicate circumstances of disclosure
- Results reported in terms of groups
- Individual child may not perform as group
- Statistically significant results Vs. important results
- Results reflect a spectrum of abilities rather than all or nothing

JEOPARDY IN THE COURTROOM: A Scientific Analysis of Children's Testimony

by Stephen J. Ceci and Maggie Bruck

published by American Psychological Association

". . . [W]e focus disproportionately on [children's] weaknesses, because it is our contention that [these weaknesses] are less well understood by experts and nonexperts. . ."

JEOPARDY IN THE COURTROOM
preface at x

"So to repeat, although the literature is skewed toward case studies that entail weaknesses, these are probably not the most common types of cases."

JEOPARDY IN THE COURTROOM
preface at x

". . . [A]lthough we think that there are data that highlight the potential weaknesses of children's reports, we do not think that these data are so consistent as to categorically discredit children from testifying or even to recommend skepticism upon hearing a child's disclosure."

JEOPARDY IN THE COURTROOM
page 4

Extreme negative opinions about the young child's ability to resist leading questions that have been proffered throughout this century are unwarranted. Assertions from the earlier historical periods, such as '*Create, if you will, an idea of what the child is to hear or see, and the child is very likely to see or hear what you desire,*' are needlessly ungenerous views of children's abilities.
Ceci & Bruck (1993)

What the Expert Witness on Children's Suggestibility *Should* Tell the Court

1. There are reliable age differences in children's suggestibility, with preschoolers being more vulnerable than older children to a variety of factors that contribute to unreliable reports.

Ceci & Bruck, *Jeopardy in the Courtroom*

What the Expert Witness on Children's Suggestibility *Should* Tell the Court

2. Although young children are often accurate reporters, some do make mistakes - particularly when they undergo suggestive interviews; and these errors are not limited to peripheral details, but may include salient events that involve children's own bodies.

Ceci & Bruck, *Jeopardy in the Courtroom*

What the Expert Witness on Children's Suggestibility *Should* Tell the Court

4. Finally it is important that the court appreciate the complexity of the interrelationships among the factors affecting children's report accuracy. As in most areas of social science, effects are rarely as straightforward as one might wish. For example, even though suggestibility effects may be robust, they are not inevitable, nor are they ineluctably large in magnitude...

Ceci & Bruck, Jeopardy in the Courtroom

Jeopardy in the Courtroom

"In short, we urge expert witnesses to review the full corpus of relevant scientific work, describing the magnitude of errors, the inconsistencies within and across studies, and the boundary conditions that might limit any generalization from the science to the case at bar."

"So to repeat, although the literature is skewed toward case studies that entail weaknesses, these are probably not the most common type of cases."

"Although the literature clearly reveals age differences in overall suggestibility, the exact mechanisms involved in producing distortion in young children's reports are still being debated by researchers. Until there is a consensus, nothing like a *Frye* test standard can be met to account for the mechanism by which age differences in suggestibility arise.

Ceci & Bruck, *The Suggestibility of the Child Witness: A Historical Review and Synthesis*

"As social scientists whose opinions can influence legal and societal decisions, we have a duty in our presntation to the media and the courts to point out that the problem of suggestibility is circumscribed and complex."

Marxsen, D., Yuille, J.C. & Nesbit, M. (1995). *The Complexities of Eliciting and Assessing Children's Statements.* 1(2) Psychology, Public Policy & Law 450.

APA CODE OF ETHICS

2.04 USE OF ASSESSMENT IN GENERAL AND WITH SPECIAL POPULATIONS

Psychologists who perform interventions or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standardization or outcome studies of, and proper applications and uses of, the techniques they use.

APA CODE OF ETHICS

2.04 USE OF ASSESSMENT IN GENERAL AND WITH SPECIAL POPULATIONS

Psychologists recognize limits to the certainty with which diagnoses, judgments, or predictions can be made about individuals.

APA CODE OF ETHICS

3.03 AVOIDANCE OF FALSE OR DECEPTIVE STATEMENTS

Psychologists do not make public statements that are false, deceptive, misleading, or fraudulent, either because of what they state, convey, or suggest or because of what they omit, concerning their research, practice, or other work activities...

APA CODE OF ETHICS

7.04 TRUTHFULNESS AND CANDOR

In forensic testimony and reports, psychologists testify truthfully, honestly, and candidly and consistent with applicable legal procedures, describe fairly the bases for their testimony and conclusions. Whenever necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions.

Expert Testimony on Children's Suggestibility: Should It Be Admitted?

Brian K. Holmgren 10(2)
***APSAC Advisor* 10 (1997)**

Arguments Against Relevance

1. **Unless the research protocol replicates the specific facts of the case in total, no expert can relate research findings to the facts of a particular case, or the abilities of a particular child witness.**
2. **Research on jurors indicates they already believe children are highly suggestible; experts aren't needed to reinforce this belief.**
3. **Highly suggestive interviews themselves undermine reliability in the child's account.**

Daubert Criteria: Theory Tested?

→Little research on children over six

→No base rates for suggestibility factors at different ages of children; generalized reporting of data across age groups

→No research on the emotional component of disclosure & relationship to suggestibility factors

→Little recognition in research of child's initial disclosure and effects on accuracy and memory produced by subsequent suggestive questioning

Daubert Criteria: Theory Tested?

→Little research on the effects of one or two improper interviews

→Little research on effects of stereotype induction involving a trusted/loved adult

→Little research testing children's resistance to suggestibility factors where children are told they can answer "I don't know/remember"

→No testing on actual abuse populations

Daubert Criteria: Error Rate?

→Research data not reported by specific age

→Conflicting data

→Suggestibility/reliability gauged by response to target questions; data not reported in terms of overall reliability of information provided

→Effect of confounding variables from tests involving multiple suggestibilityfactors

→Inability to account for individual differences

→Developmental age Vs chronological age

Daubert Criteria: Standards?

→ Divergent research methodologies and potential bias of protocols

→ One school focusing on weaknesses in children's memory and impact of suggestibility

→ Other highlighting children's strengths

→ Results reflect objectives of research and methodologies used to test hypothesis

Daubert Criteria: Standards?

→ No control in research for potential effects of linguistics in questions posed to children

→ Form of suggestive questioning varies across studies including use of forced choice questions

→ Statistically significant results involving insignificant events

→ Participatory vs. observed events

Daubert Criteria: Acceptance?

→ Discrepant findings within and between studies

→ Acknowledgment of need for further research

→ Disagreement over whether suggestibility leads to erasure of the child's original memory

→ Peer critiques in professional journals

→ Acknowledgment of lack of scientific consensus

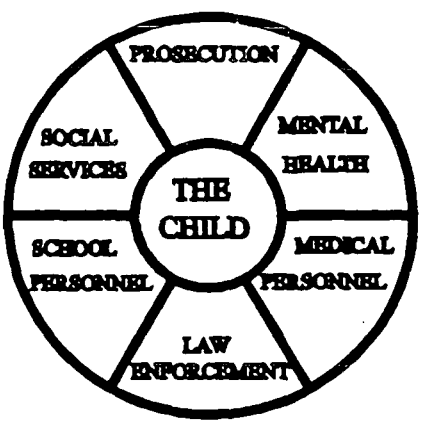
Improving the Outcomes for Children: Cognitive Interviewing

Presented by

Detective James Starks and
Social Worker Susan Samuel

IMPROVING THE OUTCOMES FOR CHILDREN

COGNITIVE INTERVIEWING



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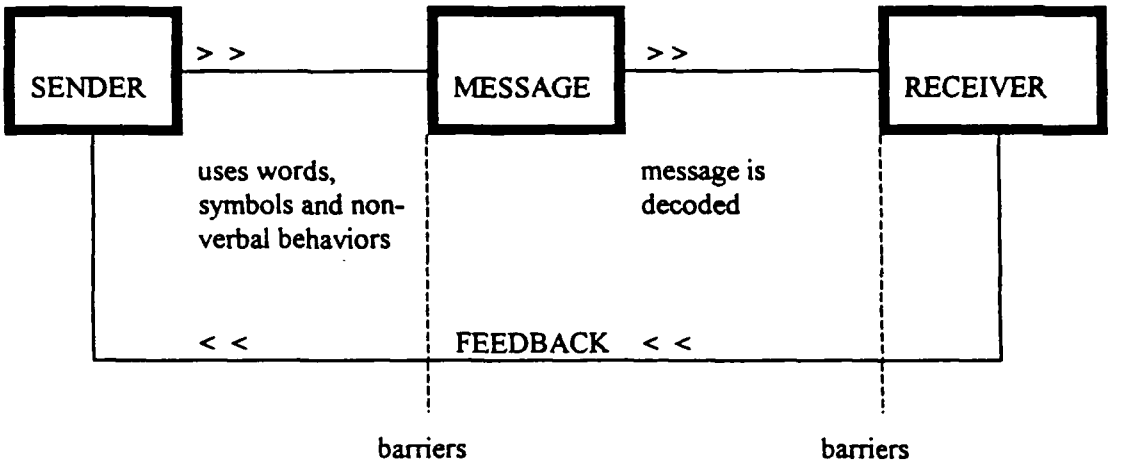
BUILDING THE FOUNDATION FOR FORENSIC INTERVIEWING

Often the child interview is the single most important component for determining both risk to the child and whether or not a crime has occurred. Child interviewing has "evolved" in the last two decades, propelled by research, court decisions and the collective wisdom of the disciplines that bear responsibility for the safety of children.

These materials combine recent research on interviewing children with selected best-practice methods.

COMMUNICATING WITH CHILDREN

COMMUNICATION: AN EXCHANGE OF UNDERSTANDING BETWEEN SENDER AND RECEIVER



(Rakich, 1992)

The child sexual abuse interviewer is both the sender and the receiver. As the sender, the interviewer is the person asking questions. When the child responds, the interviewer then becomes the receiver. Feedback is critical to determine if messages are received as intended.

Successful communication requires that the interviewer attempt to **reduce** the barriers that impede the exchange of understanding between himself/herself and the child. Barriers may be significantly reduced by choosing methods of communication that are appropriate to the child's developmental level and frame of reference

ATTEMPTS TO COMMUNICATE <u>WITHOUT</u> CONSIDERATION OF THE CHILD'S DEVELOPMENTAL LEVEL AND FRAME OF REFERENCE PRODUCE RESPONSES (FROM THE CHILD) THAT APPEAR TO BE INCOMPLETE AND INCONSISTENT. SUCH RESPONSES UNDERMINE THE CREDIBILITY OF THE CHILD.

COMMON CAUSES OF COMMUNICATION PROBLEMS

CHILDREN DEVELOP LANGUAGE SKILLS IN "LAYERS". FULLY DEVELOPED LANGUAGE CONCEPTS DO NOT EMERGE UNTIL THE TEEN YEARS. MOST MIS-COMMUNICATION OCCURS WHEN ADULTS ASSUME THAT A CHILD HAS MASTERED A PARTICULAR SKILL, WHEN, IN FACT, THE CHILD HAS NOT.

I. Defining Words (Partially adapted from Walker, 1993)

Group Exercise

II. Complex/Confusing Questions

A. Children will isolate the part of the question they **think** they understand, and will respond accordingly.

B. If they do not answer the question, they will often attempt to give **any** information that they have on the topic. (Walker, 1993)

C. If they do not understand the question, they will often repeat the end of the prior sentence. (Walker, 1993)

Example: (From Saywitz, 1988, in Walker, 1993)

Witness is a 4-year old child.

Q: When you were at your grandma's house with your daddy, whose mamma is your grandma?
A: Grandma Ann.
Q: Is she your daddy's mamma?
A: Huh?
Q: Is she your daddy's mamma?
A: Daddy's mamma.
Q: Is grandma daddy's mother?
A: She has a boyfriend, two boyfriends.

III. Pronouns/Relationships

A. To avoid confusion, repeat names (or descriptions)
Ask, "What were John and Mary doing in the living room?" rather than, "What were **they** doing in **there?**"

B. Relationships

IV. Double Negatives

To avoid confusion, use only one negative in a sentence. Say, "Did your Mom tell you not to go there?" rather than, "Didn't your Mom tell you not to go there?" (Saywitz, 1990)

V. Location/Position

A. Check child's understanding of: over-under; on-in; inside-outside; behind-in front of; first-last. Tools: Paper sac, books, crayons, etc.

B. The younger the child, the less likely to know the geographic designation (town, city).

VI. Time

A. Children are better at measuring time relative to events that are meaningful to them, rather than by the abstract concept of hours, minutes. Ask about events relative to a particular TV program, a holiday, a family tradition, the usual routine.

B. Children do not "estimate" time well. Not likely to obtain accurate response to, "How long was his penis in your vagina?"

C. The ability to recite the days of the week, months of the year, does not necessarily mean a child can accurately place an event in time.

D. When recalling an event that occurred at a much younger age, the child will process that information relative to the skills possessed at the younger age. (Saywitz, 1987)

E. When child gives a response to a "when" question, ask an immediate open-ended (focused) follow-up question.

From a 13-year-old:
Q: When did that happen?
A: In the fall, near winter.
Q: What makes you think it was "in the fall, near winter"?
A: Because when he did it to me I kept looking out the window. There was this big tree that I could see from my bed... and I saw the leaves on the tree. Almost all the leaves were gone, but some were still there.

F. The words and phrases children use to depict time, may have different meanings for adults.

From a 14-year-old:
Q: When did that happen?
A: When I was little.
Q: How little?
A: Little, little...9 years old.

From a 7-year-old:

Q: When did that happen?
A: **A long time ago**, when I was 6.

VII. Descriptions

A. The question, "What did he look like?" assumes the child understands that investigator wants to know about height, weight, hair color, age etc.

B. Age is a difficult concept for young children. They can't accurately estimate a person's age, but they may know if someone is a "grown-up or a kid"; old enough to drive a car, to be a mommy, to be a grandpa.

C. "Old" is relative.

D. Young children often think the tallest person is the oldest.

VIII. How Many Times?

A. Don't assume that because a child can count, he/she understands number concepts. Test by doing an activity that requires the child to pick three pennies from a row of ten, for example.

B. Begin by asking if something happened one time or more than one time.

C. Tie the sexual contact to a repetitive event. Then compute (approximate) the number of times.

D. Charges v. number of times.

IX. Failure to re-frame

Reframing assists children in successfully making the transition from one topic to another. Examples:

"Now I want to talk about what happened in the bathroom."

"We've talked about your Uncle Johnny. Now I want to talk about ....."

X. Literal Interpretation of Words/Phrases

Children usually pick the literal interpretation of a phrase or word.

Example: (Walker, 1993)

<u>Voir dire by the court of a 5-year-old child.</u>
Q: Okay. Do you know what your birth date is? I bet you know that?
A: No.
Q: When were you 5 years old?
A: I am 5.
Q: You are 5?

A: (Witness nods).
Q: Okay, when will you be 6?
A: When my birthday comes.
Q: Ask a silly question, get a silly answer...or get a straight answer. Okay, how long ago did you have your birthday?
A: I didn't have my birthday.

XI. Abstract Concepts - Young children have difficulty understanding abstract concepts such as "truth and lie". The more concrete the presentation, the more likely the child will understand and respond appropriately.

A. **Don't ask** a young child to "tell the difference between the truth and a lie." That task requires abstract thinking. (Fewer than 50% of 7-year olds)

B. **Don't ask** a young child to "define truth, define lie." That task requires abstract thing. (Fewer than 50% of 7-year olds)

C. **Do ask** young children to identify something as being "the truth" or"a lie." First give a concrete example, then ask if the statement is "the truth" or "a lie." (More that 80% of 7-year olds and 50% of 5-year olds)

1. "If somebody said you were a girl, would that be the truth or a lie?"

   Use "somebody said" instead of "I said" because "I said" can be more of a challenge to young children.

2. "If somebody told you my shirt was red, would that be the truth or a lie?"

D. Picture-presentation of truth/lie and "obligation to tell the truth" (adapted from Lyon, 1996)

XII. Implying Blame - When children are asked questions that imply they <u>should</u> have done something they didn't do, or that they <u>shouldn't</u> have done something they did, they feel compelled to "explain away" the act or non-act. Their responses are less reliable and accurate then information obtained without implying blame. Examples:

A. 13 year old male
   Q. Why didn't you scream?
   A. I had tape over my mouth.
   Q. Why didn't you remove the tape?
   A. My hands were tied.

B. 8 year old female
   Q. Did you ask Leroy what he was doing?
   A. Yes
   Q. What did you say?
   A. I said, "Leroy! What are you doing?"

QUESTIONING CHILDREN

When child sexual abuse has been alleged, investigators must assess future risk of harm to the child and whether or not a criminal act has been committed. Often, the most important piece of evidence in determining the credibility of the allegation of abuse is the child's statement.

Improving the Quantity and Quality

Generally, the more information obtained from the child, the more valid the assessments of risk and criminality. Even young children are capable of giving narrative responses. The material the child provides spontaneously or in a free narrative is always superior to brief, simple (Raskin & Esplin, 1991)

How the information is obtained from the child is also critical to the investigatory process. In the last decade, research and subsequent training has focused on improving questioning techniques. Investigators may choose from several different questioning "frameworks", all of which seek to enhance the quality and quantity of the child's response.

The questioning framework presented here is based on recent research conducted by the National Institute of Child Health and Human Development as well as by independent researchers across the country. These techniques have been successfully field tested by many investigators, your trainers included. Consistent use of the techniques will lead to improved quantity and quality of information.

In order to improve our questioning process we must understand the different types of questions and how the type of question affects the answer obtained.

Types of Questions

I. General Questions - Presented here in a hierarchy from less focused to more focused. These questions may be used at the very beginning of the interview or after rapport building as a transition to the substantive portion of the interview. These questions take no "cue" form anything the child has already said.

   A. "Do you know why I came to see you today?" IF NO RESPONSE

   B. "I understand something happened to you. Tell me about that." IF NO RESPONSE

   C. "I heard from your counselor, Ms. Murray, that maybe you weren't safe. Tell me about that." IF NO RESPONSE

   D. "Ms. Murray told me something about your uncle..over the weekend... Tell me about that."

II. Invitations - Directives, questions, phrases, gestures and periods of silence that "invite" and encourage the child to provide spontaneous or free narrative, verbiage. Invitations are based on something the child has already said.

   A. Directives

1. "Tell me what happened, start at the beginning, go to the middle and then to the end. Don't leave anything out, not even the little things."

2. "Tell me more about him licking your Pee pee."

3. "I want to know everything about how you got to the bedroom."

B. Questions

1. "Then what happened?"

2. "What's the very next thing that happened after that?"

C. Phrase - "And....(pause)"

D. Gestures

1. Interviewer has an expectant look on his face and makes eye contact.

2. Interviewer leans slightly forward and turns palms up in a inviting manner.

E. Silence - The most under utilized, but one of the most effective interviewing techniques.

III. Direct/Focused Questions - Relate to details already mentioned by the child and used to clarify and expand the child's statement.

A. You said, "We were in the kitchen and he touched me and stuff."

1. Who is "he"?
2. Point to the place on your body that Uncle Time touched you.
3. What do you call that part of your body?
4. Did Uncle Tim have a name for that part of your body?

B. When you first told me what happened, you said, "we were in the kitchen and he touched me and stuff."

1. What's the "and stuff" part?

IV. Leading Questions - Details not previously mentioned by the child. Leading questions are not, in and of themselves, bad questions. the younger the chid, the more leading the questions will need to be. Problems arise when investigators ask only or primarily leading questions and use the responses, which tend to be very brief or yes/no, to establish the credibility of the statement. To clarify and validate a response to a leading question, follow it with an invitation, "TELL ME ABOUT THAT." (see how this relates to the feedback loop)

A. "Did you see his penis?"

B. "Did anything come out of his penis?"

C. "Were his clothes off or on?"

V. Yes/No and Multiple Choice - May or may not be leading questions, depending on whether or not the child has previously mentioned the topic.

A. "Yes" responses should always be followed by an invitation.

B. In multiple choice, young children often give the last choice as their response.

The court ruling in State [New Jersey] v. Michaels (1994) indicates that the following types of questions are unacceptable. Little if any confidence can be placed in the validity to response obtained with these questions.

VI. Suggestive Questions - Details not previously mentioned by the child and the expected response is strongly communicated in the question.

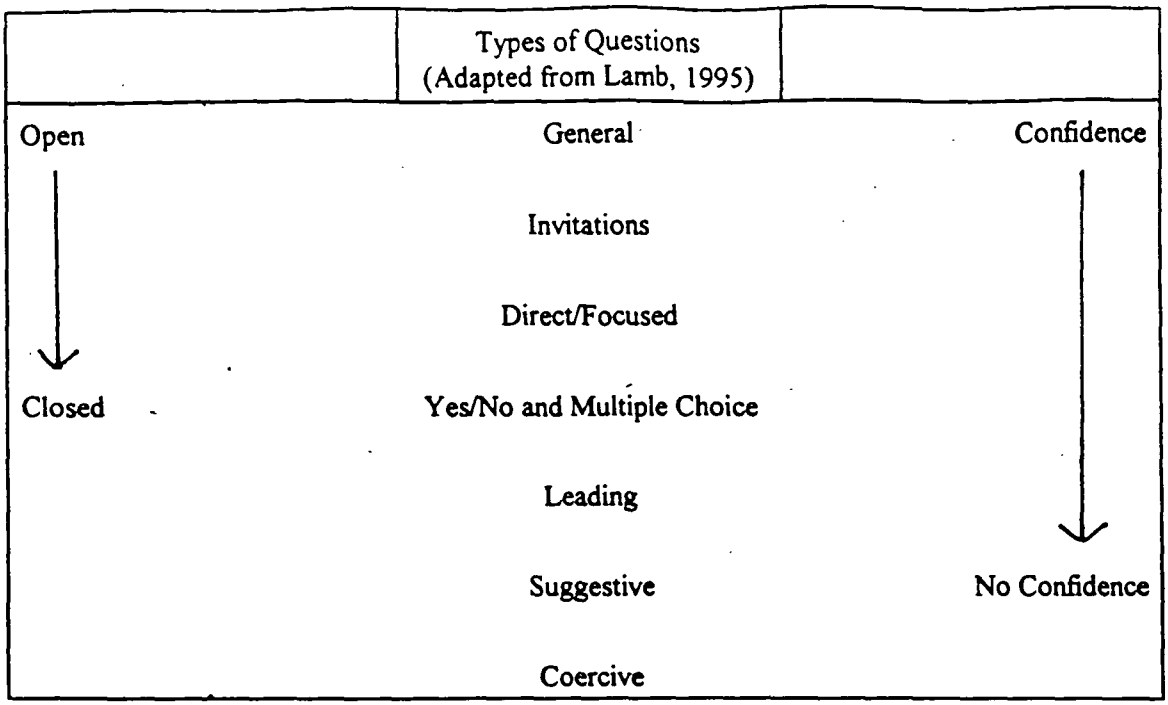
A. "Did it happen in the living room or the bedroom?"

B. "He forced you to do that, didn't he?"

C. CHILD: "We laid on the sofa."
INTER: "He laid on you or you laid on him?"

VII. Coercive Questions - The interviewer pressures the child to continue or to move in a particular direction (from State v. Michaels)

INTER: Did she put the fork in your butt? Yes or no?
CHILD: I don't know, I forgot.
INTER: You forgot. Ok, did she do anything else to your bottom?
CHILD: that's all that she did.
INTER: What was it that she did to you?
CHILD: I hate you.
INTER: No you don't.
CHILD: Yes I do.
INTER: You love me, I can tell. Is that all that she did to you? What did she do to your hiney?
2ND INT: What did she do to your hiney? Then you can go.


Types of Questions
(Adapted from Lamb, 1995)
Open
General
Confidence
Invitations
Direct/Focused
Closed
Yes/No and Multiple Choice
Leading
Suggestive
No Confidence
Coercive

COGNITIVE INTERVIEWING

The cognitive interview has been used by law enforcement since the mid-1980s. It was developed to aid forensic questioning of **adult** crime victims. A collection of techniques is used to enhance the memory of an event in a type of "guided memory search". Studies show that adult witnesses who are interviewed with cognitive techniques are able to recall 35% to 58% more information than witnesses interviewed by more standard police methods.

In 1992, cognitive interviewing techniques were adapted for use with children. The results were promising. Children in two studies demonstrated a 26% to 45% increase in accurate information given, **without increased inaccuracy**. (Saywitz, 1992)

THE COGNITIVE INTERVIEW IS BEST SUITED FOR USE WITH <u>DISCLOSING</u> CHILDREN, AGES 6 TO 17.

I. Advantages of the Cognitive Interview

- A. Easy to learn, use, understand
- B. Standardizes process
- C. Provides "framework"
- D. Backed by current research
- E. Yields more detail, information
- F. Requires only 5 to 15 minutes longer
- G. Appears to reduce the affect - child concentrates on "thinking", rather than "feeling."

II. "Steps" in Recalling a Memory

- A. A still picture in a setting with memory "keys":
  1. Hearing
  2. Smell
  3. Taste
- B. Picture moves
- C. Words describe the moving picture

III. Components of the Cognitive Interview
(Partially adapted from Saywitz, Geiselmen, & Borenstein, 1992, and from Walker, 1993)

A. Build Rapport

B. Tell the "Rules" for Answering Questions. The "rules" are a set of instructions that assist the child in understanding the interview process, the expectations of the interviewer and help reduce suggestibility and coercion. "I'm going to ask you a lot of questions today. There are some rules for answering the questions".

1. **Don't know/remember:** No guessing! There may be some questions that you don't know the answers to. That's O.K. Nobody can remember or know everything. If you don't know or don't remember, just tell me 'I don't know' or 'I don't remember'. It's important to tell me only what really happened. Only what you really remember.

2. **Don't understand:** If I ask you a question that you don't understand, just tell me 'I don't understand that question'. Then I will try to ask the question in different words.

3. **Don't have to answer:** You don't have to answer a question if you don't want to. Just tell me 'I don't want to answer that'.

4. **Repeat the questions:** I may ask you a question more than one time. Sometimes I forget what I asked, or how you answered. It doesn't mean there was anything wrong with the answer you gave the first time. You don't have to change your answer. Just tell me again what you remember the best you can."

5. **Correcting the interviewer:** Sometimes , when you answer a question, I will repeat what you have told me. I don't always get things right. You need to tell me when I get it wrong.

C. Reconstruct the Setting

Picture (**don't use the words IMAGINE or PRETEND**) in your mind that time when...as if you were there right now. Think about what it was like. Where were you? What did (the place) look like? Who was there? Could you smell, hear anything?

D. Guide the Narrative - Beginning, Middle, End

1. Tell the child, "Now I want you to tell me what happened. I want you to start at the beginning and tell me what happened, from the beginning, to the middle, to the end. Tell me everything you remember, even the little parts that you don't think are very important. Sometimes people leave out the little things because they think the little things don't matter. I want you to tell me everything that happened."

2. **DO NOT INTERRUPT** the narrative. Use non-verbal encouragers such as head nods. Limit verbal responses to, "And?", "Then what?", or, "What happened right after that?"

3. As much as possible, record the statement verbatim.

4. Ask questions to clarify the narrative.

E. Guide the Narrative - Reverse Order

Have the child recall the event in **backward** order, starting at the end. To prevent the child from leaping over events, use the prompt (repeatedly), "What happened RIGHT BEFORE that?" Ask questions to clarify the narrative.

F. Change Perspective

For children over 10, use a **Change of Perspective** technique. Say, "Put yourself in ....'s body. Tell me what you would have seen and heard if you had been ...."

IV. Why does Cognitive Interviewing Work?

Cognitive	Other Styles
Still picture in a setting - see + hear, smell, taste, feel	?
Picture moves	?
Words describe the moving picture	Words describe the un-focused moving picture

V. Practice the interview process (go to exercise)

INTERVIEWING THE CHILD (WITH SAMPLE DIALOGUE)

I. Check Seating and Room Arrangement

II. Build Rapport

A. Introduction

"My name is ..... and this is my friend, ... We're with something called the ..... Team for Children. Have you ever heard of the team? Ms. ....., your counselor, is also on the team."

B. Explain role of team, law enforcement officer/social worker.

"The team's job is to help kids be safe. I'm the social worker on the team. Can you guess what .....'s job is?"

C. Explain the interview process

"I'm so glad you told...Kids should always tell...Before we talk about what you told Ms. ....., I don't know anything about you. Would it be O.K. if I asked you some questions like your name and where you live?"

D. Ask permission to take notes

E. Acquire Bio-data (During this phase the interviewer can continue building rapport with the child and can also assess the child's developmental level and suggestibility.)

1. Full name, address, DOB

2. Former residences, child's age at the time

3. Household composition -names, ages, relationships

4. Review bio-data (primarily to test suggestibility)

SAMPLE OF ACQUIRING BIO-DATA

"Mary, what's your whole name?
What is your birthday? Do you know the year you were born? Grade in school?
Where do you live? Where did you live before that?
Do you have a telephone? What is the number?
Who lives in your house? How old is .....? How is ..... related? Tell me about your brother..
Do you have any pets? Tell me about your dog... Tell me more about your dog...
Are you married?
Do you smoke?

III. Tell the Rules-

A. **Don't know/remember:** (give an example)

B. **Don't understand:** (give an example)

C. **Don't have to answer:** (give an example)

D. **Repeat the questions:** (give an example)

E. **Correcting the interviewer:** (give an example)

IV. Shift to the incident(s). This is the **tell me** phase of the interview.

"Now I want to talk about what you told ...../about what happened. I don't know what

happened, I wasn't there. Do you know that this stuff happens to lots of kids? It's not fair and it's **never** the kid's fault. **It wasn't your fault**.

I told you before that .... and I talk to lots of kids about this stuff. I know that it's hard to talk about because some of the things are embarrassing. We want you to know that even though you might feel embarrassed, you can't/won't embarrass us.

Are we going to be talking about something that happened one time, or **more** than one time?" (If more than one time, find way to focus on a single incident, first time, last time, etc.)

V. Reconstruct the Setting

"I want you to picture that time in your mind. Think about the place where it happened. Can you see it in your mind? What can you tell me about that place?....etc. Who was in the room. How did you get in the room...how did he? What could you see, hear, smell, taste?"

VI. Guide the Narrative - beginning, middle, end

Description - (The more "free" narrative, the better.)

"Now I want you to tell me what happened in the (refer to the place). I want you to start with the very first thing you remember and then tell me what happened next and next after that. Go from the beginning to the middle to the end. Tell me everything even the tiny little things that you don't think are important. Start with .... (something related to how people came into the room)"

Ask focused questions to clarify narrative until details of events are answered

VII. Guide the Narrative - reverse order (if necessary)

VIII. Change of perspective (if necessary)

IX. Make Sure You Ask:

A. "Who was the first person that you told? What (exactly) and when did you tell them **(this can be important later in the perpetrator interview)?**

B. Did he show you any pictures/take any pictures?

C. Give you any drugs/alcohol?

D. Has any one else ever done this to you?

E. Do you know if this has happened to anyone else?

F. Where did you meet him/her?

G. Were there any threats?

H. Were there any gifts?

I. Were there any other children/adults there?"

X. Close the Interview

A. Universalize...especially, "not your fault".

B. Say that you are sorry this happened...

C. Ask child if he/she knows what to do if something like this ever happens to them again

1. Identify someone to notify **inside** the family

2. Identify someone to notify **outside** the family

D. Ask the child what he/she wants to happen to the perpetrator

E. Tell the child what will happen next, next after that

Remind child about other team members, especially those they will likely meet soon.

F. Instruct the child **(Clear instructions to the child may prevent a recant. Be sure you are communicating with the child!)**

1. "You don't have to talk about this unless you want to."

2. "Some people may think you shouldn't have told. They may even try to get you to take back what you said and tell somebody on the team that it didn't really happen. If anyone does that, tell someone on the team. **What will you say/do if someone tells you to take back what you told me?"**

3. Identify contact person/people and method of access

XI. Follow-up Activities

A. Daily monitoring by someone close to child

B. Designate one professional as the primary contact person for the child/NOP (police officer, social worker, victim advocate, school counselor or therapist).

XII. Submit Case to Multi disciplinary Team for Review.

COGNITIVE INTERVIEW WORKSHEET

Objective of this exercise: To become familiar with the cognitive interview procedure. THIS IS NOT A ROLE-PLAY. PERSON INTERVIEWED IS WHO THEY ARE, AN ADULT RELATING A TRUE EVENT FROM THEIR PAST.

1. **Choose an interviewer, person to be interviewed, observer/reporter. There may be additional observers.**

2. **Person to be interviewed may select a topic from the following suggestions: Nicest thing that ever happened; First consensual sexual experience; Scariest thing that ever happened; Funniest story about my child, husband, etc.; My experience with surgery; Worst experience with a boss or supervisor.**

3. **Using the cognitive interview framework, interviewer guides person through the interview process.**

4. **Observer/reporter (and additional observers) notes strengths and weakness of the technique. May also obtain feedback from interviewer and person interviewe**

5. **Large-group discussion.**

Components of the Cognitive Interview

A. **Build Rapport**

B. **Tell "Rules"**

   1. **Don't Know/Remember-No guessing!**

   2. **Don't Understand**

   3. **Don't Have to Answer**

   4. **Repeat Questions**

   5. **Correcting Interviewer**

C. **Reconstruct the Setting - See, Hear, Smell, Taste, Touch**

D. **Guide the Narrative - Beginning, Middle, End**

E. **Guide the Narrative - Reverse Order**

Intervening with

Non-Offending Parents:

The Mother Advocate Program

Presented by

Diya LeDuc, MSW, LCSW and
Cassandra Leslie

MOTHER ADVOCATES PROGRAM

MISSION OF THE PROGRAM - The Mother Advocate Program is designed to support non-offending parents in cases of alleged child sexual abuse in such a manner that they can act responsibly to protect and support the alleged child victim.

The non-offending parent, particularly in incest cases, is besieged by a wide array of pressures and emotions. If the child is to be protected and remain in their own home the non-offending parent often must choose to support the child in the face of their own denial, that of the alleged abuser, and the denial of their family and friends. This task is made more difficult by the array of emotions with which the parent must deal, including denial, shame, rejection, fear, anger, and loss. Added to this is the reality many such parents were themselves victimized as children, thus the alleged abuse potentially rekindles old deep seated emotions. Combined with the emotional stress is the financial impact caused by sudden separations and the loneliness and isolation often resulting from separations.

All these pressures tend to drive many non-offending parents away from supporting the child and into the arms of the alleged abuser. When that happens the non-offending parent may subtly or overtly pressure the child to recant their statements, the parent may actively seek to redefine the child's experience as something other than abuse or promise protection she can not provide. These efforts undermine the responsibility of the state to protect the child, to hold the alleged abuser accountable for his or her actions, and to attempt to keep some elements of the family safely together. In its worst form, this shifting of support from the child to the abuser can result in the renewed abuse of the child as the non-offending parent surreptitiously provides the offender access to the child, and undermines the child by discounting and actively pressuring a recant of the allegation.

GOALS:

1) Ensure the child's physical safety and assist in preserving the integrity of the mother-child family unit by:
    - Identifying the DHR safety plan for the family
    - Ensuring the non-offending parent's (NOP's) understanding of the plan
    - Identifying areas where the NOP needs assistance to carry out the plan
    - Providing support to the NOP in the concerning areas

2) Educate the NOP on her role in the investigative process by:
    - Helping her understand the legal and child protective systems
    - Assuring that she understands her role is to support the child and not to gather case facts

3) Empower the Non-offending parent to rebuild a safe and stable home by::
   - Identifying housing, transportation, education and financial needs
   - Facilitating the NOP's ability to retain the needed resources

4) Decrease the likelihood of the NOP allowing the alleged offender back into the home during the investigation by:
   - Providing consistent and professional emotional support from a Mother Advocate
   - Connecting the NOP with a broader support system through a support group conducted at the NCAC
   - Assisting the NOP in coping with the realities and complexities of the system as the case evolves.

TARGET POPULATION: Non-offending parents of children alleged to have been sexually abused residing in Madison County, Alabama who indicate a willingness to protect the child's interest during the investigative process prior to a determination of the facts or in the long term, after the Team concludes abuse has occurred and risk of renewed abuse exists. To be eligible:

- there must have been an allegation of child sexual abuse

- the parent not alleged to be directly involved in the abuse (hereafter referred to as the non-offending parent or NOP) expresses a willingness to protect the child

- the alleged perpetrator is no longer in the home and does not have unrestricted access to the child, or the family has received Family Options services and MA's is considered an appropriate follow up. In the event there is high suspicion of abuse, but not enough evidence to remove a suspected perpetrator from the home, a MA may be placed in the home, subject to supervisory review.

- the non-offending parent expresses a willingness to work with the MA and admit the MA to her home, and the NOP exhibits ongoing cooperativeness with the action plan designed by the team.

PROGRAM DESCRIPTION: The Mother Advocate provides both in home and in office services to the NOPs.

Referrals: Members of Madison County Law Enforcement & DHR investigators on the case will refer appropriate families to the MAs program coordinator. Other members of the Multidisciplinary Team may make referrals through the primary investigators. The investigators will meet with the MA coordinator and will outline the situation and the issues which they believe the MA should focus upon first. A simple Plan of Action for the MA will be prepared by the investigator and MA coordinator.

The MA will then contact the non-offending parent as soon as possible, preferably within 24 hours, and arrange a visit to the home. Non-offending parents often

experience a cycle of reactions during the investigation and aftermath of child sexual abuse. The cycle can repeat itself when circumstances change, for example, when the case goes to trial. The MA assesses the NOPs reactions and functioning and tailors the intervention to the need, generally according to the following chart.

NOP Level of Functioning	MA Intervention
Crisis: The NOP is experiencing emotional upheaval, cannot think clearly, feels helpless Doesn't know own needs	Supportive Listening, Guiding the NOP toward healthy decision making
Problem Solving: The NOP is thinking more clearly, has some awareness of her needs, but may or may not know how to meet them. She needs resources to keep child safe and home intact	Connect NOP with resources to meet needs for food, clothing and shelter
Stabilization: Basic needs are met. NOP needs assistance in resolving four basic relationship issues, (self, child, offender, system). Support system is needed	NOP joins NOPs support group. If she cannot be in group, the MA provides the education directly
Maintenance: The NOP has increased insight. She continues to benefit from some contact with the MA for emotional support. She is beginning to feel empowered.	NOP completes phase II of NOPS support group. MA interacts with phone contact as needed.

The cycle is more aptly described as a circle. The MA ultimately assists the NOP in being empowered enough to break out of the cycle.

Crisis

Maintenance Problem Solving

Stabilization

During contacts with the NOP, the MA will help the NOP develop workable strategies to protect the child and themselves; assist the NOP in beginning to work through the stages of grief, introduce the parent to the Victim Service Officer assigned to the case and to the Victim Outreach Worker, support the use of traditional services such as counseling when indicated in the plan; and help facilitate the development of extended family or other support systems. The MA will also provide telephone support to the parent in emergency cases. In addition, the MA may begin selected educational efforts to enhance the parenting skills of the NOP, if needed, or other educational activities. For example, the NOP's participation in local parenting skills groups or workshops would be facilitated by the MA.

As long as the case is open with MA's program the family will receive at least one monthly contact which may be by phone or preferably face to face. The team may choose to terminate the MA service at any time, if they believe it is no longer needed or appropriate.

The program also anticipates periods of crisis long after the case appears stable in which the MA will need to be very involved with the family on a level approaching the original crisis period. These critical stages would be times of extreme risk to the child or emotional stress for the parent, such as an offender's attempt at reinsertion of him/herself in the family, an offender being released from jail or prison, or the occurrence of critical events in the criminal prosecution of the offender.

DUTIES OF THE MA'S - The MA works 37.5 hours per week, some of which is in the natural environment of the client family, usually the home, and some of which is in the office environment. The MA will work on a flexible schedule, allowing the MA to be present in the client's home in hours convenient to the family or when the need is greatest including weekends and evenings, if needed. The MA, or a backup, will be available for crisis telephone calls from their clients, as needed.

COMMUNICATIONS WITH THE TEAM: The MA will perform her services in accordance with the plan established by the relevant Team members and MAs coordinator. The MA will prepare a written alert at any time information comes to light which would require a change in the plan, and will also place the case on the next team agenda. The plan is reviewed on a weekly basis with the MAs coordinator. The MA will prepare weekly reports on the family's status for the Team if requested.

The MA will immediately notify the investigating Team members and MA coordinator if she perceives an escalation of the risk to the child, any unauthorized contact between the child and alleged offender, a shift in the allegiance of the non-offending parent, or action or statements which suggest the non-offending parent is in any way undermining the child's emotional well-being or pressuring the child in any way to recant. The Team will review the situation and decide what action is appropriate. Based on the Team's judgment, the MAs case may continue, with or without a change in the plan, or the family may be terminated from the MAs program with the introduction of the Family Options worker, another family preservation service, or removal of children from the home, if necessary.

SUPERVISION: The Director of Intervention Services has overall MA program responsibility, which includes program development, hiring and other employment decisions, and program oversight. The MA coordinator, (who is a designated Intervention Services Therapist II) will provide direct supervision to the MAs through weekly face to face conferences and visits with the MA to the homes of each client family as deemed appropriate on a case by case basis. The MA coordinator will also provide face to face and telephone support as needed. The DHR on-call supervisor will serve as additional back-up to the MA and to the NCAC supervisory staff on safety issues.

TRAINING: Pre-service training will be provided prior to the assignment of the first case. This will include training in:

- the dynamics and recognition of child physical and sexual abuse
- the dynamics and recognition of domestic violence
- the role of the Team and the various agencies and professionals involved in these cases
- an overview of relevant mental health issues with this population (for recognition purposes)
- the appropriate ways parents can support the sexually abused child and how to role model, teach, and support it
- the stages of grief
- relevant techniques and curriculum for the Family Options Program staff and the healthy Families staff
- the Juvenile and Criminal Court systems and the various parties involved (DA, Judge, VSO, CAJA, Guardian Ad Litem, etc.)
- the use of community resources
- Mother Advocate policies and procedures

These and additional topics will be expanded upon in on-going training throughout the year.

CASELOAD: The MA should have no more than 15 total cases at a time.

LENGTH OF SERVICE: The service can be provided for a maximum of eighteen months or until the conclusion of the criminal prosecution, if longer.

MA's INVOLVEMENT WITH THE TEAM: The MA will function in accordance to the plan developed in consultation with the relevant Team members. The MA or the MA coordinator will keep the Team informed of developments in the case and attend Team meetings when there is relevant information to share on a case under Team oversight.

NOTE: The program is referred to as the Mother Advocate Program and the female pronoun is used throughout, but it is conceivable the service could be provided to a non-offending male parent.

9/19/97

GUIDE FOR FIRST VISIT

National Children's Advocacy Center
Mother Advocates Program

1. EXPLAIN TO THE NOP WHO YOU ARE AND WHY YOU ARE THERE, AND GET AN UNDERSTANDING OF WHY THE NOP THINKS YOU ARE THERE.

2. SPEND SOME TIME GETTING ACQUAINTED AND GETTING A FEEL FOR HOW THE NOP IS PERCEIVING THINGS AND WHAT HER MAJOR CONCERNS ARE.

3. EXPLORE THE FOLLOWING AREAS IN WHICH YOU CAN PROVIDE BASIC NEEDS ASSISTANCE:

   A. FINANCIAL_____
   _____

   B. TRANSPORTATION_____
   _____

   C. HOUSING _____
   _____

   D. SAFETY ISSUES (MOTHER, CHILD) _____
   _____

4. GIVE NOP THE HANDBOOK AFTER FIRST ASSESSING LITERACY. POINT OUT WHERE YOUR NUMBER AND OTHER EMERGENCY NUMBERS ARE LOCATED.

5. EXPLAIN ON-CALL PROCEDURE, ESTABLISHING CLEAR BOUNDARIES OF WHER IT IS APPROPRIATE TO CALL YOU AFTER HOURS.

6. ESTABLISH WHAT DAYS AND HOURS WILL BE BEST FOR CONTACT/ARRANGE THE NEXT MEETING.

Signature:_____ Date:_____

Reviewed Informed Consent/Confidentiality Statement with client. *Yes* *No*

Client accepted terms in verbal & written form . *Yes* *No*

THE NATIONAL CHILDREN'S ADVOCACY CENTER

CLINICAL INTERVIEW WITH CAREGIVER

Caregiver's Full Name:_____Date:_____

DOB:_____Age:_____Sex:_____Race:_____

Referral Source:_____Phone #:_____

FAMILY STRUCTURE and HISTORY

People currently in the home with the Caregiver (Any recent changes?):_____

_____

_____

Custody Status:_____

Is there currently a custody dispute:_____

_____

Is there weekend visitation with a non-custodial parent:_____

_____

Domestic Violence History:_____

_____

_____

_____

Substance Abuse History (Caregiver, Alleged Perp, Victim, other family members):_____

_____

_____

_____

Psychiatric History In Family:_____

_____

_____

Specific Medical Problems/Medications or Disabilities in Family:_____

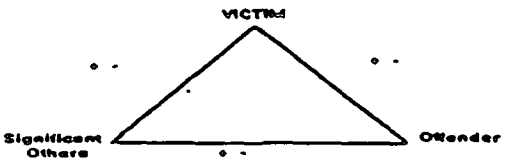
_____

Legal Problems:_____

_____

RELATIONSHIP ISSUES

Caregiver/Significant Others/Alleged Perp. Relationship Dynamics:



Does Caregiver currently have contact with the alleged offender?_____

_____

_____

Relationship with alleged offender since disclosure:_____

_____

Caregiver's Fears and Losses:_____

_____

_____

Relationship with child since disclosure_____

_____

_____

Emotional Support systems used by caregiver_____

_____

_____

Motivation of Caregiver for Change/Recovery (Is Therapy Ongoing?):_____

_____

_____

_____

_____

Other:_____

_____

_____

Family History of Physical/Sexual Abuse:_____

_____

_____

_____

Caregiver's Reported Knowledge of Child's Experience:

How Caregiver first learned of the alleged sexual abuse:_____

_____

_____

_____

What child disclosed to Caregiver:_____

_____

_____

_____

_____

_____

Family's Reaction to Abuse Report (Include Victim, Caregiver, Siblings, Alleged Offender,etc):

_____

_____

_____

Caregiver perceptions of involvement with the system (Law enforcement, Courts,DHR):

_____

_____

_____

Current status of allegations and offender (currently being investigated, waiting for trial, court outcome known):_____

_____

_____

What prompted Caregiver to seek counseling:_____

_____

_____

How are you feeling now after this interview?_____

_____

_____

What are your future concerns for yourself, child, his/her siblings and if applicable, the alleged perpetrator?_____

_____

_____

_____

How do you believe the MA/NOP's group can help you (goals)?_____

_____

_____

_____

Other Info:_____

_____

_____

_____

_____ _____

Signature Date

See over for additional information

TREATMENT PLANNING
DESK GUIDE

National Children's Advocacy Center
Mother Advocates Program

1. What does the NOP perceive as her alternatives in the current situation?

2. How does she perceive her relationship with her child(ren)?

3. How does she perceive her relationship with the alleged offender?

4. What fears and losses does she face?

5. What meaning does she give to the current situation?

6. How is she responding to your intervention or the intervention of others in the system?

7. Your assessment of the power the offender in the NOP's life.

8. Your assessment of the depth of the relationship with the offender.

9. How she perceives the duration of the abuse.

10. Your assessment of the violation of trust.

THE NATIONAL CHILDREN'S ADVOCACY CENTER

MOTHER ADVOCATES INVESTIGATIVE ALERT

Client Name:_____ Date:_____

Alleged Offender:_____

Mother Advocate:_____

1. SUMMARY OF CHANGE:

____Violation of Safety Plan

____Suspect allowed to have unauthorized contact with children

____Health concern/Communicable condition

____Avoidance of contact with Mother Advocate

____Suicidal/Homicidal risk

____Other

COMMENTS:

2. CURRENT LEVEL OF INVOLVEMENT:

Copies to: LE Officer:_____

DHR Worker:_____

DA:_____

Scheduled for Team:_____

Reading List for Non-Offending Parents

Adams, C. and Fay, J. (1995). Helping your child recover from sexual abuse. Seattle, WA. University of Washington Press.

Ashley, S. (1992). The missing voice. Dubuque, Iowa. Kendall/Hunt Publishing Co.

Bear, E. and Dimock, P. (1988). Adults molested as children: A survivor's manual for women and men. Orwell, VT. Safer Society Press

Byerly, C. (1992). The mother's book. Dubuque, Iowa. Kendall/Hunt Publishing Co.

Case, J. and Hagan, K. (1988). When your child has been molested. New York, NY. Lexington Books.

Myers, J.E.B. (1997). Incest: A mother's nightmare. Thousand Oaks, CA. Sage Publications.

Ovaris, W. (1991). After the nightmare. Holmes Beach, FL. Learning Publications, Inc.

Wikland, P. (1995). Sleeping with a stranger: How I survived marriage to a child molester. Holbrook, Mass. Adams Publishing.

Child Physical Abuse 101

Presented by

John Stirling, MD

Medical Issues for the Non-Medical Professional: Physical Child Abuse

John Stirling, MD
Child Abuse Intervention Center
Vancouver, WA

General considerations:

differences between child abuse and other medical cases
- history usually unavailable or unreliable
- different "standard of evidence" than medical evaluation
- differential diagnosis

1st concern: Is injury consistent w/ explanation?

Evaluation considers:

- ✔ **Force** involved in injury
  - type
  - amount
  - vectors
- ✔ **Dating** of injury
- ✔ **Pattern** of injury
- ✔ **"Natural history"** of similar injuries

...and compares what is seen with what would be expected.

Common abusive scenarios:

- Skin trauma
  - bruising
    - force - varies
      - impact v area
      - bleeding disorders?
    - dating - inaccurate at best
    - patterns - shapes, locations, ages
  - burns
    - types - scalds, chemical, electrical, flame
    - accidental v. neglect v intentional
  - bites
    - forensic significance
- Fractures
  - force - varies
  - dating - x-ray, clinical

screening skeletal surveys - how and for whom?
pattern - significance of location and type of fracture

- Abdominal / thoracic injuries
  - force - significant force needed
  - pattern - shearing v hydrostatic mechanisms
  - dating - can be difficult

- Head injuries
  - fractures
    - pattern - compound, diastatic
    - force - relates to type
  - brain
    - force - shaking v impact
    - dating - CT v MRI
    - pattern - edema, hemorrhage, parenchymal damage
      - retinal hemorrhages

- Fatalities
  - special considerations
    - autopsy / ME involvement
    - law enforcement investigators may differ from abuse team
    - role of death review team
  - special cases
    - SIDS v suffocation
    - drownings, poisonings - accidental v neglect v intentional

Resources

General Reference Texts: *up-to-date, broad coverage of the field of child abuse*

- American Academy of Pediatrics, Section on Child Abuse and Neglect. (1994). A guide to references and resources in child abuse and neglect. Elk Grove Village, IL: AAP.
- Briere, J., Berliner, L., Bulkley, J., Jenny, C., & Reid, T. (1996) The APSAC handbook on child maltreatment. Thousand Oaks, CA: Sage.
- Kleinman, P.K. (1987). Diagnostic imaging in child abuse. Baltimore: Williams & Wilkins.
- Reese, Robert M. (1993). Child abuse: Medical diagnosis and management. Malvern, PA: Lea & Febiger.

Periodicals: *can bring the practitioner news long before it appears in texts*

- *The APSAC Advisor;* 407 S. Dearborn, suite 1300, Chicago, IL 60605 (Email at apsacmems@aol.com) *Available quarterly to members of APSAC. Good review articles cover various disciplines; news of the field.*

- *The Quarterly Child Abuse Medical Update* ; Institute for Professional Education, Massachusetts Society for the Prevention of Cruelty to Children; 43 Mt. Vernon St., Boston, MA 02108. $80 / yr. *Quarterly abstracts from current medical journals, with expert commentary.*

Using Therapeutic Stories in the Treatment of Sexually Abused Children

Presented by

Nancy Davis, PhD

STRUCTURE OF THERAPEUTIC STORIES

Opening Paragraph(s)

Mirror the life situation:

1. Past and present behavior
2. Explain life situations
3. Use metaphors and symbols

Structures:

1. Same sex
2. Animals, people, prince/princess
3. Give symptoms

Body of the Story:

The manner in which the idea of the possibility of change (the directive or message is introduced.

1. Use the fairy godmothers, animals, angel, older wiser people, teacher, counselor, gardener, doctor, etc.
2. Use dreams/visions
3. Have main character figure out the answer for him/herself
4. Use metaphors (i.e., The old woman said,, "You have to eat breakfast before you eat dinner.")
5. Use anchors (such as gifts) to remind the person of change (Every time she saw a sunrise...")
6. Give the individual the understanding that they have the power to heal/change.

Conclusion of the Story:

New understanding - New behavior

1. Indicate new thinking, new behavior, new feelings
2. Show practice
3. Indicate change will continue into the future
4. Give directives for problem solving and continued healing

Examples of Individualizing a Therapeutic Story

"THE BUNNY WITH THE SORE NEAR HER HEART"

***Child who was abused soon after birth and removed from home during infancy:**
Once upon a time a baby bunny was born. Soon after she was born, she developed sores all over her body. At first, people rarely saw that she had sores so she developed more sores. She was a very sad bunny indeed. She thought she was getting the sores because she was bad and sometimes she got so sad she couldn't even cry. Someone recognized that the bunny had sores on the outside and the doctors healed them.....

***Child who had a happy childhood until remarriage of parent when physical abuse began:**
Once upon a time a baby bunny was born into a family where she was very happy. She was hugged and fed and given much love. Because her life was good, she believed that her life would remain happy. But alas, another bunny came into the family and soon the bunny developed sores all over her body. People rarely saw that she had sores so she developed more sores.

She was a sad bunny indeed. She thought she was getting the sores because she was bad and sometimes she got so sad she couldn't even cry. Finally someone recognized that the bunny had sores on the outside and the doctors heal them.....

***Child who was cared for until sexually abused at age of eight by a family member:**
Once upon a time a baby bunny was born into a family where she was very happy. She was hugged and fed and thought her life would always be a happy one. But alas, as she grew older something very sad and painful happened to her. Because of this she developed a pain that she was afraid to talk about. The people around her did not understand about her pain because she didn't talk about it, so her pain increased.

She was a sad bunny, indeed. She though she was in pain because she was bad and sometimes she got so sad she couldn't even cry. Then she discovered the power within herself to talk about her pain and the doctors healed it.....but what they didn't understand was that she still had a big sore, full of poison, close to her heart.

***Child's parent dies when they are eight years old:**
Once upon a time a baby bunny was born into a family where she was very happy. She was hugged and fed and thought her life would remain happy. But alas, as she grew older something very sad happened and she developed a sadness that was so great that she was afraid to talk about it. She was afraid that if she talked about her pain, the pain of those around her would increase, so she kept her pain deep inside. She even began to take care of people in her family, but this did not make her sadness go away.

She was a sad bunny indeed. She thought she was sad because she was bad and sometimes she go so sad she couldn't even cry. Then she discovered the power within herself to talk about her pain to someone. This person thought that talking about her sadness had made it disappear.....but what they didn't understand was that she still had a great big sore, full of poison, close to her heart.

***Child who is beaten and sexually abused throughout their childhood:**
Once upon a time there was a baby bunny who was born into a family where there was much sadness. She was hurt and left alone and developed sores all over her body. As she grew older, the sadness and sores continued and she had to be very smart to survive. People rarely saw that she had sores, so she developed more sores. She was a very sad bunny indeed. She thought she was getting the sores because she was bad, and sometimes she got so sad she couldn't even cry.

She grew up and left her family, and the sadness and sores went with her. She understood that she had a sore, full of poison, close ro her heart, but she didn't know what to do about it.

TAFFY AND THE INVISIBLE MAGIC BANDAGE

(A story to aide in the disclosure of a traumatic experience)

Once upon a time there was a puppy named Taffy. Taffy lived with her family and loved to play all day long. She wasn't afraid of much at all and everyone said that she was an adventuresome puppy. Taffy often went exploring all around her home, looking under rocks and barking at bugs and spiders. She especially loved the evening when the sun went down, because she could chase lightning bugs and howl at the moon with the other animals of the night.

One day Taffy went on a journey into the deep woods, and when she returned she was different from the old Taffy. She was afraid to go to sleep and afraid to be away from her family. She had nightmares and shook with fear when anyone mentioned the idea of looking under rocks or going out alone at night. She often got stomach aches, and her head hurt a lot, too.

Now her family noticed that Taffy had not been the same since her journey into the deep woods, and they asked the puppy to tell them why she had changed. But Taffy was unable to talk about her journey, because while she was in the woods she had gotten an invisible magic bandage over her mouth and was told that if she removed it, she would disappear. Taffy must have really been afraid that she would disappear, because she left the bandage in place, even though everyone around her kept asking her why she was acting so differently. It especially made Taffy afraid when they asked her questions, because she was sure that if the bandage came off surely she would disappear. When the subject of the deep woods came up she paced and ran around in circles because of all the feelings that she had inside. She turned her back on those who questioned her and felt like she was sick to her stomach.

One day Taffy was stuck by a thorn, and she cried in pain. Her family knew that she had been in the thorn bushes and they asked her where she hurt, but the invisible magic bandage kept her from telling them. Those around her tried guessing: "Is it in your leg?" "Is it in your front paw?" "Is it in your ear?" But no one could find out where the thorn was, and it continued to hurt the puppy more and more. Taffy knew it was in her tail, and she couldn't get it out by herself. Her family finally got very upset with Taffy and told her that she must tell them where the thorn was so that they could help her. But Taffy remained silent. She still had the invisible magic bandage in place and she was more afraid to take it off than she was to keep the thorn in her tail.

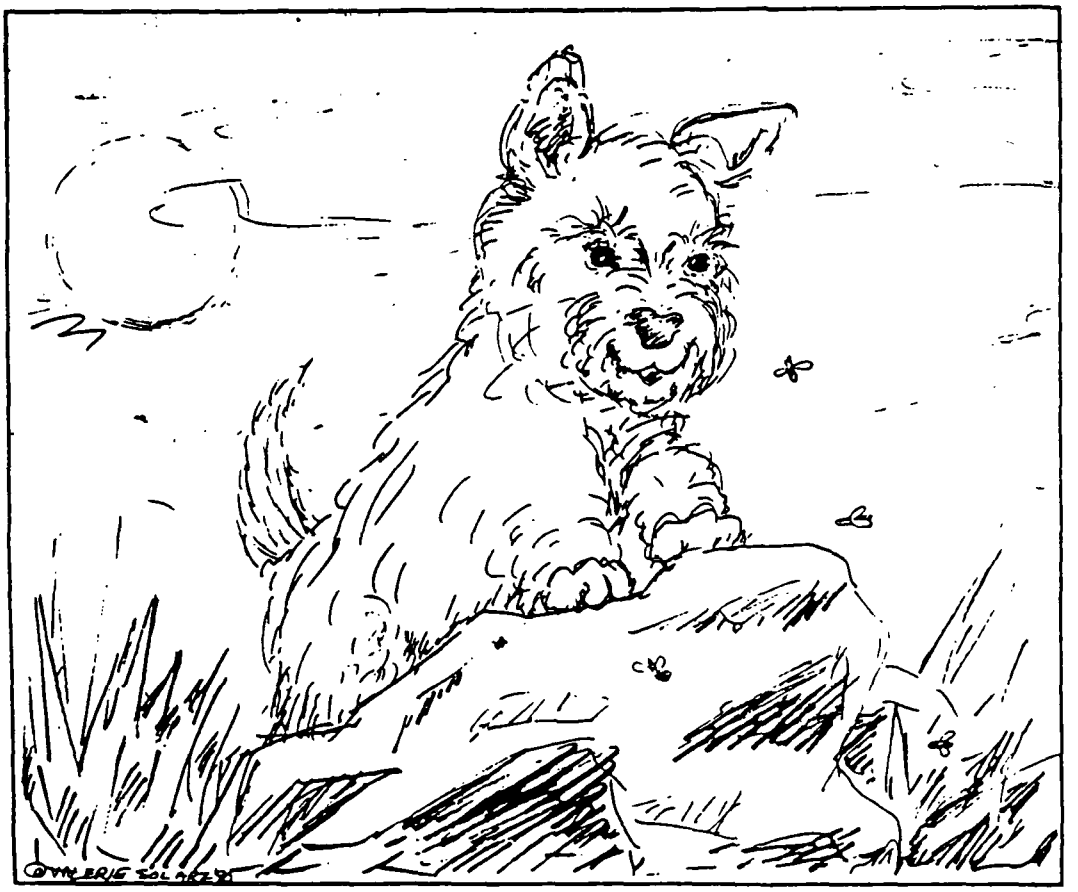
One of the other dogs, a mean old mutt named Spot, began to bully Taffy one day. "I'll bet you don't even know how to swim," he said in a nasty way. "Of all the dogs in the world, you're probably the only one who was ever born who doesn't know what to do in the water. Ha!" On and on went Spot, teasing and poking fun at Taffy, until Taffy began to realize that the old dog was just talking to hear himself talk. Going to the edge of the water (and more than just a little bit scared), Taffy waded in, moved her paws and her body, and went quickly across the pond. She <u>could</u> swim. The old dog had tried to trick her, but Taffy understood that children are not always so easy to trick. Taffy had found out that she did have the power to figure out the difference between a lie and the truth.

After her experience with Spot, Taffy began to wonder about the invisible magic bandage. She began to realize that she had been tricked into thinking that she must never remove it. So Taffy raised her paw to her mouth. Carefully she pulled at it, and it hurt a little as it came off, but Taffy DID NOT DISAPPEAR. With a great feeling of relief at being rid of the bandage, she ran home and told her family about it. Then she told them where the thorn had been stuck in her tail

and asked their help in removing it. She'd had the thorn in her tail for so long that it hurt a little as it was being removed, but she felt relief once it was out.

Soon after that, Taffy went back to being her old self, chasing after lightning bugs and staying up at night. She found that it was easier to sleep; she stopped having nightmares and wasn't afraid to be alone anymore.

And to make sure that she never got an invisible magic bandage again, Taffy told everyone all about the journey into the deep woods and how afraid she had been to talk about it. AND THE MORE SHE TOLD THE TRUTH THE SAFER AND MORE POWERFUL SHE FELT, because Taffy had discovered that the invisible magic bandage was not magic at all - it was only there to keep her quiet. She had learned a lesson that she would always remember: that talking about her journey into the deep woods to trusted adults who protect children made her feel powerful and secure.



The Oyster

Once upon a time an oyster lay on the bottom of the bay. Oysters are very rough on the outside and not very colorful. The shell of an oyster is often ground up into small pieces and used to make roads. People and vehicles ride and walk all over roads made out of oyster shells.

This oyster was no different. "I am designed to allow people to walk all over me because I'm just a yucky, ugly oyster," the oyster told herself day after day. "I was created for people to walk on me." The oyster had also heard that people sometimes became poisoned from eating oysters. So she told herself, "I'm really worthless; all I do is make people sick."

Often when oysters are served at restaurants, people remark, "Yuck, oysters are slimy, they're yucky. Why would anyone want such a repulsive thing?" So the oyster would say to herself, "they're right, I'm not worth anything, I'm slimy, people hate me, and I am worthless."

It was not surprising that the oyster was always feeling sad. "Why couldn't I have been something different? Why couldn't I have been a diamond or ruby? Why couldn't I have been a sand dollar or have a shell that could be made into earrings? Why, why, why?" the oyster asked, as she thought a lot about what she wasn't. She told herself over and over that she was ugly and awful and slimy and made many people sick.

One day a fisherman threw a net into the bay and caught this oyster in his net. The oyster was even more upset and cried out, "This is exactly what I was afraid of. Now I'm caught and everyone is going to discover just how ugly and repulsive I really am."

The fisherman had a different way of looking at things than the oyster. Finding the oyster in his net, he opened the shell with a knife. From deep within the shell, he pulled out an exquisite white pearl. This discovery surprised the oyster. She had paid no attention to the hard pearl as it grew within her. "Isn't it amazing that you can have something so valuable within you and not even realize it? How could this be?" asked the oyster. "How could I have this beautiful pearl inside me when I am so ugly?"

Because the fisherman had spent his life on the sea, he sensed the oyster didn't understand how a pearl is formed and he began to talk to her. "Long ago, when you were very little, there were things in your life that were very irritating and scary and sad and painful. To deal with this, you began to build a covering around your feelings. You wrapped and wrapped all your pain and sadness to protect yourself. This was really helpful when you were young and the pain was very real. What you did not realize and now can see, is that you changed this awful pain into a valuable pearl. You found a way to take your pain and sadness, crystallize it and change it into something exquisite. This pearl was within, just waiting to be discovered."

"Wow," cried the oyster, "that's very surprising." Then the fisherman broke away the shell from the outside of the oyster because she didn't need that anymore. He removed the yucky, slimy part because she didn't need that anymore either. Then he polished the pearl allowing the beauty and luster to shine through. The fisherman gave the pearl to his daughter. She wore it on a necklace of gold and prized it dearly.

"Isn't it amazing?" the little pearl remarked to herself. "I never realized that I am special. I was unaware that deep within there was a pearl waiting to shine like a jewel." As the pearl continued to think about life, she realized that the most valuable jewels are often buried and are just waiting to be discovered and polished.

Nancy Davis, Ph.D.

"The Oyster" is one of 105 stories contained in Therapeutic Stories that Teach and Heal available for sale by the author, Nancy Davis, Ph.D. For information call (301) 567-9297.

Ways to Use Therapeutic Stories

Do not interpret the stories as they are designed to talk to the unconscious which interprets the stories according to the needs of the listener. Interpreting moves the story into the conscious mind and diminishes their power. Make sure that you change and individualize stories to fit the listener

*For children beginning therapy: make an audio tape of about 30 minutes with stories designed for the presented problem. If the child is young, use the story "The Hero" first and use their name. Ask the child questions on the tape, since they like to hear their own voice. If they have been traumatized and need to talk about it, include the story "Rags" or "Taffy". Have the parent or caretaker play the tape as they go to sleep. It does not matter if they are asleep, the messages from the story are heard by the unconscious.

*Add stories as therapy progresses and the needs of the child changes, add more stories and make additional tapes.

*Stories can be grouped for a variety of problems including the following: symptoms and problems related to experiencing abuse and trauma, grief and loss, school and academic problems, social difficulties, rebelliousness and oppositional behavior, self-image, expression of feelings, questions as to why something happened, anxiety, fears and phobias, rape trauma, distorted perceptions, etc.

*Put stories on the tape designed for the parents; their unconscious will hear & help them to heal.

*Have family listen to the tape when leaving or coming to therapy.

*Give the parent stories to read to their child. Have the parent make tapes of the stories for their child. These stories can heal parent and child. Only do this if parent will not sabotage the stories.

*If a child or adolescent begins therapy and refuses to talk, begin reading therapeutic stories. Do not explain why you are reading the stories. Read stories that you believe will help their problems. If you read stories that are not for their problem, their unconscious will ignore them. When the session is over, say " See you next week". If they go to sleep during the session, continue reading anyway...their unconscious will listen. Generally by the third session, they begin to talk. The messages of the stories let them know that you understand and are there to help them to heal.

*If you are a psychologist assigned to test a child who refuses to be tested, after establishing that you are going to sit with them until they take the test, begin to read therapeutic stories. Generally they will begin taking the test after several stories are told.

*Read a story at the beginning or end of a group therapy session or have a member read one.

*Have a teenager or adult edit the story book or some of the stories; they learn as they edit.

*Have a teenager or adult rewrite a story so for their own issues or for someone else.

*Read the stories to someone of any age while in a hypnotic trance.

*Read a story at the end of the session.

*Make a book for a child with a collection of stories, and allow them to take them home.

*Have the child retell a story on tape that you have already told them to assess what their issues are according to how they changed the story. You can then retell the story making corrective and positive changes to help them see 'in a new way'. Child: John got very angry and hit the bully and punched him. Therapist: John got very angry and said to the bully, 'You are a bully and if you learn to like yourself, you won't be a bully anymore.

*Have the child read the story on audio or video tape.

*Tape a story and play the story to your secretary while client is in waiting room---this is particularly good for angry, resistive adolescents and adults.

*Use "The Princess and The Snake" for adults in abusive relationships with men. If the woman is willing, give her a copy and tell her to read it to herself daily. I have found this story to be the most powerful change agent in women involved with sadistic men. The woman has to be out of contact with this man, since these individuals use powerful brainwashing techniques.

*For adolescents that are "shut down" or in the numbing stage of PTSD, read stories either in or out of trance.

*Use a technique where the therapist begins a story, then points to the child. The child continues the story and then points to the therapist. Using this technique, the child's issues and problem solving style can be diagnosed and the therapist can correct poor problem solving illustrated in their version of the story.

Therapist: Once upon a time a boy went for a walk in the woods. He walked and walked. Suddenly he realized he was lost. (Points to child)

Child: So he sat down and began to cry. He didn't know what to do. (Points to Therapist)

Therapist: But then he realized that he could figure out how to solve this problem. He looked at the sun and began to walk toward in a straight path toward the sun.

*Use the person's own symbols or metaphors to either make up a story or find a story that already fits these metaphors. Use can use things that are said or symbols used in the Rorschach Projective Test.

*For children who must testify in court, make a collection of stories that empower. Use the stories for court that are appropriate. For small children, use the "Teddy Bear and The Truth".

*For children who have a parent that is going on vacation or must be away from them, have the parent make a tape of stories. The voice of the parent and the message will comfort the child.

*Have child act out stories, draw when the stories are told, videotape the stories being told.

*Use stories for nightmares. Individualize the stories to fit the child's particular nightmare.

*Use stories as a basis for art therapy.

Allow your unconscious to learn as you tell the stories from my books and soon you will discover that you can create new stories for your clients or children.

Nancy Davis, Ph.D.

African American Children and Child Sexual Abuse

Presented by

Veronica Abney, LCSW, DCSW, PhD

African-American Children and Child Sexual Abuse

- Introduction
- Cultural Considerations
- . Heterogeneity of the Culture
- . Demographics
- . Family Structure
- . Child Rearing Patterns
- . Bicultural Adaptation
- . Skin Color and Hair
- . Views on Sexuality
- Attitudes Towards Disclosure and Reporting
- What Do We Know About the Effects of Sexual Abuse on African Americans
- Assessment, Diagnosis and Treatment of African Americans
- Transference and Countertransference Issues

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Definition of Culture

- Culture is a set of beliefs, attitudes, values and standards of behavior which are passed from one generation to the next and includes language, world view, dress, food, styles of communication, notions of wellness, healing techniques, child rearing patterns, and self-identity.
- "Within a group, it is what everybody knows that everybody else knows."
- Culture is dynamic and changing, not static; it changes as the condition of the people change and as their interaction with the larger society changes.
- Every culture has a set of assumptions made up of beliefs which are so completely accepted by the group that they do not need to be stated, questioned or defended.

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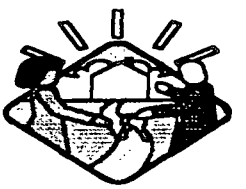
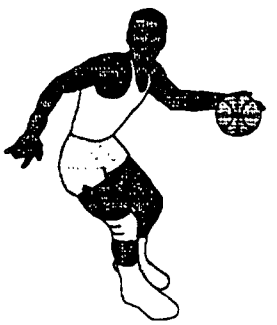
An Appropriate Value Base

- Values are the ideals, customs, attitudes, practices and beliefs that one deems as worthy and useful and which stimulate, within that individual, a strong emotional response. Each of us sees the world through culture-colored glasses. We compare others and process events based on our own value systems which we may view as superior.
- A professional's value base should have an earnest appreciation of three factors:
  - Understanding the dynamics of difference
  - Accepting the existence of bias, myths and stereotypes
  - Belief in empowerment





Ways in Which African-Americans are Diverse

- African-American's don't all want to be called the same thing. Ethnicity Vs. race.
- 80% of African-American's have a mixed ethnic background and some have a first language other than English and may not consider themselves black or African-American.
- Class is the African-American community is determined less by the factor of income because African-American's do not get the same return for their education.
- African-American communities are more diverse socioeconomically than White communities due to housing discrimination.

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Demographics (a) (1994)

- 12% of US population
- 47% male; 53% female
- Median age of AA's is 28 y.o.
- 50% lower class; 40% middle class; 10% upper class
- 47% married couple families; 46% are female headed households
- 36% of those over 25 y.o. high school grads.
- 13% of those over 25 y.o. BA or higher
- median income is $22,000

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Demographics (b) (1994)

- 15% male and 21% females hold managerial and professional jobs (1995)
- 43 % never married; 33% spouse present; 7% spouse absent
- 27% below the poverty level
- 44% of children below poverty level
- 27% of AA's seniors below poverty line

6 Cultural Themes in African-American Culture

- adaptability of family roles
- strong kinship bonds
- strong work, education and achievement orientation
- strong religious orientation
- humanistic orientation
- endurance of suffering

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Guidelines for Cross-Cultural Practice

- Do not stereotype!
  - No cultural group is homogeneous
  - Cultural groups vary in rates of biculturality assimilation & acculturation
- Differences in communication styles (verbal & nonverbal)
- Language Differences
- Family values & strengths
- Religious beliefs
- World view (group centered Vs individual centered)
- Views of wellness, healing & mental illness
- Time perspective
- Behavioral & emotional expressiveness
- Response to oppression, racism & discrimination
- Child rearing beliefs & patterns
- Racial & ethnic identity
- Sex roles & sexuality

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Factors Influencing Client and Therapist

- Overall life experience
- Cultural experience
  - language
  - styles of communication
  - notions of wellness, mental illness & healing techniques
  - views on sex roles & sexuality
  - family values & strengths
  - religious beliefs
  - views & experience of oppression, racism & discrimination
  - assimilation & acculturation
  - standards of acceptable behavioral & emotional expressiveness
  - child rearing beliefs & patterns
- Professional training & theoretical orientation (for helper only)

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Our American Society:

Are We Raising a Generation

of Sexual Thieves?

Presented by

Jan Hindman, MS, LPC

It's about CHILDHOOD
THE HINDMAN FOUNDATION, INC.

SENSORY-BASED TREATMENT

We have all been trained to provide a therapeutic intervention for our patients, based on a traditional psychotherapy approach. Our beliefs have been anchored in an understanding that through cognitive based, "talking" resolutions, our patients would recover from **TRAUMA BONDING** and the Post-Traumatic Stress Disorder they suffer as a result of sexual abuse. We embraced the idea that our therapeutic influence would relieve the trauma patients suffer in their ongoing daily lives.

Unfortunately, it is clear that there is a sensory foundation to the most commonly used diagnosis for sexually abused patients–Post Traumatic Stress Disorder. Not only is **PTSD** sensory-based, but different from other patients who suffer from Post-Traumatic Stress Disorder, the sexual victim is asked to repeat the traumatic event, suffered in childhood, as they attempt to be sexual in their adult future. As an example, the Vietnam Veteran will avoid sensory triggers that connect him back to traumatic events that occurred more than 20 years ago. Unfortunately, the sexual abuse victim does not have the luxury. Sexual victims, in their attempt to be sexual, will repeat the traumatic event as sight, sound, taste, smell, and touch, "triggers" the patient's sexual future.

Even if the sexual victim is not functioning as a sexual person, it is clear that the foundation for the Post-Traumatic Stress Disorder diagnosis is found in the senses. As the sexual victim moves about in daily living functions, sensory bombardment occurs, triggering the sexual victim back to the traumatic event. Each day the patient struggles to remember, to review, and to collect the resolutions that occurred within the therapeutic environments. Much energy is expended by the sexual victim who desperately wants to battle sensory triggers with the cognitive resolution that occurred in our office.

We owe our patients the best possible opportunity for recovery. We need to use our traditional approach to therapy, allowing cognitive resolutions to occur, but we need to add a sensory-base, in a tangible form. The process of **"REVIEW"** and **"REPETITION"** is the most powerful form of learning. Therapy is a process of unlearning, learning, and relearning. In order for our patients to be successful and recover, they need to have access to our therapeutic brilliance. They need to have a tangible, (sensory-based) representation of their steps to recovery to review and to protect them from ongoing sensory triggers that occur in their daily lives.

This approach does not ask us to disregard our training from a psychotherapy or cognitive perspective. It simply requires us to recognize that our therapeutic process must be captured in a tangible form to enhance the patient's ability to review, to repeat, and to recondition. If the trauma has a sensory-base, the recovery for patients must begin with a cognitive process, but find its final form in sensory-based treatment.

Thank you for your consideration.

Jan Hindman, M.S., LPC
Clinical Director

JH/lm

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OUR AMERICAN SOCIETY

ARE WE RAISING A GENERATION OF "SEXUAL THIEVES" ?

INNOVATIVE INTERVENTIONS WITH SEXUALLY ACTING CHILDREN

CHILDREN WHO SEXUALLY ACT—THE DEADLY DILEMMA

- What if we don't intervene?
- What if we intervene in error?

CONTEMPLATIONS AND CONCERNS

- What about semantics and fear of language?
- What about expungement of juvenile records?
- Should laws for children be a mirror of adult laws?
- And, what part does our society play in encouraging sexual offending?

IF WE TEACH OUR CHILDREN NOT TO BE RAPED, ARE WE TEACHING OUR CHILDREN NOT TO BECOME RAPISTS ?

THE SEX FAIRY MYTH

- The issue of supply and demand?
- Which team wins?
- How does this determine normal?

CONTEMPLATIONS AND CONCERNS

- What is normal sexual development?

WHEN DOES SEXUALITY BEGIN?

- In the womb?
- In the classroom?
- In the pubescent period?
- In the back seat of the Ford?
- In the hotel, following our wedding reception?

LET US DEFINE NORMAL SEXUAL BEHAVIOR

- Is it what is most common or most accepted by a society?

NORMAL (FOR NOW) SEXUAL DEVELOPMENT

- Movement

- Moving from one paraphilia to another
- No stopping

THEREFORE

- Is sexual appreciation
- Is sexual responsibility
- Is sexual tenderness
- Is sexual safety

THE NORM?

Or the Exception?

OR IS

- Sexual thievery
- Sexual exploitation
- Sexual taking
- Sexual aggression

THE NORM?

IF INTERVENTION IS IN ERROR

- Stigmatization
- Fixation
- "Create" deviancy
- System perpetration of trauma
- Critical "victim/offender identity damage"

IF NO INTERVENTION

- The cycle of offending
- Physiological reinforcement
- Enhance desensitization to criminal consequences

QUESTION??????

- Can seven-year-old children "sexually offend"?
- Can thirteen-year-old children sexually play?
- Can seventeen-year-old children innocently rape?
- Can nine-year-old children molest thirteen-year-old children?

THE ANSWER IS.....

YES ✓

NO ✓

Depending on Culpability

WHAT IS CULPABILITY?

- Knowing
- Knowing inappropriateness of actions
- Knowing consequences of inappropriate actions
- Culpability of the offender has NOTHING to do with trauma to the victim
- Culpability does not always relate to risk
- Culpability can relate to risk

- "Harry and Harriet"

FOUR TRAC'S OF TREATMENT

TRAC I
- Criminal, Culpable
- Restitution Model
- Four Phases of Treatment
- Polygraphs
- Plethysmograph
- Behavioral Monitoring
- No Contact Order
- Group/Individual
- Sexual Arousal Control

TRAC II
- Criminal, but perhaps lower level of culpability
- Criminal, but perhaps extensive pervious treatment
- Sexual crime charge
- Less opportunity for clarification
- Use "Menu" for special treatment needs

SIX TREATMENT MODULES
- Society and Offending
- Criminal Thinking
- Sexual History
- Victim Empathy
- Positive Sexuality
- Problem Solving

TRAC III
- Not culpable, but worrisome
- charged nonsexual crime
- Use "menu" for special treatment needs
- Creative "no contact" order
- Creative clarification
- Must complete six modules

TRAC IV

PLAN A
- Low culpability
- Cooperative parents
- Formal/Informal diversion
- Six Modules

PLAN B
- Culpability Question
- Limited Legal Options
- Informal/Formal Diversion Possibility
- Creative Planning

- Control Through Adolescence
- Be Proactive
- Six Modules

THE JUVENILE CULPABILITY ASSESSMENT

- Does NOT supersede the law or the court's jurisdiction
- Has not been standardized or "normed"
- It is meant to assist in making better decisions about ALL children who sexually act

THE CULPABILITY ASSESSMENT IS AN INTERVENTION TOOL

- Which children are criminals?
- Which children are worrisome?
- Which children need education?
- Which children need prevention?
- Which children need parents to help?

ISSUE #1

JUVENILE'S AGE

- "Simply a matter of age and assumed intellectual growth over time"

ISSUE #2

JUVENILE'S INTELLIGENCE

- "A matter of actual intellectual functioning, regardless of age"

ISSUE #3

JUVENILE'S INTELLECTUAL OPPORTUNITIES

- "An assessment of the opportunities available to the juvenile that would allow potential intellectual functioning to emerge"

ISSUE #4

JUVENILE'S INTELLECTUAL INHIBITORS

- "An assessment of those factors which may inhibit the potential for intellectual capacity" *

*Note: All four issue items concerning intellectual culpability may significantly impact all other culpability "opportunities"

ISSUE #5

AGE DIFFERENTIAL BETWEEN JUVENILE AND "CONTACT"

- "A matter of discerning between sexual playing and partnership from implied coercion through age differential"

ISSUE #6

TIME SPAN BETWEEN FIRST AND LAST INCIDENT (SOCIAL MATURATION)

- "A matter of time equaling social maturity"

ISSUE #7

SOCIAL CAPACITY FOR EMPATHY (ANTI-SOCIOPATHY)

- "A matter of learning delayed gratification and learning about the needs of others"

ISSUE #8

JUVENILE'S SOCIAL SKILLS

- "A matter of social competency, suggesting social culpability"

ISSUE #9

SEXUAL INFORMATION AVAILABLE TO JUVENILE

- "A matter of not only the amount, but the nature of sexual information available"

ISSUE #10

SEXUAL ABUSE INFORMATION AVAILABLE TO JUVENILE

- "A matter of not only the amount of sexual ABUSE information available, but the nature of that abuse information"

ISSUE #11

JUVENILE'S SEXUAL VICTIMIZATION

- "A matter of CONNECTED OR DISCONNECTED issues, correlating with the issue of independent actions"

ISSUE #12

TYPE OF SEXUAL BEHAVIOR

- "A matter of sexual sophistication"

ISSUE #13

NUMBER OF CONTACTS

- "A matter of the likely possibility of the juvenile meeting resistance"

ISSUE #14

NUMBER OF INCIDENTS

- "A matter of increased incidence (over time) suggesting development of knowledge or culpability"

ISSUE #15

KNOWLEDGE OF CRIMINAL BEHAVIOR

- "A matter of understanding consequences for sexually inappropriate behavior"

ISSUE #16

LEVEL OF COERCION

- "A matter of coercion implying automatic knowledge of the behavior being inappropriate"

TREATMENT OF JUVENILES

- Pleasure or reinforcement IS sensory

THEREFORE

- Treatment and change must be sensory
- Treatment must process
- Treatment must be positive "sexuality"
- Treatment must be careful of labels
- Treatment must be SCRAPBOOK

RESTITUTION THERAPY

THE ULTIMATE IN DEVELOPING VICTIM EMPATHY FOR SEX OFFENDERS
THE ULTIMATE IN REPAIRING DAMAGE TO SEXUAL VICTIMS

This type of restitution therapy has been developed by Jan Hindman based upon two needs. First, traditional, but well intentioned, Victim Empathy exercises for offenders can be an erotic process since the intensity of victim suffering seems to fuel the arousal of sex offenders. For many offenders there appear to be an attraction toward power and control over victims and, therefore, generic Victim Empathy treatment (poem reading, victim panels, exposure to incest books) can be counterproductive, if not arousing and erotic.

Secondly, research pertaining to the suffering of victims (Hindman. et.al) indicates that a mobile, vague, or moving memory of the sexual abuse causes trauma and suffering over time. As the brains' ability to perceive and retrieve memories of a past event changes, the traumatic experience tends to change. Guilt and responsibility are visiting ghosts to the moving memory. When victims have a clear, accurate, immobile memory, removing all guilt and responsibility, they tend to heal and recover, as the memory does not change and the victim's innocence is captured correctly.

In balancing the needs of both offenders and victims, the **CLARIFICATION** therapeutic effort becomes the vehicle of recovery. This process was developed from extensive work with both victims and offenders, recognizing that sexual offenders need to face the specific, unique damage they have caused, while victims need to receive an accurate, clear, tangible representation of their innocence, in order to prevent trauma bonding in the future.

PHILOSOPHY OF RESTITUTION THERAPY

Sex offender treatment should be considered as a privilege, not an automatic right. Treatment should not be initially considered for **THE OFFENDER'S BENEFIT** or feeling the "sting of consequence" will be robbed from the offender. Instead, the offender should be provided with an opportunity to repair the damage caused by the criminal behavior. Treatment should begin with a philosophy that the offender's needs are secondary to paying **RESTITUTION**. Through Phase One, Two and Three, the offender must pay emotional, psychological, and financial restitution to all those who have suffered. It is only in Phase Four that the offender's needs become a priority. Through this unique approach, the offender is forced to feel the sting of consequence (which is an investment into avoiding recidivism) while at the same time all four levels of victims (child, family, community, and society) feel vindication and have an opportunity for recovery.

THE CLARIFICATION IS NOT

- An apology
- A letter
- A forgiveness
- A guarantee of the offender's virtue
- A simple statement of responsibility

THE CLARIFICATION IS

- An explanation/clarification of the sexual assault
- A solid, immobile memory
- A sensory-based recreation to protect future sensory-based trauma triggers
- A method to capture childhood
- A desensitization process
- The ultimate in developing Victim Empathy for offenders
- The ultimate in repairing the damage to victims

CLARIFICATION COMPONENTS

- Greeting
- Morning Of (optional)
- Description
- What
- Trauma Assessment
- How
- Why

FOUR PHASES OF RESTITUTION THERAPY

PHASE ONE

- Complaint to sentencing
- "Silent Observer" status for the offender
- Treatment is a privilege attitude
- Guilty plea is negotiated/evaluation completed
- Sentencing a pre-requisite to treatment commencement
- Celebration

PHASE TWO

- Contract assignments/acceptance
- Change criminal thinking
- Compliance polygraphs
- Preparation of sexual history/polygraph as foundation for change
- Rearrange family dynamics
- A successful sexual history polygraph
- Celebration

PHASE THREE

- Clarification preparation process to the product
- Prepare in 3 x 5 cards, written form, finally scrapbook
- Present to significant other or guardian of child
- Present to victim and family
- Scrapbook presentation, two weeks following final session
- Consider reunification
- Compliance polygraphs
- Celebration

PHASE FOUR

- Traditional therapy for victim and family
- Initiate new strategy for "no contact" order
- Positive parenting visits (No tradition!)
- Communication Skills
- Relapse Prevention
- Problem Solving
- Compliance Polygraphs
- Understanding/Controlling Arousal
- Destructive Lifestyles
- Anger/Stress Management

UNDERSTANDING THE SEXUAL OFFENDER ISSUES AND ANSWERS IN A CORRECTIONAL AND COMMUNITY SETTING

PREAMBLE

In late November 1996, the Justice Department in Washington, D.C. organized a National Summit, bringing together selected experts in the field of Sexual Criminality. The overall purpose of this National Summit was to develop strategies in managing the epidemic problem of sexual offenders residing in our communities. Although many conclusions and recommendations were eventually sent to the President of the United States, the single most important factor that emerged from this summit related to the need of understanding offender typology and to make management and legislative decisions based on the difference in sexual offenders rather than viewing them as a homogeneous group. It is only when we understand the different types of sexual offenders – especially discerning those with arousal problems from those who act out for other reasons, that our management can be effective and our communities (even a Corrections or Institution community) can achieve safety.

I. LET'S GET THE SEX BACK IN SEX CRIMES

A. What is Arousal? (Overview of Arousal Measurements)

B. History of Mythology Concerning Arousal

C. General Overview of Differences of Arousal in Sexual Offenders

---

OFFENDER TYPOLOGY

An accurate offender typology cannot generally be determined without the use of a Penile Plethysmograph Assessment or Abel-Screen II. Some speculation can occur, however, separating pedophiles (who have an erotic preference for prepubescent children) from other child offenders who demonsrate a capability for deviant acts, primarily due to criminal thinking and lack of empathy, but who may also manifest healthy arousal potential. Levels of dangerousness and treatment recommendations may differ depending on whether the offender appears to have pedophilic tendencies or may be an "opportunistic" or "indiscriminate" type of child offender. It may also be helpful to determine if those who commit rape or sexual assault do so because of an erotic preference for violence (being somewhat dysfunctional in consenting, intimate relationships) may commit violent sexual acts because of opportunity or other situational disinhibitors such as criminal thinking or psychopathology. Again, risk and treatment may differ between these type of rapists. Finally, offender typology must identify those offenders who commit sexual crimes due to such other factors as neurological impairment, mental/development dysfunction, or unusual fantasy, fetish fulfillment needs.

II. THOSE WHO OFFEND OUR LITTLE ONES

A. The Classic Pedophile

Pedophile Characteristics

✓Long, early history of sexual involvement with prepubescent children with no pubic hair, muscle build-up, or breast development
✓Poor relationships with women/men same age peers
✓Inadequate personality development
✓Seems to be "equal" in sexual or other relationships with children
✓Playing or relationship enticement in crimes
✓Seems to be fixated in a stage of sexual development
✓Often uses child pornography
✓Works in jobs to be near children
✓Often offends outside home or establishes relationships with women who have children
✓Rarely offends own children
✓Is predatory to gain contact with children
✓Can be married, but often to an asexual "parenting" type of partner
✓Will abandon children when they develop secondary sexual characteristics
✓Will often have many positive relationship skills, especially with children

- Good baby-sitters
- Boy/Girl Scouts
- Teachers
- Etc.

B. The Opportunistic/Indiscriminate Child Offender

✓Often offends own child, stepchild, or relative with whom a relationship exists
✓Often has high antisocial attitudes and tendency
✓May have affairs as result of boredom or partner dissatisfaction
✓May be very patriarchal and in control of family--often aroused to power
✓Or may have no control, therefore, turns to children for a sense of power
✓Has ability to sexually perform with adults and would prefer adults, if convenient
✓Often involved with drugs and alcohol that provide disinhibitors
✓Often socially competent - high need for sexual intensity - unsatisfied in "old" relationship
✓Often has criminal versatility (the sexual assault is simply another crime)
✓May have sex with consenting minor (usually teenager) which results in conviction
✓Believes that the world owes him/her -- high sociopathic tendencies
✓May be terribly ignorant about laws
✓Often offends older children - 8 to 9 years old and up
✓Often interested in sexual development or onset of puberty
✓Because of criminal thinking processors to arousal tend to be cognitive
✓Sex crime is often "to feel good" (ejaculate or orgasm) rather than like a pedophile who wants to have a relationship

C. The "Salad" of Other Offenders of Children

1. The Business Person

2. The Neurologically Impaired Offender

3. Etc.

III. THOSE WHO RAPE

A. The Situational Rapist

✓Seems to rape when opportunity of victim vulnerability arises
✓Often rapes when intoxicated or impacted by drugs that disinhibit
✓Seems to rape for hurried sexual pleasure
✓Wants victim to cooperate or to respond (doesn't particularly want violence, but will resort to violence if necessary)
✓Often has high level criminal thinking or antisocial history
✓Often commits rape when committing other crimes
✓Seeking quick need for sexual pleasure
✓Seeking way to express anger, but does not use anger as arousal focus

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B. The Arousal Rapist

✓Often plans and enjoys thinking about sexual assault
✓Often uses weapons for sexual excitement
✓Is sometimes impotent or sexually dysfunctional with consenting partners
✓Wants victim to resist, scream, demonstrate fear for arousal satisfaction
✓Often wants long sexual encounter to include kidnaping and capture
✓May use drugs and alcohol, but these chemicals may interfere with ultimate pleasure attainment
✓Often hostile and hateful to women (in some cases, men) in general -- (arousal to aggression)
✓Often superficially charming and confident
✓Will often have serial crimes and may escalate in need for victim suffering
✓Often rape has nonsexual injury to victim to induce ultimate pleasure
✓May have high needs for sexual intensity, "Nice" relationships are boring

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IV. NEUROLOGICALLY IMPAIRED OFFENDER

✓Seems to be "out of control" and sex is one of many control problems
✓Offends children or rapes because he/she is "busy" doing a variety of sexual things
✓Has extensive pornography, high frequency of masturbation and seems to be in constant state of arousal (Neurological Tension Build-up)
✓Often has ADHD in past or present
✓May have had head injury to frontal lobe of brain
✓Has history of early sexual intensity and neurological tension build-up
✓May escalate, but may simply have ongoing and constant need for the orgasmic response
✓Has clear, physical arousal without common cognitive percussors to arousal, Physiological triggers develop arousal needs rather than the cognitive process of criminal thinking
✓Would have potentially high benefit from hormonal therapeutic intervention
✓Not all neurologically impaired individuals are sexual offenders, Many were victims of early childhood sexual arousal

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V. UNUSUAL CIRCUMSTANCES OFFENDERS

✓Arousal to strange fetish (shoes, underwear, defecation, etc)
✓Seems to be motivated for sex crimes involving these unusual objects
✓Clearly has focused sexual arousal on "things" rather than primary people
✓May be mentally ill or developmentally delayed and, therefore, has no control over unusual attraction
✓May have sexual interest in non-person things, such as bestiality, pornography, clothing, etc
✓Has bizarre fantasies/behaviors, interests, in sexual activity, not sexual relationships
✓Has many paraphilias - voyeurism, exhibitionism, etc

VI. ASSESSING MANAGEMENT TECHNIQUES IN PARTNERSHIP WITH UNDERSTANDING DANGEROUSNESS

A. Psychopathology -- A Key to Understanding Typology, Risk, and Potential Change

1. The MMPI and Other Testing

2. The Hare Psychopathy Checklist

The Hare Psychopathy Checklist is the primary clinical instrument used to assess psychopathology in criminals. Individuals who suffer from psychopathology have longer criminal careers and begin these activities earlier than do non-psychopaths. The crimes of these individuals tend to be more frequent and violent compared to other criminals. When released on parole, probation, or post-prison supervision, psychopaths tend to recidivate three to four times the rate of non-psychopaths. They tend to respond poorly to treatment and there is some evidence that some psychopaths may use information which they learn in treatment for committing new crimes.

The Hare Psychopathy Checklist provides a perspective which represents the extent to which an inmate may correlate with the "prototypical psychopath." Although it is clear there are no absolute dimensions for individuals who can be judged as psychopathic, this assessment attempts to evaluate individuals within two factors of antisocial behavior. Factor One reflects the degree of callousness and lack of remorse toward others. Factor Two reflects socially deviant behavior, which brings about an unstable, parasitic, and antisocial lifestyle. According to the makers of this assessment, individuals should be evaluated concerning both Factor One and Factor Two in order to determine specific levels of psychopathology as well as an overall correlation with other individuals who fit an Axis II diagnosis of Antisocial Personality Disorder.

Some of the traits or behaviors which are used in the Hare Psychopathy Checklist include:

1. Glibness, superficial charm, usually accompanied by facile verbal skills.
2. Grandiose, over inflated sense of self-worth (A braggart, feels superior to others).
3. Constant need for stimulation, easily bored.
4. Pathological lying.
5. Conning and manipulative (Uses deceit and deception to cheat others).
6. Lack of remorse or guilt.
7. Shallow affect.
8. Callous, lack of empathy (Unable to imagine himself in another's life situation).
9. Intentional parasitic lifestyle - little or no real effort to support himself.
10. Poor behavioral controls (often run by emotions especially anger and rage with violence).
11. Promiscuous sexual behavior (indiscriminate partners, many partners "one night stands").
12. Early behavior problems, before age 12.
13. Lack of realistic long term plans.
14. Frequent impulsive behavior (moves, quits jobs, leaves relationships).
15. Irresponsibility, does not fulfill obligations to others.
16. Failure to accept consequences and take responsibility for his actions.
17. Many short term marital-like relationships (one month to one year duration).
18. Juvenile delinquency (committed major offenses before age 18).
19. Revocation of conditional release (parole violation, escape, new offense while on supervision).
20. Criminal versatility (commits many different types of crime).

B. Megargee Classifications and Chemical Dependency in Evaluating Offenders -- "Uses and Those Who Use"

EASY

Unless other concerns mandate differently, management considerations for individuals with this type of profile do not need to include any special precautions or settings. As a group they are relatively well-adjusted, capable, and intelligent. They can be expected probably to adjust well in the general prison population. Unless specific problems have been noted, these individuals do not seem to have any special treatment needs. They are likely to respond well to educational and/or vocational programming if these are indicated. Likewise they should profit from any other programs.

CHARLIE

Individuals with this profile usually require a secure setting. They should be separated from more vulnerable offenders. Their overall institutional and interpersonal adjustment is likely to be poor. They do best in a highly structured setting where they are allowed to work on their own. These individuals tend to be hostile loners and have an overall paranoid attitude which interferes with their ability to function well with others. While they may have educational deficits, they generally lack motivation to profit from educational programming. They may need extensive and/or repeated attention from the mental health staff. It is recommended that any treatment

FOXTROT

Individuals with this profile are predatory, seek power over others, and need to be housed separately from more vulnerable offenders. They require a very structured environment. Generally, they experience very poor institutional adjustment with a relatively high rate of institutional assaultive behavior, a high number of infractions, high utilization of sick calls, and poor ratings on work performance and interpersonal adjustment. These individuals tend to be hostile yet can be very manipulative with staff. While they manifest deficiencies in many areas, they generally do not profit from educational, vocational, or other skill-building programs. If specific problem areas are noted, they may profit if treated in a group consisting of other individuals who share a similar profile. They need a highly structured, problem-focused, contingency management approach.

BAKER

Unless other considerations mandate differently, these individuals do not seem to have any exceptional management needs. If no specific circumstances have been noted, they should be able to reside in the general prison population. While these individuals may accumulate an above average number of infractions, these probably will result from passive-aggressive behavior rather than violent acting out. They are likely to profit from any specialized treatment, educational, or vocational programming which may be indicated. A supportive approach to treatment is recommended. Counseling focused on helping these individuals to change self-defeating patterns and learn more productive ways of coping with stress could be beneficial.

ABLE

Unless other concerns mandate differently, management considerations for individuals with this type of profile do not need to include any special precautions. They would seem to adjust satisfactorily in the general prison populations. While the ability to get along with others may be a strength in these individuals, at the same time it should be noted that as a group they are very manipulative and highly opportunistic. When placed in community programs and/or loosely structured situations, these individuals may become problematic when not closely supervised due to their tendencies to be impulsive, irresponsible, and willing to risk illegal shortcuts to satisfy their desires as quickly as possible. They could profit from any indicated specialized treatment program as well as any suggested educational or vocational programming. A confrontive group treatment modality seems to be indicated for this group.

ITEM

Unless other concerns mandate differently, management considerations for offenders with this type of profile do not need to include any special precautions or settings. As a group they are friendly, responsible and well-adjusted with minimal problems. They have minimal needs for structure and can be expected to adjust satisfactorily in the general prison population. Unless specific problems have been noted, these individuals do not seem to have any special treatment needs. They are likely to profit from educational,

HOW

Individuals with this profile type are a very heterogeneous group. In general, these people have many problems -- some having serious psychiatric problems -- and warrant the further attention of mental health professionals. Treatment in a correctional mental health facility may be desirable for this person. A more thorough individual psychological evaluation is strongly recommended. Such an evaluation could provide further useful information regarding management recommendations. Their institutional adjustment tends to be quite poor. They tend to be withdrawn and passive and some may be vulnerable to victimization. At the same time others with this profile may be quite aggressive. Overall, the various individuals with this profile tend to be aggressive and hostile toward authority figures -- especially when these figures are placing demands on them. Precautions need to be taken to place these offenders where they are less likely to be exploited and/or, for the few who are predatory themselves, where they are less able to exploit more vulnerable offenders.

GEORGE

Unless other concerns mandate differently, management considerations for individuals with this type of profile do not need to include any special precautions or settings. These individuals can be expected to adjust satisfactorily in the general prison population. Unless specific problems have been noted, these individuals do not seem to have any special treatment needs. They are likely to profit from educational, vocational, or any other programming which maybe indicated. Practical career-oriented counseling could be of definite benefit to people in this group.

C. Development Delays and Intelligence

D. Psychosis and Mental Illness

1. Axis I

2. Axis II

E. General Dangerousness Factors

Several factors can be considered suggesting less dangerousness (less likelihood of re-offending) and more risk or dangerousness for sex offenders include a short criminal sexual history, a first time offense, absence of force or violence in the crime, a single victim and/or a single paraphilia, offenders living with the victim or who have a relationship with the victim, offenders who admit to their guilt, as well as offenders who appear amenable for treatment and who have what appears to be a stable relationship history.

Those factors which increase dangerousness include extended sexual criminal history, multiple victims or paraphilias, various ages of victims, and victims of both genders. It is also believed that dangerousness is often found to a greater extent for sexual offenders who have pedophilic or violence to arousal tendencies, who are strangers to their victim, who use force, torture, sadism, or ritual violence. Other risk factors would indicate that the sex crime is motivated by money, high deviant arousal, and those offenders who either deny their participation in the offense or minimize their sexual responsibility. Most significantly in predicting dangerousness would appear to be those offenders who have clear deviant arousal and those offenders who have failed at previous treatment and/or probation/parole privileges.

F. Factors that Tend to Reduce Dangerousness

✓Absence of force used in the crime
✓Amenability to treatment
✓Single victim
✓Single paraphilia
✓Single gender victim
✓Offender living with victim
✓Offender well known to victim
✓First conviction
✓Admission of the sex crime
✓Amenability to treatment
✓Stable relationship history
✓Appropriate intelligence

G. Factors that Tend to Increase Dangerousness

✓Signs of mental illness or developmental delay
✓Multiple victims
✓Multiple paraphilias
✓Multiple ages and sexes of victims
✓Presence of homosexual pedophilia
✓Offender a relative stranger to victims
✓Minimization or denial of sex crime
✓Use of force in the sex crime
✓Use of torture, sadism, ritual violence
✓Sex crime motivated by desire for money
✓Past conviction
✓Past treatment
✓Past treatment probation/parole failure
✓High deviant sexual arousal
✓Are not living with their victim(s)
✓Totally deny their participation in the offense(s)
✓Totally deny the need for treatment
✓Demonstrate high pretreatment deviant arousal
✓Manifest instability of personal relationships
✓Has predatory behavior

VII. VARIOUS AND SUNDRY ISSUES

A. The Female Offender

B. The Juvenile Offender

C. Our Most Famous Criminals -- "Who is Driving the Train?"

A Community Response to

Child Predators

Presented by

Commander Bradley L. Russ,
Sergeant. Gary O'Connor,
Patty Wetterling and
Ronald Laney

COMMUNITY RESPONSE TO CHILD PREDATORS:

INVESTIGATION

Police Response

- Critical Hours
- Type of Response
- Intensity of Resources

Factors Influencing Response

- Perceived threat to child
- Departmental organization/resources
- Departmental policy
- Existence of pre-plan

Law Enforcement Response: Dispatch

- Intake and preserve initial report
- Obtain basic facts
- Dispatch officer
- Broadcast known details

8 Law Enforcement Tasks

- Determine validity of abduction
- Obtain the "victimology"
- Conduct the neighborhood investigation
- Set up command center

8 Law Enforcement Tasks (con't)

- Establish support services
- Establish liaison with victim's family
- Set up media procedures
- Conduct searches

Determining Validity

- Assume worst until proven otherwise
- Location
- Time of day
- Potential witnesses
- Area search
- Child's history

Victimology

- Physical description
- Photographs
- Friends/relatives/siblings
- Problems
- Interests

Victimology (con't)

- Relationship between abduction scene + child's routine
- Parental attitudes
- Family's financial status
- Child's room

Neighborhood Investigation

- Conduct as soon as possible
- Keep officers free from CFS
- ID any possible witnesses
- Obtain positive identification of all persons
- Note and recontact vacant locations
- Utilize detailed maps

Neighborhood Investigation

- Appoint single N.I. coordinator
- Photograph and videotape neighborhood
- Determine dynamics of neighborhood
- Determine history of neighborhood
- ID areas where victim could be taken
- ID areas where suspect may have been
- Check for prior attempts

Case Organization & Management

- Administrative Head
- Lead Investigator
- Media Coordinator
- Support Coordinator
- Special Operations Coordinator
- Pre-planned mutual aid

Command Center

- Away from victim's home
- Accommodate large number of phones/personnel
- Some degree of privacy/security
- Nearby area for media briefings
- Amenities
- Information management system
- Tip lines
- Trap and Trace

Liaison Officer at Victim's Residence

- Brief family
- Trap and Trace
- Log and record
- Contact with command center
- Screen and log visitors
- Record tags

Liaison Officer at Victim's Residence (pt. 2)

- Secure the residence
- Search thoroughly
- Photographs of victim
- Enhance victim information
- Obtain "key" information (unique to victim)
- Interview friends
- Obtain letters, diaries, etc.
- Obtain fingerprints, hair samples

Liaison Officer at Victim's Residence (pt. 3)

- Counsel victim's family
- Explain procedures
- Prepare family for emotional stages/changes
- Link family with appropriate support
- Help family meet basic needs
- Provide a sense of security and professionalism

Search Coordinator

- Organize both ground and air searches immediately
- Law enforcement present w/all search elements
- Utilize all resources
- Logistical support
- Positive ID on all searches

Media Coordinator

- Single spokesperson
- Prepared statement
- Anticipate questions
- No deadlines for results
- Give law enforcement number only
- Reward information

Investigative Case Management

I. Introduction

A. In this class we will review a systems response to Missing and Abducted Children
   1. Child Abduction Homicide Characteristics
   2. Policy and Supervision Issues
   3. Framework for Managing a Child Abduction
   4. Major Case Management Responsibilities
   5. Information Management/Lead Tracking Systems
   6. Child Abduction/Recovery Practical Exercise

II. Child Abduction Homicide Research

A. Washington State Attorney General's Office preliminary results drawn from:
   1. 577 cases in 46 states (1971-1995)
   2. 621 victims (77% female/23% male)
   3. All size state, county and local law enforcement
   4. All geographic areas represented

B. Case selection criteria
   1. Victim under 18 years
   2. Victim is murdered
   3. Body is recovered
   4. Case handled as an abduction
   5. Parental child abuse excluded

C. Police involvement began as:

1.	MISSING PERSON	58%
2.	DEAD BODY	23%
3.	ABDUCTION	9%
4.	RUNAWAY	9%

D. Victim Gender Differences

1.	MALE	24%
2.	FEMALE	76%

E. Victim Age Groups

1.	1-5	9%
2.	6-9	21%
3.	10-12	21%
4.	13-15	28%
5.	16-17	21%

F. Victims as Targets
   1. Younger males are more apt to be victimized than older males
   2. Older females are more apt to be victimized than younger females

G. Time Delay in Reporting
   1. 60% of cases over 2 hours lapsed before police were notified of missing child
   2. The older the child the greater the delay

H. Time victim alive after abduction
   1. 44% of cases victim dead within 1 hour
   2. 74% of cases victim dead within 3 hours

I. 22% of victims were **still alive** when reported missing

J. 42% of victims were dead **before** they were reported missing

K. Time is of the Essence
   1. Mobilize all resources immediately
   2. Information dissemination critical
   3. No geographic limits/turf issues
   4. Think outside the box

III. Policy and Supervision Issues

A. Pre-Planned Critical Incident Response
   1. Policy and Procedural Guidelines for:
      a) Telecommunications
      b) First Responders
      c) Street Supervisors
      d) Notification of Investigations (BIS)
      e) Involvement of additional resources

B. Front-end vs. Reactive Management
   1. Policy and Procedure Development
   2. Guidelines
   3. Checklists
   4. Roll call and department-wide training
   5. Mock disaster training
   6. Consistency and accountability

IV. Child Abduction Policy

A. Purpose
   1. Guide activities of responding units
   2. Manage complex and protracted investigations

3. Establish a framework
4. Allow flexible or partial application
5. Should be reviewed annually and tested

B. Case Guidelines for Investigative Commanding officer
1. Establish contact with on-scene supervisor
2. Obtain synopsis of incident
3. Determine location of command post
4. Establish double perimeter
5. Patrol outer/CID inner
6. Crime scene processing only
7. Media and public outer perimeter

C. Initial Briefing Participants
1. On Scene Supervisor
2. 1st Responding Officer
3. Patrol Supervisor
4. CID Personnel
5. Crime Scene Personnel
6. Other agencies (as appropriate)

D. Initial Briefing
1. Determine actions prior to arrival
2. Ascertain facts known at time
3. Determine lead agency/unit
4. Assign lead investigator
5. ID representative's from other agencies
6. Determine specific role
7. ID and assign assist agency lead
8. Determine need for additional investigator
9. Assign investigator as recorder
10. Assign tasks (pre-numbered MCI form)
11. CID Commander assigns investigator and administrative supervisor
12. Determine chain of command
13. Assign investigator to crime scene(s)
14. ID Areas for witness interviews (secure)
15. Stress importance of :
    a) Slow things down
    b) Don't get caught up in excitement
    c) Team work
    d) Communication (yo-yo)
    e) No tunnel vision
16. Keep lead investigator informed
17. No investigative assignments for supervisor
18. All information funnels through supervisor
19. Assign investigator to victim(s)/family
20. Provide CP with list of personnel

21. Brief P.I.O or department designee
22. Utilize pre-numbered lead sheets
23. Determine need for additional resources:
    a) Clerical/sworn personnel
    b) K-9 units/air support
    c) Civilian volunteers
    d) Federal/state resources
    e) Office space
    f) Phone banks/special numbers
    g) Computers/copy and fax machines
    h) Administrative supervisor to coordinate

E. End of 1st Day Briefing Participants:
1. All CID personnel assigned
2. Crime scene unit personnel
3. Representative's from participating agencies
4. Public information officer (PIO)
5. Command staff
6. Prosecutor's office

F. Purpose of 1st Day Debriefing
1. Discuss investigative progress
2. Describe tracking system/leads
3. Stress accuracy/thoroughness
4. Confidentiality outside work group
5. Opportunity to brainstorm

V. Major Case Management Responsibilities

A. Investigative Supervisor
1. Regular reports to CID Commander
2. Updates progress/status
3. Ensures compliance with procedures
4. Charts assigned personnel
5. Radios/frequency
6. Cell phones/beepers
7. Cars/special equipment
8. Distribute copies
9. Reviews leads, establishes priorities
10. Makes assignments
11. Classifies information status (lead sheets)
12. Reviews data base printouts
13. Coordinates and attends briefings
14. Responsible for investigator security

B. Administrative Supervisor
   1. Reports to CID Commander
   2. Attends daily briefings
   3. Responsible for administrative support
   4. Coordinate/training and briefing of:
      a) Call takers
      b) Clerical staff
   5. Establish proper paperwork flow
   6. Responsible for quality control:
      a) MCI follow-up forms
      b) Supports lead sheets
      c) Master log sheets
      d) Binders/files etc.

C. Lead Investigator
   1. Coordinates and supervises investigation
   2. Crime scene properly managed
   3. Evidence properly collected/maintained
   4. Evidence properly submitted/returned
   5. Reviews and assigns leads
   6. Reviews and classifies completed lead sheets
   7. Coordinates/manages all follow-up/leads:
      a) Suspect interviews
      b) Polygraphs
   8. Search warrants
   9. Keeps prosecutor's office informed
   10. Responsible for master file security

D. Crime Analyst
   1. Reports to lead investigator
   2. Develops database system
   3. Provides training and coordinates data entry
   4. Provides liaison with lead sheet manager
   5. Regularly prints requested reports
   6. Conducts quality control of data

E. Lead Sheet Manager
   1. Reports to administrative supervisor
   2. Leads forwarded to supervisor
   3. Maintains master log of all leads
   4. Maintains files for leads classified as:
      a) No value
      b) Investigative
      c) Active/Inactive

F. Call Taker
   1. Completes MCI Form
   2. Completes background investigative query
   3. Preserve tapes of phone calls
   4. Notify supervisor of "hot" leads

G. General Points
   1. Designate a conference area in command center
   2. Set-up separate room for phone calls
   3. Staff hotline 24 hrs. a day
   4. Install caller ID and record all phones
   5. Assign liaison to each assist agency
   6. Pair investigator with assist agency person
   7. Utilize Crime Analyst as scene recorder
   8. Utilize Crime Analyst to record daily briefings
   9. Assign Investigator to brief roll calls
   10. Consider completing VICAP Forms
   11. Limit distribution of database printouts
   12. Stress importance of team work and communication

VI. Information Management

A. Information Management
   1. Centralization of information
   2. One person or section responsible
   3. System for storing and retrieving information
   4. Automated or Manual (card system)
   5. Visual aids
   6. Flow charts
   7. Time lines
   8. Graphs (analytical correlation)

B. Information Evaluation
   1. One person accountable for
   2. Maintenance
   3. Evaluation
   4. Developing reports
   5. Dissemination analysis
   6. Roll call bulletins

C. Flow of Information
   1. Everyone responsible for information input
   2. Information must be available to all investigators
   3. Regular briefings essential
   4. Especially with multiple jurisdictions
   5. Garbage in-Garbage Out (GIGO)

D. Standardized Information Procedures
   1. Utilize standard forms
   2. Missing Child Form
   3. Lead sheets and Tip/Hotline Forms
   4. Uniform narrative and summary reports
   5. Uniform Case Tracking Reports

E. Tracking Tips & Leads
   1. Requires a procedure
   2. Specifically designed forms
   3. Helps with flood of information
   4. Prioritize and assign
   5. Ensures follow-up/accountability
   6. Consider telephone recording
   7. E-911 or Caller ID (Fast Trak)
   8. Train call takers

F. Case File Contents
   1. CAD Log
   2. Teletypes
   3. MV and Record Checks
   4. Global/Local Checks
   5. Database searches re:
      a) Previous incidents
      b) Suspects fitting MO
   6. Tapes of phone/radio traffic
   7. Phone messages
   8. Copies of all initial reports
   9. Copies of any court orders
   10. Custody
   11. Temporary placement
   12. Domestic orders
   13. All taped interviews
   14. Witness Statements
   15. Vehicle Canvass
   16. Neighborhood Canvass
   17. Include people not at home
   18. Crime scene reports
   19. Photographs
   20. Evidence Log
   21. Search Warrant/Return
   22. Lab submittal slips
   23. Lab reports
   24. Photos/video of child
   25. Flyers/bulletins
   26. Press releases

27. Newspaper articles
28. TV coverage
29. VICAP report
30. Suspect profile
31. Polygraph results
32. Off-line searches
33. CPS records
34. Medical/Dental records
35. School records
36. Assist agency reports/records
37. Crime Stopper Bulletins
38. Legal paperwork
39. Warrants/UFAP
40. Affidavits
41. Civil Proceedings
42. Suspect Records
43. Employment
44. Criminal (verify with prints)
45. Nexis/Lexis search
46. Professional Licenses
47. Fed Parent Locator Service
48. Postal records
49. Credit check

VII. Practical Exercise

S320196

Snakes in My Belly

Presented by

Ellen L. Stirling, MSN and
Donna Pence, SA

PRINCIPLES FOR HELPING CHILDREN COPE WITH THE DEATH OF A LOVED ONE

HONOR EACH CHILD: Recognize that each individual experiences grief in a unique way. Be aware of the individual child's developmental stage.

LISTEN TO THE CHILD: Be attentive to what the child expresses and understands. Understand that at the basis of the child's perception will be his/her own "data bank" of information and life experiences. The technique of careful listening and meaningful response means to address exactly what the child wants to know. . . nothing more, nothing less.

TELL THE TRUTH: A child deserves honesty. Use simple, clear words plus reassurance and expressions of love. Use the words "death," and "dying," not "gone away" or "left us." Telling the truth doesn't always mean a complete description of all details. Listen to the child and learn what he/she needs and wants to know.

BE AWARE THAT MAGICAL THOUGHTS ARE A PART OF A CHILD'S THINKING: A child may not understand the circumstances of a death and may even feel somehow responsible. . . i.e., "Step on a crack . . . break your mother's back." Listen for confused thinking and work to help the child understand.

BE AWARE THAT YOUNG CHILDREN ARE OFTEN UNABLE TO UNDERSTAND THE PERMANENCE OF DEATH: For this reason, a child will often ask you to repeat again and again the "story" of the death.

BE AWARE THAT CHILDREN INCORPORATE THEIR GRIEF INTO THE REST OF THEIR LIVES: One moment a child may seem completely oblivious to the death and the next, he/she may be very sad and crying.

RECOGNIZE THAT IT IS IMPORTANT TO SHARE APPROPRIATELY YOUR OWN FEELINGS OF GRIEF WITH YOUR CHILD: A child may be confused about his/her own feelings and have some difficulty identifying these feelings. It is helpful for the child to realize that he/she is not alone in his feelings of grief.

RECOGNIZE THAT A CHILD WILL NATURALLY REVISIT THE FEELINGS OF LOSS AS HE/SHE MATURES IN UNDERSTANDING.

TRUST THE CHILD'S PROCESS AND KNOW THAT YOUR JOB IS TO BE WITH HIM/HER IN A SUPPORTIVE AND UNDERSTANDING WAY.

These principles were developed for use in the Stepping Stones Program by Program Coordinators Ellen Stirling, MSN, and Gerri Hayes, MSW. 11/5/91.

DEVELOPMENTAL AGES AND POSSIBLE REACTIONS TO DEATH

AGE	THINK	FEEL	DO
3-5 years (Preschool)	•death is temporary and reversible •finality of death is not evident •death mixed up with trips, sleep •may wonder what deceased is doing	•sad •anxious •withdrawn •confused about changes •scared •cranky (feelings are acted out in play)	•cry •fight •are interested in dead things •act as if death never happened
6-9 years	•about the finality of death •about the biological processes of death •death is related to mutilation •a spirit gets you when you die •about who will care for them if a parent dies •their actions and words caused death	•sad •anxious •withdrawn •confused about the changes •angry •scared •cranky (feelings acted out in play)	•behave aggressively •behave withdrawn •experience nightmares •act as if death never happened •lack concentration •have a decline in grades
9-12 years	•about and understand the finality of death •death is hard to talk about •that death may happen again, and feel anxious •about death with jocularity •about what will happen if their parent(s) die •their actions and words caused the death	•vulnerable •anxious •scared •lonely •confused •angry •sad •abandoned •guilty •fearful •worried •isolated	•behave aggressively •behave withdrawn •talk about physical aspects of death •act like it never happened, not show feelings •experience nightmares •lack concentration •have a decline in grades
12 years and up (teenagers)	•about and understand the finality of death •if they show their feelings they will be weak •they need to be in control of their feelings •about death with jocularity •only about life before or after death •their actions and words caused the death	•vulnerable •anxious •scared •lonely •confused •angry •sad •abandoned •guilty •fearful •worried •isolated	•behave impulsively •argue, scream, fight •allow themselves to be in dangerous situations •grieve for what might have been •experience nightmares •act like it never happened •lack concentration •have a decline in grades

TASKS OF MOURNING

All of human growth and development can be seen as influenced by various tasks. Likewise, mourning, the adaptation to loss, may be seen as involving the basic tasks outlined below in order to complete the mourning process. Mourning is a "process" that requires effort, thus we speak of a person doing "grief work." The time involved for completion of these tasks is variable and individual.

1. **To Accept the Reality of the Loss**
   When someone dies, even if the death is expected, there is always a sense that it hasn't happened.

   The first task of mourning is to come full face with the reality that the person is gone and will not return.

2. **To Experience the Pain of Grief**
   It is necessary for the bereaved person to go through the pain of grief in order to get the grief work done. To avoid or suppress this pain can be expected to prolong the course of mourning. Not everyone experiences the same intensity of pain or feels it in the same level of pain.

3. **To Adjust to an Environment in Which the Deceased is Missing**
   Adjusting to a new enironment means different things to different people depending on what the relationship with the deceased was and the various roles the deceased played. For many survivors, it takes a considerable period of time to become aware of all the roles played by the deceased. The survivor may need to develop new skills and take on new roles themselves.

4. **To Emotionally Relocate the Deceased and Move on with Life**
   This is often the most difficult task. To withdraw emotionally from the deceased and to reinvest in other activities and/or relationships. This can be frightening and a challenging time for the survivor; however, earmarks their going forward with living.

Wm. Worden, Grief Counseling and Grief

COMPLICATED GRIEF

Seven high-risk factors fall into two categories predispose any individual to complicated mourning.

The First Category:

- Sudden, unexpected death (especially when traumatic, violent, mutilating, or random)
- Death from an overly lengthy illness
- Loss of a child
- The mourner's perception of the death as preventable

The Second Category:

- A pre-morbid relationship with the deceased that was markedly angry or ambivalent, or markedly dependent
- Prior or concurrent mourner liabilities (unaccommodated losses and/or stresses and mental health problems
- Mourner's perceived lack of social support

Helping Someone When A Loved One Has Been Murdered

By Wanda Henry-Jenkins
Philadelphia, Pennsylvania

When a former high school classmate was murdered during a fight, I was saddened. When my sister's brother-in-law was slain several years later by a drug-crazed man, I helped the family get through the funeral and burial. But, on February 12, 1972, homicidal loss became my own personal experience when my mother was killed.

My mother left behind nine children, my father and her mother to mourn her murder, but we never shared our suffering together beyond the funeral and burial. We were eleven individually bereaved persons, each trying to handle his or her own grief. At the same time, we were putting on happy faces and trying to encourage one another that we could go on living.

All the while, other family members, friends, news media, police, clergy, mortuary personnel and curious onlookers were peeping in on our devastation. The murder was never solved, and within two weeks of her homicide, we (her bereaved family) were left alone and expected to recover without much help or direction.

Though all death leaves behind human pain and suffering, murder is preventable, and it screams terror, mutilation and "bad" death. No one, regardless of place or goals in life, should be killed. The sad truth is, however, that every day nearly sixty families experience the agony of learning that a loved one has been murdered. Both immediate and distant family members and friends are caught up in the shock and outrage of such violent loss of life.

Murder is like a violent thief in the night, causing great suffering. The funerals of murder victims often attract large crowds, but once the ceremonies are over, few remain with the bereaved to help dry their tears or relieve the burden of their pain. Family members are encouraged to recover and heal from the violent wound in their emotional fabric, but no one tells them how to heal.

Friends, church and community members, and co-workers can become facilitative comforters who help themselves and the family to feel cared for through the journey to recovery. Here are some suggestions that may help:

Be Open

If you would provide comfort and consolation, be open to accept whatever statements of pain and rage those who have experienced homicidal loss may express. Immediately after a homicide the bereaved may make some terribly shocking statements. Do not attempt to be the survivor's conscience. Just listen carefully and respond compassionately to their needs.

Emotions following homicidal loss often range from numb passivity to overwhelming rage. Survivors may appear the same outwardly, but they are irrevocably changed. They cannot go back to being the same person they were before, but they can become renewed and healthy.

Be Observant

Some of the things that survivors say they want to do could harm themselves or someone else if they were carried out. Be observant and keep a close watch on friends or family members. They are secondary victims in the awful aftermath of murder.

You have probably watched a news telecast or read a newspaper account where a bereaved person sought out and killed the mur-

derer of their loved one.

When multiple family members have been killed, some survivors o longer want to live. Without appropriate support, they may attempt or complete suicide. By your presence, encourage them that they are not alone. Take them out to dinner or to a movie, hug them and encourage grief counseling.

Be Honest

Honestly share your own grief experiences with your friend, but don't try to identify with the experience of someone else. You can be a bridge over the murky waters of murder by seeking to understand how bereaved survivors see their experience.

One survivor reported that the dawning of her recovery from turmoil came when she was told by another grieving survivor, "I can't tell you how to feel. I can only share what it was like for me when my son was murdered." nother said that the cloud of ragedy she felt over her life began to lift when a friend asked, "Tell me what you are feeling, because I have never known anyone who was killed."

Be Non-Judgmental

The most miserable "comforters" are those who have all the answers! "It was too late at night for a woman to be out," or, "He was in the wrong place at the wrong time." Also, "What did you expect? They were drug dealers," and, "If you play, you must pay."

These statements or similar ones only serve to hurt and further isolate the survivors. There are times when it's best to not say anything. Murder is a mixture of pain and frustration that is not helped by judgment.

Be Respectful and oving

Those who have been bereaved by murder are already upset with God and humanity. Their faith in fair play and divine protection has been destroyed. Such statements as, "The good die young" only infuriate them and hamper their ability to mourn effectively. Show the kind of respect and love to the bereaved that you would want to receive under the same conditions.

Be Patient

Homicide bereavement is cyclical in nature. The three cycles of grief are crisis, conflict and commencement. The crisis period is from the time of death notification through the burial. Conflict begins with the trial and ends after the sentencing of the murderer. The commencement cycle begins when the survivor is ready to grieve the loss and move toward a healthy resolution.

Cycles can intermingle and relapse in grief recovery is common among survivors of murder victims. Complicating circumstances may be the arrest of the murderer, the trial itself, the parole or death of the murderer or an unsolved murder.

Mourning is hard work and it takes time — sometimes many years. This is especially true in the case of an unsolved murder. The amount and quality of available lay, peer and professional support can make a major difference.

Be Supportive and Available

In the aftermath of murder, it is common for survivors of murder victims to feel alone. However, the grim and escalating statistics from FBI records and emergency room files report multiple thousands of new murder victims are added yearly.

Survivors often can be helped by support groups that are especially for families of murder victims, but sometimes the hardest step is going to the first group session. As a caring friend, your most effective support may be to accompany your survivor/friend to the group meeting. One best friend reported to a support group, "I am here to learn how to help my friend." Being available is the best support a friend can provide.

Be Aware of Your Own Needs

Since some friends and co-workers may have spent their time with the person who was murdered, they may not know the family members as well. Be aware of your own grief needs in the aftermath of tragedy. Share your feelings and how you are resolving your grief.

The best thing a friend did for me was to cry over my loss. I felt she loved me and recognized my great pain. Remember, there may be times when you cannot help your friend due to your grief, family obligations or professional competence. Admit your feelings to your friend and refer him to another part of the support system.

Be Knowledgeable About Available Resources

Survivors of murder victims sometimes do get stuck in their grief. They report continual nightmares, suicidal or homicidal ideas, excessive drinking or the use of drugs. Any of of these reasons is important enough to warrant a visit to a professional.

Call your local mental health organization, district attorney's office or victim's assistance program to discover who may be the appropriate caregiver. Then, gently suggest to your friend that professional intervention may help to resolve the grief.

These nine steps are only suggestions for helping someone whose loved one was murdered, but by following these steps you can provide comfort, compassion and consolation. In the end, you will also strengthen your family ties or friendships.

Children and Trauma
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Improving Community Response to Child Abuse

Presented by

Nancy O'Leary, Anne Lynn,
Teresa Cain and Diana Schoendorff

SOUTHERN REGIONAL CHILDREN'S ADVOCACY CENTER

In 1985, recognizing "We are the system and we can change it," professionals and volunteers in Huntsville/Madison County, Alabama, established the National Children's Advocacy Center program through which they redesigned the system so that its primary focus became the child victim and his or her family. Law enforcement, child protective services, prosecution, mental health, medicine, education and other agencies started working together in a coordinated community response to child abuse.

Almost from the moment the National Children's Advocacy Center opened its doors 11 years ago, professionals from across the United States and foreign countries have requested assistance in learning how Children's Advocacy Centers could be started in their communities and how to improve their skills in responding to child sexual abuse.

The SOUTHERN REGIONAL CHILDREN'S ADVOCACY CENTER (SRCAC) was established through a grant to the National Children's Advocacy Center (NCAC) from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. The mission of the NCAC has been to assist professionals and volunteers in establishing Children's Advocacy Center programs that are patterned after the Huntsville model, but designed to meet the unique needs of their own communities. The SRCAC continues that mission by providing information, consultation and training in establishing child-focused programs that promote coordination among agencies responding to child abuse.

The SRCAC assists communities with the flowing: Consulting and assessing their capacities to provide services. Developing a comprehensive, multidisciplinary response to child abuse. Establishing separate, child-friendly facilities for interviewing and providing services to child victims and their families. Preventing or reducing trauma to children caused by multiple contacts with community professionals and involvement with the courts. Increasing community understanding of child abuse. Identifying and developing funding and marketing strategies. Maintaining open communication and case coordination among community professionals and agencies involved in child protection efforts. Enhancing the skills of professionals and volunteers who support child abuse intervention programs, such as the local Children's Advocacy Center Developing and negotiating interagency agreements and protocols. All SRCAC training and technical assistance services are provided by experienced faculty. These individuals work daily in the field of child sexual abuse and are recruited from active, successful Children's Advocacy Centers.

The NCAC and the SRCAC form a powerful tool in confronting the crisis of child maltreatment in this community and the region as a whole. Like the original team, we have found that only by pulling together diverse skills, experiences and knowledge bases can we be most effective. The SRCAC serves seventeen states: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Maryland, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

Southern RCAC Products

One of the products produced by the SRCAC is a full-color publication on "Improving Community Response to Child Abuse." A simple straight forward publication that tells about Children's Advocacy Centers and the benefits a CAC provides the children, their families, the community, and the professionals who work with these children. The ten-page publication is used to create interest in CACs, to inform professionals and communities about the benefits of a CAC, to help CACs raise funds for their programs, and to train multidisciplinary teams.

The SRCAC publishes a bi-annual newsletter "The Front Porch," a regional informational publication addressing the services and activities of the SRCAC as well as information regarding specific CACs. Updated conference and training information are also included.

The National Children's Advocacy Center has informally mentored new and emerging centers for over a decade on a volunteer basis. Building on this tradition, the SRCAC is pleased to offer the 1997 Mentoring Program. Limited funding has been made available by the U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime (OVC) to support a small formal mentoring program. The goal of this program is to provide assistance to communities working with the SRCAC who wish to establish a Children's Advocacy Center. We want to provide an opportunity for one or several members of a working committee to consult with and travel to an established full-member (NNCAC) center.

RCAC is accepting requests from community organizations wishing to serve as Training hosts. The SRCAC will provide customized training to developed and developing Children's Advocacy Centers. This training will directly enhance the ability of a community to establish and maintain a Children's Advocacy Center. The most important benefit SRCAC offers the training hosts is the opportunity to sponsor high-quality, low-cost training on developing, operating and working within children's advocacy center programs. SRCAC Training Faculty representing primary disciplines involved in child abuse cases are active practitioners in their field.

SRCAC will assist the host organization in developing various means of funding the costs. This can be accomplished within your community as well as with various contacts SRCAC may have with funders.

Suggested training topics:

Exploring Children's Advocacy Centers
What is a CAC? What do you need to get started? Where do you go from here?

Organizational Development
Collaboration, Planning, Board Development, Volunteer Management, Public Relations, Resource Development, Financial Management, Evaluation

Team Building
Team investigation of child abuse; Developing shared team purpose; Individual contribution; Enhancing team communication skills; Team functioning; Pulling the team together; Shared leadership; Team work skills; Conflict Management; Skill Building

For further information about our services or products, please contact either of the staff listed below.

Nancy O'Leary, Project Director
70 Woodfin Pl, Ste. 400
Asheville NC 28801
704-285-9588
704-285-9548 FAX
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MIDWEST REGIONAL CHILDREN'S ADVOCACY CENTER

located at La Rabida Children's Hospital & Research Center
East 65th at Lake Michigan, Chicago, Illinois 60649

Funded by the Office of Juvenile Justice and Delinquency Prevention, the Midwest Regional Children's Advocacy Center offers a full range of training, technical assistance, and resources to developing and already existing multidisciplinary teams in the investigation of child abuse and neglect. Training modules and technical consultation is offered both onsite at La Rabida and offsite within a 12-state Midwestern Regional that includes: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

The intent of our services is to assist new communities with program start-up and strengthen prospective multidisciplinary teams and child advocacy centers by supporting their passage through developmental stages. The goal of the intervention is to assure coordinated, child-friendly services to children and their families who are victims of abuse and neglect. Community and CAC needs addressed by the MRCAC may include such topics as:

- Conflict resolution/Team building
- Institutional and community barriers
- Interviewing training and skills development
- Professional roles clarification
- Physician training
- Law enforcement training
- Development of protocols and interagency agreements
- Establishment of funding streams
- Follow-up care and treatment
- Computer-based tracking and follow-up
- Multidisciplinary team case review

The MRCAC offers many different resources. If we do not have the information on hand, the MRCAC will direct you to possible sources. Resources may include but are not limited to:

- Sample interagency agreements, protocols, and policies
- Written material on research & issues related to multidisciplinary teams & CACs

Copies of the MRCAC's *Guidelines for Hospital-Based Collaborative Forensic Investigations of Child Sexual Abuse* can be ordered by calling the National Network of Children's Advocacy Centers at 1-800-239-9950.

The MRCAC offers quarterly Forensic Interviewing Training onsite at La Rabida. Look for announcement of this training in our next issue of our quarterly newsletter, *Footnotes*.

For more information, to be placed on our mailing list, or to request training and technical assistance, please call Diana Schoendorff or Fred Nirde at 1-888-422-2955.

NORTHEAST REGIONAL CHILDREN'S ADVOCACY CENTER

The NRCAC was established to foster and encourage the development of a collaborative multidisciplinary agency approach to child abuse intervention throughout the Northeastern United States. Activities include but are not limited to:

1.) Encouraging the development of Children's Advocacy Centers through educational and training programs that establish the need for multidisciplinary coordination of child abuse investigations.
2.) Establishing the capacity to help local groups determine the feasibility of establishing a CAC, remediating problems that inhibit the development of a CAC, and providing technical assistance to establish the CAC.
3.) Serving as a continuing source of support through technical assistance and training to CACs and others involved with abused children to provide high quality services to child victims, non-offending caretakers and families, and
4.) Working with the National Network of Children's Advocacy Centers and the Regional Children's Advocacy Centers to develop and coordinate the implementation of national standards of practice, as well as national models for providing training and technical assistance to CACs.

PRODUCTS AND SERVICES:

General Information Packets including:

* description of Children's Advocacy Centers including membership criteria
* articles/literature about benefits of inter-agency investigations
* sample protocols/inter-agency agreements from existing CACs
* description of products and services offered by the NNCAC and the NRCAC
* listing of Advisory Board Members in each state in the region
* copies of the National Network News and the Northeast Regional News

Children's Advocacy Center Development Materials including:

* Four-Step Methodology
* Fundraising Manual for Children's Advocacy Centers
* Resource library with books, manuals, videotapes

Training/Technical Assistance Mentoring:

The NRCAC holds annual regional training conferences designed to provide training on aspects of CAC development and specific skill building for the disciplines involved in child sexual abuse intervention. On-site community specific training/technical assistance programs are also designed to focus on the specific training needs of a developing or existing CAC. The Mentoring Program provides resources for developing CAC to visit an established CAC to foster ongoing mentoring relationships between established and emerging CACs to further the development of both. Services are available to communities in Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, Pennsylvania, and New Jersey. The NRCAC is located at 4000 Chestnut St., 2nd Fl., Philadelphia, PA 19104. For more information contact Anne Lynn, Project Director, at 1-800-662-4124 or by e-mail at nrcachq@ix.netcom.com

Avoiding Pitfalls in the Treatment of Victims of Abuse: From Research to Practice

Presented by

Toni C. Johnson, PhD

First Do No Harm
Pitfalls In The Clinical Treatment Of Child Sexual Abuse

Toni Cavanagh Johnson, Ph.D.
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South Pasadena, CA. 91030

1. There are differential effects of sexual abuse:

Jennifer L. Steel, Greg Wilson, Herb Cross, and James Whipple, Mediating Factors in the Development of Psychopathology in Victims of Childhood Sexual Abuse, *Sexual Abuse: A Journal of Research and Treatment*, vol. 8, no. 4, 1996, pp. 291-316

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2. Beware of the halo effect and self-fulfilling prophecies..

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3. There are four major categories of adaptations after being sexually abused:

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4 . "She was a victim." Beware. This has come to have a very negative connotation when applied to a mother who is supporting her child's allegations of abuse.

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Berliner Article Mothers who have been abused can experience PTSD when her child discloses abuse.

5. Differentiate between abuse and trauma. How many victims have PTSD?

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Carlson, Eve B., Furby, Lita, Armstrong, Judith, Shlaes, Jennifer (1997). A Conceptual Framework for the Long-Term Psychological Effects of Traumatic Childhood, Child Maltreatment, Journal of American Professional Society on the Abuse of Children, Volume 2, Number 3, August, pages 272-295.

6. Widen your scope, there are many bad things which happen to children. Don't focus on one type of abuse at a time and then attribute all of the effects to that form of abuse. Some of what we are attributing to sexual abuse is maternal/paternal loss, abandonment, emotional neglect, physical neglect, etc.

Daro, D. Current trends in child abuse reporting and fatalities: NCPCA's 1995 Annual Fifty-State Survey, *APSAC Advisor*, Vol. 9(2) Summer 1996

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7. Intergenerational transmission of physical abuse

Kaufman, J. & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry*, 57, 186-192.

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8. What percentage of sexual offenders were sexually abused as children?

Lorraine Waterhouse, Russell P. Dobash, James Carnie, Child Sexual Abusers, Scottish Office Central Research Unit, 1994

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Hanson, R. K. (1991). Characteristics of sex offenders who were sexually abused as children. In R. Langevin (Eds.), Sex Offenders and Their Victims Oakville, Ontario: Juniper Press.

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9. What percentage of sexual offenders were physically abused as children? What percentage of sexual offenders were sexually abused as children? Which is higher?

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14. Are we vulnerable to overinterpretation? How vulnerable? How can we counteract it, if it is happening?

Hoarding/Eating Disorders/Boredom
Anal penetration and constipation
"Nobody believes me."
"I hate him."

15. Sex Offenders

Two recent studies of thousands of sex offenders found current treatments to be highly effective - especially treatment for child molesters. Post-treatment relapse rates cited by a study sponsored by the Ministry of the Solicitor General of Canada were 12.7% and by a Wisconsin Department of Corrections study were less than 11%.
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Sexually Transmitted Diseases

Update

Presented by

David Muram, MD

The diagnosis of a sexually transmissible disease (STD) is fortunately a rare occurrence in childhood. Most survey studies estimate the incidence of STDs in children to be 1-5%. Generally, if the child is asymptomatic prophylactic antibiotic therapy is not necessary. The low prevalence and the minimal risk for upper genital tract disease allows the practitioner to await culture results prior to instituting treatment, so that optimal therapy can be instituted. The purpose of this handout is to provide the clinician with a brief overview of the distinctive aspects of STDs as they relate to the medical evaluation of child victims of abuse. (White & al 1983, Sweet & Gibbs,1990, Neinstein & al. 1984, Ingram DL, 1990).

Gonorrhea

Beyond the neonatal period, sexual contact is nearly the exclusive cause of gonococcal infections in children. (Sweet & Gibbs, 1990, Ingram DL, 1990). A question of fomite transmission was raised, but never identified. There is only one documented case of an identified fomite transmitting *N. gonorrhea* to a child. The most commonly infected sites are the vagina, rectum, pharynx and conjunctiva. The vaginal epithelium of the prepubertal child may be infected if exposed to this organism. The absence of endocervical glands on the ectocervix of the prepubertal child makes the cervix more resistant to infection, and ascending genital tract infection with *N. gonorrhea* is rare in children. Most children with genital infections exhibit signs of vulvo-vaginitis. Therefore, the yield from GC cultures obtained from asymptomatic children is extremely low. (Muram & al. 1996).

Selective cultures are required to establish the diagnosis of *N. gonorrhea*. If a nonselective media is used, confirmation of N. *gonorrhea* is necessary, using methods such as carbohydrate degradation, enzyme substrate or immunologic testing. It is also recommended that isolates obtained from children be stored at -70o Celsius for additional confirmatory testing, should this be needed at a later date.

The use of indirect testing methods for *N. gonorrhea* is not recommended in children; both false positive and false negative tests have been reported with monoclonal antibody and direct fluorescent antibody testing methods prior to adolescence. However, DNA probes for *N. gonorrhea* may prove useful once clinical trials in children are completed.

The Centers for Disease Control (CDC) recommends the use of ceftriaxone in children with gonococcal infections. Children weighing more than 45 kg are treated as adults, and children weighing less than 45 kg with uncomplicated infection (vulvovaginitis, urethritis, pharyngitis, or proctitis) may be treated with a single, 125 mg intramuscular dose of ceftriaxone. Spectinomycin 40 mg/kg may be used intramuscularly in children who cannot tolerate ceftriaxone. It is recommended that children over 8 years of age also receive a 7-day course of doxycycline. Children with complicated gonococcal infections (conjunctivitis, peritonitis, arthritis or meningitis) should be given a more prolonged course of parenteral ceftriaxone. Follow-up cultures after treatment are important to document cure.

Because of the relatively high association of infection with *N. gonorrhea* and *C. trachomatis in* children, coverage for *C. trachomatis* should be included in treatment for children with gonococcal infection if chlamydial cultures are not available. After treatment, reevaluation should include a test of cure.

Chlamydia trachomatis

The primary modes of transmission of *C. trachomatis* involve direct contact, rather than fomite transmission. Concomitant infection with *C. trachomatis* and *N. gonorrhea* is fairly common. At birth, the neonate may be inoculated by contact with infected secretions. Vertical transmission at the time of cesarean section performed after the rupture of membranes has also been reported. (Mulchahey 1994, Sweet & Gibbs, 1990).

Infection of the genital tract is the most common presentation in children beyond infancy. The "atrophic," unestrogenized vaginal epithelium may be directly infected with the organism, causing a true vaginitis. However, asymptomatic colonization of the genital tract may occur in up to 60% of children. Perinatal exposure may also result in colonization of the vagina and rectum. Longitudinal studies of infants exposed to *C. trachomatis* at birth have shown carriage of the organism up to 55 weeks in the rectum and 53 weeks in the vagina. A more recent study has demonstrated rectal colonization up to two years of age after prenatal exposure. In these studies, the vast majority of the infants were asymptomatic.

Cell culture, using a monolayer of susceptible cells, e.g., McCoy cells, is regarded as the optimal method. Because this organism is intracellular, it is important to obtain epithelial cells for the

culture, rather than simply culturing any discharge that is present. In prepubertal children, a careful vaginal or urethral culture is necessary. The use of an adequate growth and/or transport media is also important. Urethral swabs of calcium alginate are often useful in obtaining cultures from children because of their small diameter. When the cultures grow *C. trachomatis*, freezing of the organism at -70o C is suggested for future forensic confirmation.

Antigen detection testing, e.g., Microtrak, Chlamydiazyme, has become increasingly popular in response to the expense and limited availability of cell cultures for *C. trachomatis*. The CDC recommends against the use of these testing methods in prepubertal children. The low prevalence of *C. trachomatis* infection in sexually abused children and the need to test anatomic sites other than the cervix and urethra contribute to unacceptable sensitivity and specificity rates. Up to 50% false positive and false negative rates have been reported with the use of antigen detection methods in children.

Erythromycin is the treatment of choice for genital chlamydial infections in children eight years and younger. Tetracycline is recommended for children more than eight years of age. *C. trachomatis* is also susceptible to sulfonamides and trimethoprim. However, this antibiotic had not been widely used because of its lack of activity against other sexually transmitted diseases.

Syphilis

Except is rare situations, syphilis in a child beyond the neonatal period will be acquired through sexual contact. Fortunately, this is one of the least common STDs noted among sexually abused children. Accidental transmission in laboratory accidents and during surgery on infected

individuals has been described. Transmission during transfusion of blood, by contact with syphilitic lesions on the breast of a nursing mother, and by "nonsexual" kissing have all been described; however, these forms of transmission are very rare. (Mulchahey 1994, Sweet & Gibbs, 1990).

The CDC currently recommends that CSF samples be obtained on children to rule out congenital syphilis. They recommend that any child with congenital syphilis or evidence of neurologic involvement be treated with aqueous crystalline penicillin G (200,000 - 300,000 units per kilogram per day) for ten to fourteen days. If congenital and neurosyphilis can be ruled out, children may be treated with 50,000 units/kilogram of intramuscular benzathine penicillin, not to exceed the dose on 2.4 million units administered to adults.

Genital herpes

Herpes simplex virus is transmitted by close contact with an individual who is shedding the virus, with the virus entering mucosal surfaces through an epithelial break. Genital herpes lesions, caused by both HSV 1 and 2, have been reported in children. Transmission by sexual contact is the most common source of childhood genital herpes. Autoinnoculation from nongenital lesions has been documented as a source of genital herpes during childhood. Causal transmission and fomite transmission have not been documented. (Mulchahey 1994, Sweet & Gibbs, 1990).

The diagnosis of genital herpes in a child is made by viral culture of suspicious lesions. However, false positive cultures may occur in children with herpes zoster due to the similar cytopathic effects of herpes simplex and herpes zoster in cell culture. For that reason, it is recommended that

positive herpes cultures in children be subjected to confirmatory testing. False negative cultures may occur if specimens are obtained from lesions with decreased viral shedding, such as recurrent lesions or those, which are ulcerated or crusted. Antigen detection testing has not been evaluated in children and is not recommended.

There are no treatment guidelines for children with genital herpes infection. Acyclovir has been demonstrated in adults to be effective for the treatment of primary herpes and suppressive treatment of secondary lesions.[56] Since thetheraputic safety of acyclovir during childhood has been demonstrated with neonatal herpes simplex and childhood herpes zoster, some clinicians will treat children with genital herpes. Others prefer to use symptomatic treatment of the genital lesions with local care, sitz baths, and drying agents. Bacterial superinfection is uncommon, however, when present may require antibiotic therapy.

Condyloma acuminata

In recent years there was a dramatic increase in the number of clinical cases of HPV. Vertical transmission at birth, casual transmission, and sexual transmission have all been implicated as possible means of infection in children with HPV. As the incubation period in children is up to 20 months, the majority of presumed perinatally transmitted HPV cases have been reported in children less than two years of age. Sexual transmission is likely to occur in older children. In series excluding children under 2 years of age, sexual transmission was documented in as many as 90% of the children evaluated. (Mulchahey 1994, Sweet & Gibbs, 1990).

Prepubertal children are more likely to present with periurethral and perianal condylomata. Studies examining the upper genital tract of prepubertal girls for the presence of HPV lesions have shown this to be unusual. However, HPV lesions are often present in the anal canal.

The diagnosis of genital condyloma acuminata in children is often established by careful clinical inspection. The application of 3-5% acetic acid on a compress for 10-15 minutes may elicit the classic acetowhite appearance of condyloma. Biopsy may be indicated in cases were the diagnosis is in question. Recent series have examined the role of DNA typing in the assessment of pediatric genital condyloma. HPV 6/11 are most commonly reported, with occasional reports of HPV 2. The clinical usefulness of HPV typing of pediatric lesions however, is not clearly defined.

Although spontaneous regression of condyloma has been described, it is not recommended as a treatment of choice in children. Podophyllin is widely available as a 20-25% solution with tincture of benzoin, which has been used in the pediatric age group. It has been suggested that more dilute solutions of podophylline, e.g., 5-15%, may be more appropriate for use in children.[96] The therapeutic value of all topical agents is limited by the discomfort or actual pain involved in their use. An older child with a few condylomas may tolerate these treatment modalities well. However, in children with more extensive disease, the usefulness of topical agents will be limited. There are no long-term studies of effectiveness in the use of Interferon in children with genital condyloma. It has been used only sporadically for the treatment of genital HPV in children.

The use of the carbon dioxide (CO2) laser has become increasingly popular in the treatment of genital condyloma. It allows control over depth of tissue destruction and avoids much of the

scarring associated with electrosurgery. The CO_2 laser may also be used to treat lesions in the periurethral and perianal area, as well as in the anal canal, where other modalities are more difficult to use. Recovery is well tolerated by the children. Even so, recurrence rate of almost 30% has been reported.

Trichomoniasis

The single cell protozoa, *Trichomonas vaginalis*, is an uncommon finding in prepubertal children beyond the neonatal period. In this period of life, the organism is a relatively common cause of vaginitis. However, the unestrogenized is relatively resistent to infection and colonization with this organism. The urinary tract may be the primary source of infection, and the protozoa may be seen on urinalysis.

When symptomatic, girls usually present with a copious froth discharge, which is often described as yellow-gray in color. There are often accompanying complaints of vulvar pruritus and dysuria. Since the prepubertal vagina is less likely to support the growth of this organism,

The possible roles of fomite transmission and acquisition by nonsexual contact are unclear but appear unlikely. Sexual contact is the most common mode of infection in children. However, the organism is not commonly seen even among victims of sexual abuse. In one series, the organism was found in only 1% of sexually abused girls.

Diagnosis of trichomoniasis is usually made by the appearance of the motile organism on a wet prep of secretions. At higher levels of magnification, the flagellum of the organism may be visualized. Significant numbers of leukocytes often accompany the organism,

making careful inspection of the wet prep important. Culture of the organism is both more sensitive and specific in making the diagnosis but not widely available or used.

Children who require treatment, may be given metronidazole in three divided doses of 15 mg/kg/day (maximum dose 250 mg) for seven days. The use of single dose treatment, as frequently used in adulthood, has not been evaluated in children.

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Legal Pitfalls and Perceptual Errors in Forensic Interviewing

Presented by

Kee MacFarlane, MSW and
Melissa Steinmetz, ACSW

Categories of Current Legal Controversy

(Legal Bulls Eyes)

1. Ability/Competency of Interviewer

- **a. Education**
- **b. Training**
- **c. Experience**

2. Competency of Child

- **a. Memory**
- **b. Suggestibility**
- **c. Emotional Stability**

3. Subsequent Conclusion and Interpretations

- **a. Supported by findings?**
- **b. Supported by research literature?**
- **c. Supported by opposing expert?**

MINIMIZING INTERVIEWER CRITICISM
(Reducing The Size Of The Bulls-Eye)

Leading Questions

Funnel Approach; don't narrow down too quickly

Don't ask for particular answers

Use "W" words (interrogatories); avoid "Did" questions

Get child to introduce possible "abuse identifiers", i.e. alleged perpetrator's name, location of abuse, etc. during a 'safe' stage of interview,

Avoid forced-choice options

Suggestion

Test level of suggestibility early on

Do Childrens Rules

Don't assume; Don't imply

Put prior information into questions, not statements; i.e. "Was someone else there? Did anyone else see what happened?"

Contamination

Don't interview kids together

Don't relay information from prior interviews or repeat specifics of what you've been told by others

Don't move from general to specifics too quickly

Don't put witnesses from same case (even siblings) together (in therapy, in waiting room or court hallway alone)

Reinforcement

Be consistent with praise; choose an affirmative response and stick with it

Avoid bribing "After we talk, then you can play"; avoid bargaining("I'll do X if you'll answer my question"), ("I'm here to help you...")

Don't only respond, perk up to abuse and details and then lose interest to other data

Watch your face and body language (nodding responses, etc.)

Pacing: Don't pummel with questions, especially in relation to a particular topic

No promises: "You'll feel better if you talk....."

Coercion

Decrease differences between you; empower child

Don't use voice or size to intimidate

Don't put parents in room (if possible)

Don't do rapid-fire questioning; leave silence, create dialogue

Repetitive Questions

Own them to the child; give disclaimer (want to make sure....

Be deliberate; be able to defend your work; ask again with consistency; space questions apart; change order

Blueprint for Annual Giving

Presented by

Sharon J. Porier

14th National Symposium on Child Sexual Abuse

March 17-20, 1998

"Children's Advocacy Centers and the Annual Fund: The Base From Which the Pyramid Grows"

Thursday, March 19, 1998

Presenter: **Sharon J. Porier**
Development Director
The National Children's Advocacy Center
Huntsville, Alabama

I. Philanthropy and Giving In the United States

A. Long history of philanthropic support of social services

B. Current Giving statistics - 1996 total - $150.70 billion

C. Constituencies for Giving

D. What donors look for in an organization

E. Giving Behavior

1. Why people give
2. Why people don't give

II. The Components of a Fund Raising Program

A. Annual Giving

1. annual giving drive
2. special events
3. groups, guilds and support organizations
4. membership programs (acquisition and renewal)
5. direct mail
6. grants
7. federated giving groups
8. Memorial and holiday gifts

B. Major Gifts

1. endowment campaigns
2. special campaigns
3. major gifts from individuals
4. major gifts from Corporations and Foundations

C. Planned Giving

1. Bequests
2. Planned gifts

D. Capital Campaigns

III. Laying the Groundwork for a Fund Raising Program - Creating a Development Plan

A. The Case Statement - written

B. The Strategic Plan - Calendar Year Organization
   1. Budget needs and development costs
   2. Goals
   3. Fund Raising Options
   4. Staff and Volunteer capacity

IV. The Comprehensive Annual Giving Program

A. Definition and Purpose of Annual Giving

B. Synergy - Synergistic Fund Raising

C. The Components of Annual Giving
   1. Special Events
      a. Agency Driven Events
      b. Community Driven Events
      c. Tips for Events
   2. Federated Giving Programs
   3. Grants
      a. Federal, state, and local government
      b. Local and national foundations
   4. Corporate Donors
      a. Employee Giving Groups
      b. Corporate Giving Offices
      c. Corporate Sponsorships and Marketing
   5. Memorial and Holiday Giving Programs
   6. Groups, Guilds and Support Organizations
   7. Direct Mail
   8. Membership Program

V. Membership Program

A. Types of Membership

B. Why have a membership program?

C. Important Facts to remember:

D. Strategic Membership Plan

1. The Goal
2. Levels of Membership
3. The Budget
   a. What do you need?
   b. What do you have?
   c. Records
4. Publications
   a. What do you need?
   b. Design and Printing
5. Publicity Plan
6. Staff and Board Drives
7. The Committee or "Team"
8. Schedule of Events
   a. The Staff and Board Membership Drive
   b. Volunteer Luncheon
   c. Drive Kick-off
      Overcoming the Fears of Asking
      Five Steps to Handling Objections
9. Who to ask

10. **Record keeping**

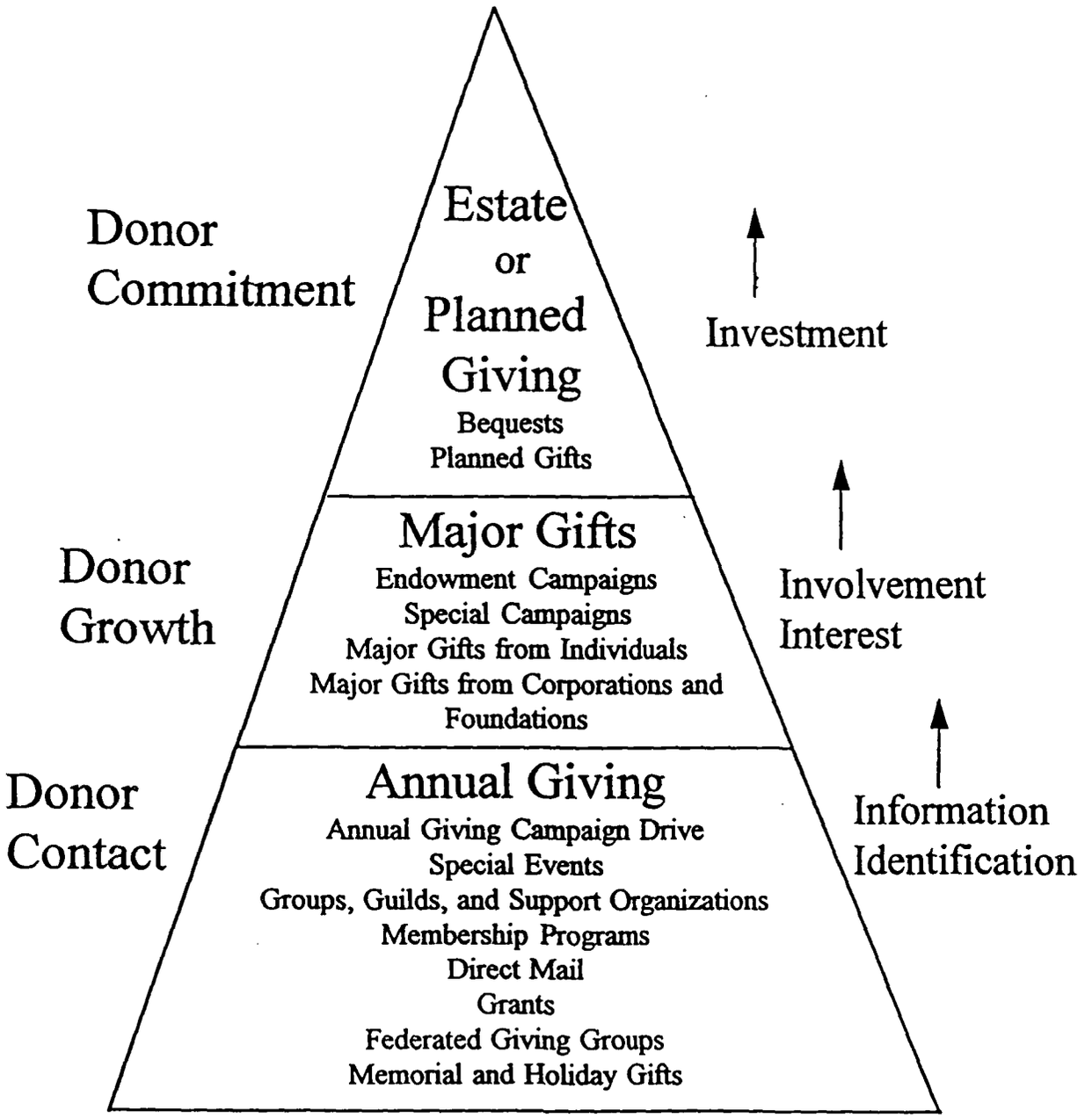
E. **Benefits of Membership**
   1. **What do you have to entice members?**
   2. **Use the cause**

F. **Acknowledgment System**
   1. **Facts about Donor Acknowledgment**
   2. **Materials for Acknowledgment**
   3. **Acquiring, Retaining and Cultivating Donors**
   4. **Keeping Your Donors**

VI. **Performance Analysis**

VII. **Conclusion**

The Pyramid of Giving



Characteristics of Your Organization

List the Selling Points of Your Agency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Divide Them Into Most and Least Important Categories

Most	Least

A Checklist of Reminders When Asking for Membership Gifts

1. Be a good listener, as well as presenter.

2. Be yourself.

3. Ask for a gift in a particular range and ask for enough.

4. Remain positive throughout the entire meeting with the prospect.

5. Make sure that you have given your own gift before asking someone else.

6. Know your prospect and do your homework!

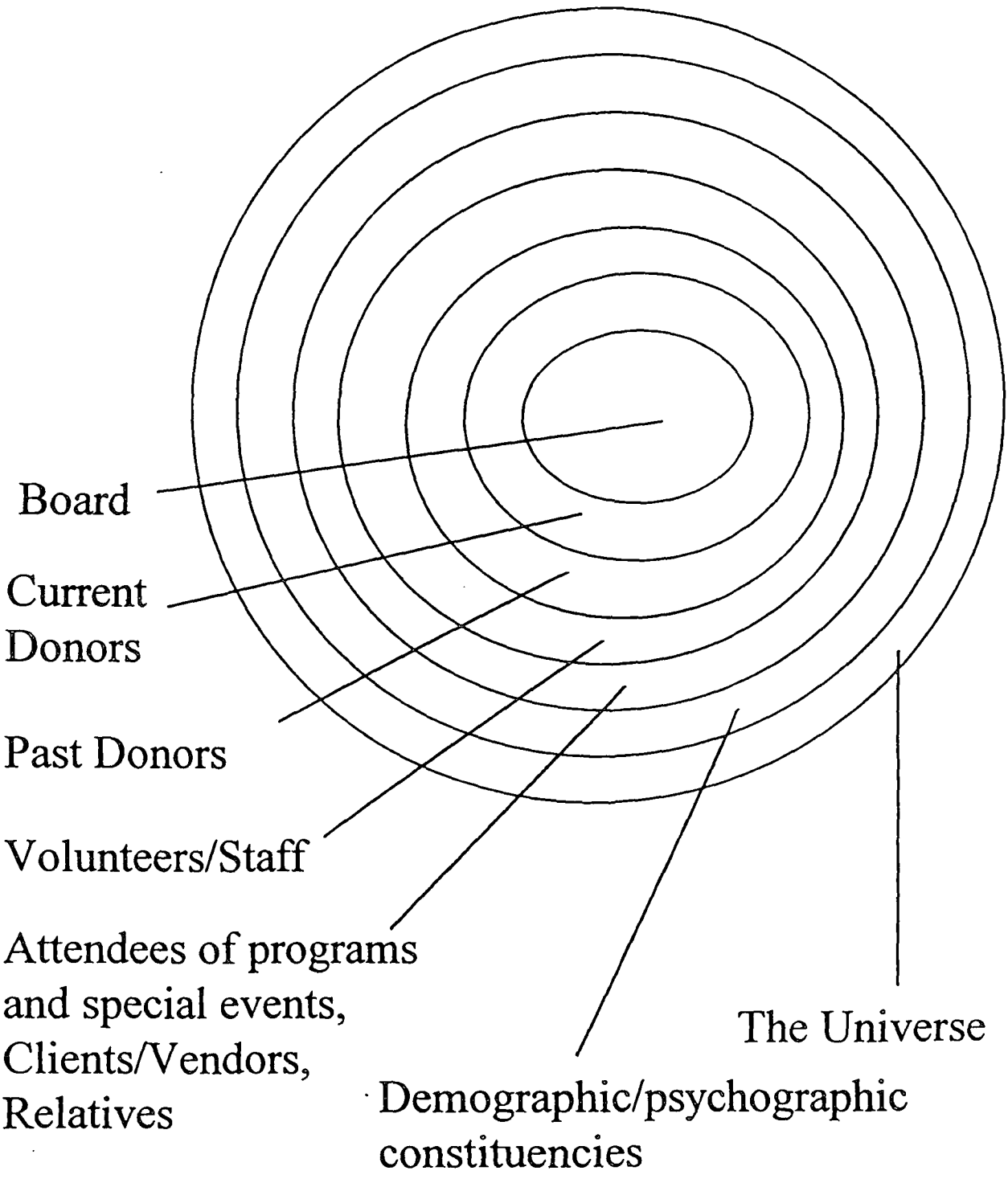
7. Match your presentation to the donor's interests.

8. Anticipate the prospect's objections and be prepared with answers.

9. Leave a written proposal as a record of your request.

10. Use knowledge to reduce the fear of asking for money.

The Best Prospects



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Periodicals

The Chronicle of Philanthropy

NonProfit Times

Fund Raising Management

Grantsmanship Center Magazine

Contributions

New Directions for Philanthropic Fundraising

Nonprofit Management and Leadership

Organizations

Grantsmanship Center
P.O. Box 6210
Los Angeles, CA 90014

Independent Sector
1828 L Street NW, Suite 1200
Washington, D.C. 20036

Indiana University Center on Philanthropy - The Fund Raising School
550 West North Street, Suite 301
Indianapolis, IN 46204

National Center for Non-profit Boards
2000 L Street NW, Suite 411
Washington, D.C. 20036

National Society of Fund Raising Executives
1101 King Street, Suite 3000
Alexandria, VA 22314
1-800-666-3863

Effective Cross-Examination Strategies in Child Abuse Cases

Presented by

Brian K. Holmgren, JD

EFFECTIVE CROSS-EXAMINATION STRATEGIES IN CHILD MALTREATMENT CASES

Presented by: Brian K. Holmgren, Senior Attorney
American Prosecutors Research Institute's
National Center for Prosecution of Child Abuse

I. INTRODUCTION

Prosecutors have the responsibility to present evidence because we carry the burden of proof. Cross-examination is often considered less significant to the prosecution's case than to the defense case, in part because we so rarely get to do it. In most criminal cases, defense lawyers are loathe to put their clients on the stand. However, in crimes against children, defendants, character witnesses and defense experts seem to testify more often. There may be several reasons for this phenomenon, but chief among them are the defendant's need to deny guilt, the perception that if the defendant testifies the jury will see the issue as a child's word against an adult's, and the ability to cloud the issue by presenting conflicting expert testimony. Consequently, cross-examination is an important trial skill in these cases. We can improve our skill by watching defense attorneys, reading, and by trying cases. As in all phases of trial practice, we must remain true to ourselves. Cross-examination poses unique challenges. Prosecutors must be in control at all times, remain flexible to the dictates of the case and the different challenges each witness poses, and be willing to take the occasional risk. Experienced trial attorneys appreciate that cross-examination is a blend of science and art. The prosecutor who masters the basic knowledge of the "how to" of cross-examination, and uses this to develop an individualized and creative style will enjoy greater success in the courtroom, and have fun in the process.

A. BASIC SKILLS

1. Preparation
2. Listening to the witness' testimony and responses
3. Assessment of the witness' direct testimony
4. Assessment of the witness' personality
5. Alignment
6. Questioning formats and tones
7. Control over the witness
8 Plan of attack
9. Transitions and headliners
10. Patience, pace and finesse
11. Incorporating visuals
12. Confidence

II. PREPARE CROSS-EXAMINATION IN ADVANCE

A. ANTICIPATE THE DEFENSE

1. If you know the defense, investigate it.

2. Listen for clues to the defense during pre-trial motion hearings, plea negotiations, discussions with opposing counsel, and opening statements.

3. **Listen** to the testimony of witnesses, both on direct and during cross, for clues to the possible defense.

4. Carefully review any statements made by the defendant or his witnesses.

5. Examine weaknesses in your case and anticipate that they may be the focus of a defense attack supported by possible expert testimony.

6. Determine if witnesses have been questioned by opposing counsel and what was discussed which might indicate potential defense strategies.

B. DO YOUR HOMEWORK. INVESTIGATE THE DEFENDANT AND WITNESSES

1. Interview everybody. Obtain written statements whenever possible.

2. Check the defendant's or witness' prior record. Review any closed files or current cases your office is investigating or prosecuting that involve the defendant, or a defense witness including those where they are only a witness, or are the victim.

3. Obtain documentation necessary to prove prior convictions.

4. Check pre-sentence reports; application for a court appointed attorney; Bureau of Identification records; jail visitation records; all police reports ever filed on the defendant/witness; and the defendant's bond application.

5. If your jurisdiction requires reciprocal discovery, depose any listed defense witness and have those depositions transcribed.

6. Determine prior contacts with the defendant, his family, his attorney.

C. PREPARATION FOR EXPERTS

1. See generally, Stern, P. (1997). *Preparing and Presenting Expert Testimony in Child Abuse Litigation: A Guide for Expert Witnesses and Attorneys*. Thousand Oaks, CA: Sage; DerOhannesian, P. (1995), *Sexual Assault Trials*. Michie Co., Charlottesville, VA; Myers, J.E.B., *Evidence in Child Abuse and Neglect Cases*, (3rd ed. 1997), Wiley Law. (See also Holmgren, *Notes on Expert Witnesses*, detailing additional references, arguments and explanations for the materials presented throughout this Outline; Holmgren, *Cross-Examination of Expert Witnesses on Children's Suggestibility*. Available from the National Center for Prosecution of Child Abuse)

2. Determine if a defense expert will be called in the case. Speak with the defense attorney and ask them if they will be calling an expert. Then file a discovery demand and/or pretrial motion for the disclosure of any potential defense expert witnesses. See the Federal Rules of Evidence (FRE) 702-706 and the Notes accompanying those Rules. See also Federal Rules of Criminal Procedure16[b][1][C]. Occasionally, information on the identity of defense experts is not obtainable. However, there may be records which can lead to the discovery of such experts. For example, if the defendant is indigent, there may be an order or motion in the court file seeking appointment of an expert. There may also be a copy of a subpoena for an expert. If your jurisdiction permits reciprocal discovery and/or depositions, take advantage of this opportunity to find out who the defense expert will be, obtain all discoverable materials from them, and depose them. These should include but not necessarily be limited to:

   a. Current CV

   b. Articles authored, including those published, submitted for publication, and rejected

   c. Prior cases in which the expert has testified or been precluded from testifying

   d. List of presentations the expert has given

   e. Copies of solicitations or advertisements for services as an expert

3. Interview everybody that may be called as a witness and/or used to provide foundational support for the expert's opinions. Call the expert and ask to speak with them about the substance of their proposed testimony, and their past experience as an expert. If the expert refuses to talk with you, this can be brought up during cross.

4. Conduct a background check on the expert through Lexis-Nexis to see where they have testified before, and any articles they may have written. Ask the expert to provide this information if it is not set out in his/her CV or if it is not otherwise discoverable. Contact the prosecutors in any jurisdictions where the expert has testified and speak with them about their knowledge of the expert, prior subject matters of testimony, vulnerabilities and strategies, etc. Contact the National Center for Prosecution of Child Abuse to see if they have information on the expert including transcripts of prior testimony. Attempt to verify or impeach any information included on the expert's CV, especially information relating to the expert's credentials and licensing. Inquiry should be made into any civil suits filed against the expert, any ethics complaints or professional grievances filed, etc.

5. Occasionally the expert will have a prior criminal record and this area of inquiry should not be ignored just because the person is an expert. Determine the admissibility of this type of impeachment evidence pursuant to the rules in your jurisdiction. It will often be advisable to seek a pre-trial ruling on this issue. Bringing a successful motion to impeach the expert using a prior conviction may cause the expert to withdraw from the case, or prompt the defense to choose not to use the expert.

6. Determine the extent of the expert's prior contacts with the defendant, his family, and his attorney. This may be learned from personally speaking with the expert, and also from examining jail visitation records, billing records from the expert, and other documentation. This type of information will let you know how much time the expert has spent on the case, how thoroughly he has prepared, and the sources for information the expert may be relying on.

7. Obtain and read the writings of the expert. These are often a fruitful area for cross either because the expert has written something contrary to what he's offering as his opinion, or because the expert's writings bear no relation to the topic at hand. The absence of prior writings on the subject is also a fruitful area for undercutting the expert's expertise. Additionally, the writings may have been subjected to criticism by other professionals in other publications. If the expert has authored an article which has been published without peer review, this can be brought out. Similarly, if an expert's article(s) on the topic of testimony has been rejected for publication, this can be inquired into to demonstrate that the expert's opinions were not shared by other professionals. Of course some publication decisions such as law review articles may be made by individuals with less knowledge on the topic than the expert, or rejected for reasons other than the quality of the article.

8. Know the field. Review relevant law review and scientific articles dealing with the topic. Consult with your expert and other experts regarding the topic matter so that you are well informed and can ask appropriate and intelligent questions. Understand the methodology and significance of data reported in research likely to be used by the expert.

9. Obtain relevant and helpful learned treatises. These will form the basis for potential cross-examination questions of the defense expert in the event his testimony deviates from the general scientific literature. The expert should be asked if they acknowledge the authority of the treatise and if they do not under Rule 803(18) the cross-examiner may have to establish the treatise's authority through its own expert. Even if the expert does not acknowledge the authority, the expert can be asked if other professionals rely on the treatise, cite it, etc. Some evidentiary statutes, discovery rules and local practices require pre-trial notification of intent to rely on learned treatises. If such notification is not required, the prosecutor must make a strategic decision about whether he or she will disclose this information to the defense and the expert prior to trial, or wait to confront the expert at trial. Disclosure may reign in the expert's testimony because they know you know the subject area. It may also alert the defense to the weakness of their expert's position prompting them to rethink using the expert, or their position on negotiating the case for plea resolution. However, disclosure gives up the element of surprise at trial and allows the defense and the expert to prepare explanations to distinguish or explain the impact of the treatise.

D. QUESTION THE NEED FOR EXPERT TESTIMONY

1. Evaluate the proposed expert testimony under your jurisdiction's standards for admissibility of expert testimony (*Frye*, *Daubert*, FRE). Bring motions to preclude or limit expert testimony. The five *Daubert* criteria can be an effective outline for cross-examination of the expert prior to testimony

before the jury (voir dire). These include:

a. Whether the theory or technique has been tested

b. Whether the theory or technique has a known error rate and what it is

c. Whether there are standards controlling the technique's operation

d. Whether the theory or technique has been subjected to peer review and published

e. Whether the theory or technique is generally accepted in the relevant scientific community

If the expert is purporting to testify regarding a "syndrome", consideration should be given to whether the syndrome is scientifically valid or diagnostic. For example, the American Psychological Association does not recognize the Battered Woman Syndrome as a mental disorder. The Parental Alienation Syndrome of Richard Gardner has been referred to by one child abuse professional as "[p]robably the most unscientific piece of garbage I've seen in the field in all my time." The "False Memory Syndrome" has no diagnostic criteria which have been subjected to empirical testing. Obtain a copy of DSM-IV for your office and reference this treatise whenever experts purport to offer testimony on a "syndrome".

2. Expert not needed in this area because subject matter is understood by jury

3. More prejudicial than probative

4. Use of court appointed experts vs. expert retained by litigant

5. Prior reported decisions and cases in which the expert has been excluded

6. Attack credentials (is this really an expert). Consult with other experts to determine the credentials a true expert should have, and other credentials a highly qualified expert will have. Establish this expert's qualifications don't measure up.

   a. Degrees, specialized training, board certifications, licensure, continuing education. Just because the expert has a Ph.D. or M.D. does not necessarily mean they are qualified as an expert in a specialized field of knowledge. The background check should already have revealed information on these areas which can then be used to try to exclude the expert on the basis of their qualifications, or to impeach them during cross-examination by showing their educational background, professional licensing or areas of practice and continuing professional education have little or no relationship to the topic they are testifying on.

   b. Practical experience in field including clinical and research experience and teaching experience. Specialized knowledge or expertise can be used to qualify an expert independent of the criteria in (a) above. However, the absence of expertise gained from practical experience can undermine the expert's qualifications even

though they satisfy these educational and licensing criteria.

c. Writings and publications, topic areas consistent with expert's testimony, peer reviewed publications, participation on editorial boards, etc.

d. Membership in professional organizations.

e. Absences from practice in field for time periods and reasons for this, e.g. termination, revocation of license, etc.

7. Voir dire of expert to establish parameters for testimony.

a. Establish permissible/impermissible opinions.

b. Ensure warnings are given by the court regarding sanctions for failure to follow court's rulings.

8. Don't permit the expert to comment on the defendant's mental state. See FRE 704(b).

9. Is there an adequate foundation for the expert's testimony independent of inadmissible evidence. See *People v. Wernick*, 674 N.E.2d 322 (N.Y. 1996), FRE 705 and discussion of this case and the evidentiary rule in *Notes on Expert Witnesses*.

E. MAP OUT A STRATEGY

1. What type of witness is it? Is it an eye-witness, an "alibi" witness, an expert witness, a character witness, a mother, a child, a clergy-person?

2. What is your objective for the cross-examination?

3. Primacy and recency principles should be considered.

4. Menu of cross-examination topics to choose from.

a. Relationship to the case - how did the witness or expert become involved.

b. Bias. Most people testify for love, money or family. Experts commonly testify for money, professional exposure, or because they have a personal or professional agenda.

c. Explore knowledge or lack of knowledge of facts and participation in events.

d. Helping your side - establishing areas of agreement.

e. Comparing versions between witnesses.

f. Opinion inconsistent with scientific literature.

g. Concluding questions that leave a lasting impression. (Prior conviction, financial interest or hired gun, prior termination from professional employment, failure to come forward or discuss case earlier, violation of ethical standards of profession, etc.)

5. Make sure that any necessary foundation or exhibits necessary for cross of the witness or expert have been introduced in evidence during the case in chief. For example, if you want to cross-examine a defense medical expert using photographs of the victim's injuries, make sure those photographs have been previously introduced by the state's expert or the person who took them. If you need to cross-examine on a prior statement, that statement should be identified earlier as an exhibit by the person who took it.

F. ALIGNMENT

1. How and with whom will you align yourself on cross?
2. With the judge's values, expectations and prior rulings?
3. With the witness?
4. With your expectations of the juror's sentiments and reactions?
5. Perceptions of fairness.
6. Courtesy vs. conflict.
7. Gender issues.

G. ASSESS THE WITNESS' TESTIMONY

1. Resist the temptation to cross.
2. Did this witness hurt me?
3. Do I need to cross-examine?
4. What can I hope to gain by cross-examining?
5. What are the risks from cross-examining?
6. What is the witness' motive and allegiance in testifying?
   a. Is there a financial motivation for the witness' testimony or the expert's opinion?
   b. Is there an apparent agenda or motivation for the expert's opinion?
   c. Is the expert routinely testifying only for the defense?
   d. Is the expert an advocate or an objective assessor of facts?
   e. How did the witness become involved in the case, volunteer, subpoena, observation of incident, hired, etc.?

f. Is the witness a friend, family member, co-conspirator, character witness, etc?

7. What is the personality and style of the witness, and how can that help me or hurt me?

8. Is the expert's ego apparent to the jury?

H. Listen To The Witnesses' Responses On Direct And Cross

1. What was said and what was not said.

2. Visualize the responses to create a story.

3. Look for the gaps in the storyline.

4. Cross-examination is a conversation, not a script. The witness' response should lead into the next question.

5. Identify the expert's opinions.

   a. Is the opinion reasonable?

   b. If the opinion is not reasonable does it nevertheless appear plausible to the jury?

   c. Simply because the expert's opinion is different than your own does not mean the expert is wrong - reevaluate your own opinion or your expert's.

III. OBJECTIVES OF CROSS-EXAMINATION

There are three main objectives of cross-examination:

A. Objective: Enhance And Support Your Case

Have the witness corroborate as much of your case as possible. Use the defendant and other defense witnesses to bolster the victim's credibility.

1. Victim has **no motive** to fabricate.

   Example: Defendant testifies he had "great" relationship with victim.

2. Victim is generally credible.

   Example: Defendant agrees with victim on surrounding circumstances.

3. Defendant had the **opportunity** to commit the crime.

   Example: Defendant agrees he was alone with victim.

4. Defendant in a position of trust and authority with victim.

Example: Defendant agrees victim generally followed his instructions, obeyed him.

5. Have the expert corroborate as much of your case as possible.

6. Get defense expert to agree with as much of your expert's opinions as possible.

   Example: Can we agree Doctor that this child had retinal hemorrhages? And those are commonly associated with Shaken Baby or Shaken Impact Syndrome?

   Example: Doctor you're familiar with the report of Dr. J., do you agree with any of his conclusions? Which ones?

B. OBJECTIVE: DEMONSTRATE THE UNREASONABLENESS OF THE DEFENSE

1. Incorporate **physical evidence, demonstrative evidence** and **visual aides** to show how ridiculous the defense really is.

   Example: Use time line charts to illustrate defendant's access to child during relevant time, charts showing defendant's or witnesses changing or conflicting versions.

   Example: Defendant testifies "we were wrestling" - use his size to demonstrate unreasonableness of defense.

   Example: Defendant claims touching was for medical purposes, use models, demonstrate masturbatory nature of touching.

   Example: Defendant claims victim fell off a piece of furniture and injured self, bring in furniture item to show height, or picture of flooring to illustrate surface.

   Example: Have defendant demonstrate for jury how he "accidentally dropped" victim, force used to spank child, or manner of shaking child.

   Example: Question witness about whether defendant demonstrated how he "accidentally dropped" victim, the force used to spank child, or his manner of shaking child. Be careful of potential fifth amendment issues with this line of inquiry.

   Example: Recovered pornography that defendant showed child or patterned his behavior after.

   Example: Have defendant identify injuries he was personally responsible for causing from photos.

   Example: Crime scene photographs and diagrams that impeach the defendant's account of the incident.

   Example: Have expert illustrate mechanism(s) they claim could produce all of the injuries.

Remember the smallest seeds hold the greatest truths.

2. Use **common sense** and your imagination to expose the defense.

Example: Defendant testifies he was "never alone" with victim; common sense indicates that's not true.

Example: Defendant claims he was unaware of risk of harm to child from shaking; illustrate violence and child's head movement to show any reasonable person would appreciate the harmful nature of the conduct.

Example: Defendant claims all the victims are lying; demonstrate they all give similar independent accounts of his conduct, socialized with defendant before and after abuse and generally got along with him, etc.

Example: Defendant suggests he wouldn't be able to commit offenses because others at home or in next room; illustrate how we all sneak around to do things in our own homes when others are there.

Example: "The opinions and testimony you're offering here are based on the information you received from the defendant, aren't they?" "And you have accepted the information provided by the defendant as accurate information in formulating your opinions, correct?" "If the information you received from the defendant was false, that would affect your opinion wouldn't it?" "You're aware that the defendant lied to the police during the investigation of this case, right?" "And you would agree the defendant has a strong motivation to try to 'help himself out'?"

Example: Would you agree that it is important for medical personnel treating children in life threatening situations to obtain accurate information about the cause for the child's condition? And in the absence of such accurate information the treatment of the child's condition may be compromised? You're aware of cases where this has happened because a child's caretaker lied to the treating medical personnel?

Example: Doctor isn't it true that a 'discrepancy between medical findings and historical information supplied by the caretaker' is a major factor in diagnosing that injuries are the result of child abuse, rather than accident? (This is part of the diagnostic criteria under the Battered Child Syndrome and a conclusion echoed in numerous medical articles discussing the diagnosis of abusive injuries). Stated another way doctor, when the caretaker's explanation for the injury is not consistent with (the nature of the injury, the force needed to produce it, the mechanism for the trauma, the clinical symptoms resulting from the injury, or the developmental capabilities of the child) this false history would cause a reasonably prudent doctor to diagnose that the child's injury was the result of abuse correct?

Remember the principle of "verisimilitude".

C. OBJECTIVE: DISCREDIT THE WITNESS OR MODIFY TESTIMONY

1. The **identity** or **allegiance** of the witness is sometimes more important than what they say. The bias, prejudice, or relationship of the witness to other persons in the case may affect their credibility and, the significance of their

testimony.

2. Using uncontroverted facts, show what the witness does not know about the defendant.

   Example: Witness may not know defendant convicted of other crimes (be careful); or of how complaint was made; or of corroborating evidence.

   Example: If witness wrong about major aspect of defendant's life, how can they be certain now.

3. Demonstrate the extent of the bias of the witness.

   Example: "Isn't true that you don't believe the defendant is capable of the acts he's accused of and that's why you're testifying on his behalf?"

   Example: Would your opinion of the defendant change if you knew he committed the acts he's accused of. (If answer is no then a follow up question is not necessary. If yes then point should be made in closing that witness' opinion is conditioned on jury's assessment of the defendant's guilt, not vice versa.)

   Example: "Isn't true that as a treatment provider you have a professional interest in the defendant not being held criminally responsible for his conduct?"

   Example: "Haven't you testified on behalf of several other defendants supporting similar positions to those you're offering here?"

   Example: Doctor, isn't it true that you advertise your services as an expert witness in professional publications? Isn't one of the reasons you present at conferences is the fact you generate business as an expert from those presentations? Haven't you generated business in the past? And don't you continue to give presentations?

4. If the witness has a criminal record, impeach him or her according to the rules of your jurisdiction.

5. Establish that the defendant or attorney contacted the witnesses about testifying.

6. Establish the defense witness did not cooperate in discussing the case prior to trial, or come forward with information favorable to the defendant and present that to the authorities, despite knowing that the defendant was charged and/or in custody.

7. Impeach the witness with any specific instances of conduct which may bear directly on their credibility.

8. The defendant's testimony.

   a. There is no need to ask questions to establish that the defendant has a **motive to lie** in court.

b. Show that the defendant has prior criminal convictions.

(1) Ask questions in a manner consistent with law in your jurisdiction.

(2) Be sure to have proof of convictions available as required by your jurisdiction.

c. If the defendant gave a statement to the police or to any other witness, point out all **inconsistencies.** Inconsistencies may be between statements, with other testimony, or with common sense. Use demonstrative aids such as charts listing all the statements side by side to show inconsistencies, or blow ups of the actual statements. (This is also an effective tool with alibi witnesses).

Example: Defendant testified victim was not in his home (where she says abuse occurred) yet she knows who was present at relevant time.

Example: Threats or bribes are inconsistent with denial of guilt.

Example: Evidence of flight or use of alias inconsistent with denial of guilt.

Example: Evidence of contacts with victim/family in violation of court orders for no contact.

d. Make the defendant **accountable** to the community.

Example: Defendant's work as Boy Scout leader to demonstrate number and age of boys with whom he has regular contact.

e. Demonstrate defendant's controlling/manipulative personality.

Example: You never allowed your adolescent daughter to attend any school function/spend time with friends, did you?

Example: "The children violated the rules and regulations of the house." "The wife would let them run around and then tell me to impose discipline."

IV. MEETING AND DEFEATING COMMON DEFENSES

Your approach to meeting the **common** defenses will be very case-specific. It will vary from no cross-examination at all to very confrontational cross-examination. What follows are very "generic" illustrations or suggestions of possible approaches.

Remember--You only need answers or testimony that allow you to make the summation you prepared pre-trial. Do not overreach.

A. DEFENSE: Fantasy

Example: Have defendant agree victim did not learn sensory details she describes

such as how sex felt, smells or tastes, dialogue described from claimed video she watched or magazine exposed to.

Example: Victim did not fantasize about sex with strangers, mother, etc.

Example: Victim did not have access to sexually related materials to gain knowledge about sex..

B. **DEFENSE:** Misinterpretation of Innocent Touch

Example: Emphasize secrecy aspects brought out in case in chief.

Example: Focus on why innocent touch only on genitals, under clothes or in private.

C. **DEFENSE:** Mental Illness or Defect

Example: Get defendant to admit victim was reliable in other respects.

Example: Cross defendant on victim's abilities in school and home inconsistent with claimed infirmities.

D. **DEFENSE:** Retaliation

Example: Get defendant to explain at length how victim allegedly manipulated entire criminal justice system.

Example: Get defendant to acknowledge that victim has not achieved objectives he claims she has.

E. **DEFENSE:** Custody

Example: Get defendant to confirm chronology of events: there was no "custody dispute" until after the disclosure; or that the disclosure came after a period of separation (which permits the argument that the disclosure came when the child was safe).

Example: Use court records in divorce to establish custody or visitation was not an issue.

F. **DEFENSE:** SODDI

Example: Allow defendant to admit that victim was indeed sexually abused, but it was by someone other than him, and he may or may not know who that person was.

Example: Establish defendant's awareness of prior abuse, and knowledge of victim's vulnerability.

G. **DEFENSE:** Brainwashing

Example: Have the defendant explain, in as much detail as possible, the process of the victim's "brainwashing."

Example: Establish defendant could not get victim to follow all his rules around

house.

H. **DEFENSE:** Reasonable Doubt

Example: If defense "went after" child on inability to remember peripheral details, do the same with every defense witness.

Example: Establish victim could not relate all the details about other non-abusive events in life.

I. **DEFENSE:** Discipline

Example: Get defendant to talk about **his** conduct when administering "discipline" so it becomes clear to jury defendant's actions were unreasonable.

Example: Have defendant define what he believes is or is not appropriate discipline (force, number of spanks, location, use of object, for what infractions, alternatives to corporal punishment).

J. **DEFENSE:** Accident

Example: Have defendant describe in detail how child fell off bed or furniture item.

Example: Question every injury child has and mechanism for how it occurred.

Example: Go through any inconsistencies in explanations offered by defendant.

K. **DEFENSE:** Defendant not the sort to do this.

Example: How well do you know the defendant? Know what his sex life is like? Know what goes on behind closed doors?

Example: Know what defendant has done on other occasions - prior bad acts?

V. TECHNIQUES OF CROSS-EXAMINATION

A. FORM OF THE QUESTION

1. Monologue or dialogue. The dialogue is used to obtain information from the witness in a non-accusatory format. The monologue is used when the format of questioning becomes accusatory, or more control is needed over the witness. The monologue format affords the questioner the opportunity to testify through declaratory questions answered with yes or no responses. Once the cross-examination becomes accusatory, it is virtually impossible to obtain information under a dialogue format. For this reason, if part of the objective during cross is to enhance and support your case by obtaining agreements with the state's evidence or expert, this must be done first in the series of questions posed to the witness or defense expert.

2. There are several types of questions used during cross-examination.

   a. Interrogatory: Did you ever examine the defendant? Did you ever give your daughter a bath?

b. Accusatory: You examined the defendant at the request of the defense attorney didn't you? The only times you gave your daughter a bath were when your wife was at work, isn't that right?

c. Anticipatory: You relied on information provided by the defendant in formulating your opinions isn't that right? You can't think of any reason for your daughter to lie about saying you gave her baths can you?

d. Open ended: Who, what, where, when, why, how.

e. Rhetorical: Do you really suggest that this child sustained all of these injuries in a fall?

f: Sarcastic: So this circumstance is the one exception to all the other medical literature supporting a medical opinion different than your own? So everyone else is lying except you?

g: Telegraphing: I'm sure you wanted to let us know that information but would you please answer the question that I asked, and not simply volunteer the answer you want to give?

h. Cluster questions: Stock groups of questions asked in response to common answers.

Example: "I'm not sure." Well what are you sure of? Are you sure of X? Y? Z? Why is it you're certain of X and Y but not Z?

Example: "I didn't have those materials provided to me?" And you didn't request those items from the defense attorney did you? You also didn't call the district attorney's office and request that information correct? Hasn't it been your experience as an expert that if you express to the attorney(s) involved your need for such materials they would be provided? And this material might have been helpful to you in formulating your opinions? So you must have felt comfortable rendering your opinion in the absence of this potentially helpful material?

B. TONE OF THE QUESTION

1. The tone of questioning frequently is determined by the form of the questioning.

2. Use your voice to convey:

   a. humor

   b. sarcasm

   c. surprise

   d. anger

3. Be aware of the jury.

4. Do not make the jury angry by seeming unfair or a bully.

C. APPROACH

1. When appropriate, use a friendly, low-key approach and tone to elicit cooperation with the witness.

2. Do not argue with a witness.

3. Jurors often expect a confrontational approach during cross but seldom tolerate one.

4. Multiple approaches can be used with the same witness if the appropriate order is followed.

D. CONTROL OF THE WITNESS

1. The form of the question determines the control you have over them. The most control is exercised through leading questions using short declarative phrases.

2. Attorneys often believe that the only form of question that should be asked on cross-examination is a leading question. Such an approach obviates the opportunity to create avenues for effective cross-examination by giving the witness enough rope to hang themselves. Shakespeare's famous words "Me think thou doth protest too much" have salience in this context. So too with several of the other commandments commonly bantered about by cross-examination wizards, such as never ask a question you don't know the answer to. These commandments may have more relevance in a civil context where the parties enjoy reciprocal discovery and the opportunity for pre-trial depositions, but they were not written by prosecutors who don't have these options and often have to fly by the seat of their pants.

3. Control can also be exercised by control-oriented questions during the examination.

   Example: If you cannot answer a question with a simple yes or no I want you to just tell me that instead of going ahead and answering the question, all right?

   Example: Is there some reason you won't answer the question that was asked?

   Example: If you don't understand a question, I want you to tell me that all right?

   Example: Your honor, the answer was non-responsive, would you please direct the witness to answer the question?

4. Short declarative questions which consistently call for yes answers also control the witness and psychologically condition them to respond to future questions in a similar manner.

E. USE TRANSITIONS

1. Transitions form a bridge between questions involving one topic during cross, and another separate topic. They are also an easy way to orient the witness to the subject area of questioning providing further control for the questioner.

2. Transitions also serve to refocus the jury's attention on selected portions of the direct examination which the cross-examiner wants to highlight.

3. Transitions are not really questions but instead short declaratory statements. They can be turned into questions if an objection is posed by adding a simple tag on to the end such as "is that all right?" or "do you understand?"

   Example: I want to talk about your report that you prepared for defense counsel.

   Example: I want to talk about your relationship with the defendant.

   Example: Now you told us on direct that .... I want to ask you some questions about your testimony on that subject.

F. USE PATIENCE, PACE AND FINESSE

1. Don't rush to the kill - set up the brick wall before you knock it down.

2. Establish the parameters for the *coup de grace* to avoid any escape routes. Commit the expert to the facts and assumptions supporting their opinion before attacking those facts or assumptions. Commit witnesses to prior statements.

   Example: Doctor you base your opinion in this case on X, Y and Z and nothing else, is that right? If any of those factors were to change or be inaccurate that could affect your opinion, correct?

   Example: Now you gave a statement earlier in this case? And that statement was accurate? You didn't lie to the police did you?

3. Use an indirect approach to lead the witness to the point you want to make - avoid a head on challenge.

4. Lull the witness into a false sense of security by obtaining repeated "yes" answers in response to leading questions.

5. Don't change the subject of questioning if you're drawing blood. Finish a theme or topic area of questioning before moving on to another line of questions.

6. Allow the response to feed into another question.

7. If the question is unresponsive, ask it again and let the jury know you want the question answered.

   Example: Please Doctor I believe the question called for a yes or no answer,

not a detailed explanation, now what is your answer, yes or no?

8. Maintain control of yourself and the dialogue.

9. Use repetition of questions on similar subjects to emphasize the point and hammer home the absurdity of the witness' position.

   Example: So Doctor would you please explain how this child got this injury on the arm? Are you saying this injury is consistent with accidental trauma? How about this one on her leg? Is this injury also consistent with accidental trauma? What about this one on her head? And this one on her back? Doctor do you have an opinion that any of these injuries covering this child's body were caused by abusive conduct?

   Example: So what your saying is that Suzy has lied about these allegations? And she has made up the details about what your touching felt like on her? And she has acted emotionally upset when talking about these incidents so others would believe her? And she has been able to maintain the consistency of this story through all the different people she's talked to and her testimony?

G. GUIDELINES FOR CROSS-EXAMINATION OF EXPERTS.

1. Definitions of terms used.

   Example: Doctor are you familiar with the term Battered Child Syndrome? Would you explain your understanding of that term? Do you agree that this is a well recognized medical diagnosis with widely accepted diagnostic criteria? And would you say that this child's injuries satisfy those criteria?

2. Familiarity with applicable legal definitions. For example, "reasonable degree of medical or psychological certainty," "mental illness or disorder."

3. Opportunity to observe or examine.

   Example: Doctor you did not have an opportunity to personally examine the victim did you? So you would agree that (the state's expert) was in a better position to assess the child's condition?

4. Opinion based on information defendant provided.

5. Focus on specific facts, ignoring other facts. Focus on specific injuries while ignoring the totality of injuries.

   Example: Now Doctor you've told us that it is your opinion that the skull fracture this child sustained could have resulted from a fall off of the changing table is that correct? That fall would not account for the numerous bruises the baby had on his legs and arms would it? And isn't it true that the more injuries that a child has, the less likely that all of the injuries are the result of accidental trauma? And similarly, doesn't the fact that the baby has numerous bruises make it less likely that the skull fracture is the result of this claimed fall off the changing table? Although it is a possibility that this fracture was caused by this type of a fall, it's not probable if one considers all of the injuries together, is it? In fact the definition of Battered Child

Syndrome would suggest that when you have multiple injuries of this nature that the medical diagnosis would be one of abuse isn't that correct?

6. Areas where expert is not as qualified as State's expert.

   Example: Doctor your specialty is not in pediatric radiology is it?

   Example: Doctor while you may have seen retinal hemorrhages before, you are not a pediatric opthamologist are you? So unlike Dr. J. who testified earlier, you wouldn't have occasion to examine thousands of children's eyes as part of your normal practice?

7. Familiarity with all of the case materials? Would your opinion change if.....? Emphasize information not previously made known to the expert by the defense attorney or defendant. Here again repetition becomes important. The more things that can be brought forward that the defense expert was unaware of will support the argument that the expert is willing to opine in a vacuum, or is unwilling to alter his opinion regardless of the information brought to his attention.

8. The expert's practical experience in the subject area they are testifying on, or reliance simply on literature and research.

   Example: Do you actually treat children who have been sexually abused or are you simply familiar with the literature on this topic?

   Example: How many victims of child abuse do you examine every month? How many cases of Shaken Baby Syndrome have you seen this year? Are you involved in child abuse fatalities as well as cases involving injury? Do you have any experience as an emergency room physician or work in a pediatric intensive care unit where you might have direct contact with the caretakers at a time when they might offer a false history?

9. Expert's position within the relevant scientific and professional community.

   a. You've testified in this fashion before on numerous occasions...?

   b. Isn't it true that other professionals in the field have been very critical of your opinions, position, writings, etc....?

   c. Isn't it fair to say that the opinions you are expressing here are a minority position in the professional community?

   d. Despite the criticisms of your opinions by other professionals and the challenges to your testimony previously made during cross-examination, you've continued to take the same position and offer the same opinions correct?

   e. Have you reevaluated your position and opinion in light of this criticism? It's fair to say you continue to insist that you're right?

   f. You were paid for your opinions in those prior cases? And you're being paid to express those same opinions here?

10. Testimony excluded previously by court, prior failures to qualify as an expert witness, negative prior comments by courts regarding expert's testimony, etc.

11. Scientific methodology - Is the method or data relied upon reliable?

    a. Did the expert use proven practices and procedures?

    b. Is there literature critical of the procedures or their usefulness in forming opinions?

    c. Is the data or information capable of different interpretation?

    d. Are the conclusions based on empirical data or subjective interpretation?

12. Cross-examination based on textbooks and articles. Use selective quotes from other experts or leading articles and ask for agreement with their contents or conclusions. See FRE 803(18) Learned Treatises.

    Example: Are you familiar with the literature on injuries received by children from short falls? In fact there have been 20 or so studies reported in the medical journals? And these studies have looked at thousands of children? And the consensus from these studies is that children do not sustain life threatening or fatal injuries from falls under 5 feet, do they? In fact children in these studies rarely sustained any type of serious injury isn't that right?

    Example: Are you familiar with the publication Sexual Abuse: A Journal of Research and Treatment? That is a well respected journal for professionals in the field of evaluating and treating sexual offenders correct? And are you familiar with an article authored by... entitled ... stating that MMPI responses are not capable of satisfactorily distinguishing between sex offenders and non-sex offenders? Do you agree with the conclusions stated from that research in that article? Nevertheless you have come to court here suggesting that the defendant does not fit the profile of a sex offender based on your assessment of his MMPI scores - do you stand by that position?

13. Frame questions relating to the expert's opinion in terms of any applicable jury instructions on reasonable doubt, degree of certainty, etc. For example "Is it possible? Probable? Likely? Remote?" "Are you certain? Speculating? Hypothesizing?" "Possibilities are not probabilities are they?" "Are you saying that in your opinion this injury was caused by...? And you're offering that opinion to a reasonable degree of medical certainty?" "What is the most likely cause for this finding?" **There are always lots of *possibilities* but generally few *probabilities*.**

14. Be the master of the facts. Incorporate the facts into your questions. Use as many uncontroverted facts as possible. Utilize any facts the expert was previously unfamiliar with. Always include questions calling for an opinion in light of the "totality of the facts and circumstances," not simply a fact or injury in isolation. "Doctor when you look at the totality of injuries in this case is your opinion that they are consistent with accidental trauma.? Are they consistent with child abuse?"

15. Draw distinctions between hard and soft sciences and reliability of opinions in the two areas. Human behavior is not tangible and opinions about human behavior are not objective. No one has a crystal ball, no competent behavioral scientist can express an opinion on the state of mind of another human being. When it comes to human behavior there are no scientific absolutes. See also FRE 704(b) prohibiting such opinions.

16. Establish areas of inconsistency or disagreement between the opinions of multiple defense experts.

17. Never fight with the expert.

18. Use of appropriate ethical standards. See *Cross-Examination Strategies Using the APA Code of Ethics.*

19. Cross-examination can always be effectively concluded with questions dealing with the fee paid for work on the case and past cases. Earlier in the questioning the expert can also be asked questions relating to the percentage of income derived from testifying in litigation, or the amount of annual income from such pursuits, in order to frame the context of his answers as those of a hired gun. Experts routinely suggest they don't keep track of that information at which point they should be asked why they don't since they are most likely asked that question numerous times a year if they are testifying frequently. Make sure you draw distinctions between the payments given your experts and those given the defense experts. Many state's experts actually volunteer their time as a witness, are paid only their regular salary, or lose money while testifying vs. what they are paid in private practice. Many defense experts make a living testifying and consulting.

H. WHAT NOT TO DO DURING CROSS-EXAMINATION

1. Do not repeat direct examination.

2. Do not use compound questions.

3. Do not ask the one question too many, if you know what that question is.

4. Do not react to what seems like a "bomb."

5. Do not restrict yourself to leading questions when you know the answer, when the answer will be an admission, or when the witnesses' explanations are expected to create further avenues for impeachment.

6. Avoid arguing with the witness.

7. Do not allow these rules to prevent creative cross-examination. Remember that few answers can really hurt your case, **if** you have prepared adequately.

Remember that the response often is not as important as the question itself

8. **Do Not Be Intimidated**

VI. RULES TO REMEMBER

A. BE YOURSELF.

B. BE CONFIDENT AND IN CHARGE.

C. CONTROL THE WITNESS.

D. USE SHORT, CLEAR QUESTIONS.

E. VARY YOUR VOICE AND GESTURES.

F. THINK BEFORE YOU SPEAK.

G. BE FLEXIBLE - NO TWO WITNESSES ARE ALIKE; NO TWO CASES ARE ALIKE.

H. MAKE THE POINTS YOU NEED TO MAKE AND SIT DOWN.

I. END ON A HIGH POINT - LEAVE THE JURY WITH A LASTING IMPRESSION.

J. REMEMBER THERE'S ALWAYS CLOSING ARGUMENT TO BRING HOME YOUR POINTS.

K. HAVE FUN.

SAMPLE QUESTIONS FOR CROSS-EXAMINATION OF EXPERT WITNESS USING THE AMERICAN PSCHOLOGICAL ASSOCIATION CODE OF ETHICS

Prepared by Brian K. Holmgren
National Center for Prosecution of Child Abuse

The *American Psychological Association's (APA) Ethical Standards for Psychologists*, and *Specialty Guidelines for Forensic Psychologists* provide an excellent source for cross-examination of psychologists. These rules generally provide that the expert must disclose any qualifications or limitations in their opinions, either as a result of conflicting research findings or data, or literature in the field which supports a different position. This is generally not hard to do in the child abuse arena because of the wealth of literature, peer critiques of the literature and research, shortcomings in research findings, etc. The key to destroying the expert's credibility is to establish they failed to disclose contrary authority which might mitigate their opinions. This is achieved by laying a foundation which controls the expert and eliminates any opportunities for escape when the expert is confronted with the applicable ethical provisions. First the attorney must establish the expert is aware of contrary authority in the field, and get the expert to acknowledge and identify specific articles or treatises that express a countervailing opinion. The attorney can then establish that the expert is generally familiar with the code of ethics, and then direct attention to specific code provisions dealing with expert testimony. The expert is then confronted with the impeaching question establishing that if the expert was aware of both the contrary authority, and under an ethical obligation to disclose and discuss that authority as part of his testimony, why didn't he do so during the direct examination, and would he have disclosed such authority if the attorney hadn't asked specific questions about the contrary authority during cross-examination. There were significant recent changes to these ethical guidelines and principles in 1991. Some commentators have remarked that these changes potentially suggest that psychologists can take a less objective approach in forensic work. See generally, Ziskin, J. (1995). *Coping With Psychiatric and Psychological Testimony*, 5th ed. Vol. III, Chapter 2 on "Making Use of Ethical Principles, Guidelines and Standards", and Donald Bersoff, *Ethical Conflicts in Psychology*, Chapter 9 on "Forensic Settings", discussing ethical considerations in the presentation of expert psychological testimony and evaluations. Attorneys should obtain a current copy of the APA Code and become thoroughly familiar with all its provisions before attempting to use the suggestions that follow. In general, however, the provisions set forth in the "General Principles" section of the Code, and those in Standards 1-3 and 7 are the most applicable in the forensic setting.

Suggested Questions Utilizing The APA Code

1. Are you a member of the APA (American Psychological Association)?
   -Foundational question setting parameters for further questioning
   -Only APA members are bound by the Code of Ethics
   -Psychologists who are not members of the APA should nevertheless follow the ethical precepts of their profession as set forth by the most significant professional organization

   If the expert says they are not a member, then when it becomes time to confront the expert with the questions under 8 and 9, the expert should be asked a modified version of that series of questions along the following lines:
   -Doctor, even though you are not a member of the APA, are you nevertheless familiar with the Code of Ethics for the APA?
   -The APA represents the main professional organization for psychologists in this country correct?
   -Most psychologists are members of this organization are they not?
   -As the main professional organization for psychologists, don't the APA's guidelines for professional behavior and the APA's Code of Ethics represent the consensus of most psychologists regarding appropriate professional and ethical behavior for psychologists?
   -You would agree that the principles articulated by the APA Code of Ethics should guide the conduct of professionals even if they are not a member of the APA?

   The attorney can then proceed with the remaining series of questions as indicated under 8 and 9.

2. What do you do to become familiar with the professional literature in the (topic area for which you are providing testimony here today?
   -Even though this question is open ended, it represents a double edged sword. The questioner does not care how the witness responds. The witness either says "nothing" or "I do my best to ..." If the expert says "nothing" you not only establish that the expert is lazy and uninformed, but you establish an ethical violation under secs. 1.05 and 7.01 of the APA Code and Principle A: Competence. Alternatively, if the expert suggests familiarity with the relevant body of literature on the topic, we can test the extent of that knowledge through further questioning as set out below. The witness who claims to do a lot to keep abreast of the literature can then be challenged on any literature with which he's not familiar by asking "Well you claim to do x, y and z to keep current with the relevant literature, why is it that you don't know about ... (citing a relevant article on the topic)?"
   -It's critical to stay abreast of current literature in this area isn't it?
   -A primary way of keeping current is to read professional journals correct?
   -Another way is to attend professional seminars?
   -It's important to read articles that offer competing positions or which discuss alternative positions isn't that right?

-This insures that a professional has the opportunity to consider alternative hypothesis and engage in critical analysis on the subject, isn't that right?

3. If the answer to the above question was yes, the witness should be asked to describe the literature and specific articles they are familiar with, and which they believe supports the position they are offering in court.
-What articles are you familiar with?
-Have you read any particular articles in preparation for your testimony here?
-Are there any articles which you consider to be seminal articles in the field?
-Are there any articles which you believe to be most important in understanding this issue?
-Have you personally spoken with any of the authors of these articles?
-Have you attended any training seminars at which these authors presented?
-Have you authored any articles on this topic yourself?
-Have you participated in any research in this area? Reported the data from that research?
-Do you have any articles with you in court today? (Ask to review and have copied)

4. Are there any other articles you can think of that are relevant or important to consider regarding your testimony, which you have not previously mentioned?
-Exhausts possibility of other articles being "forgotten" when witness is confronted by articles supporting a contrary position

5. Are there any articles or treatises which you have read which you have discounted, or do not feel are reliable, in reaching your conclusions and forming your opinions?
-Have them identified
-Go through the same series of questions as set out under #6 below to establish that the witness is thoroughly familiar with the points raised in these articles which support a contrary position. This will support the later questions set out under #8 suggesting the witness has deliberately not disclosed this contrary authority, although aware of its existence
-Have witness explain reasons why they discount these articles

6. For every article you have in your file which the expert has not named, and which supports a contrary position, ask the witness if they are familiar with and have previously read that article. These articles could previously be filed with the court as a "learned treatise". (This necessitates a tactical decision by the attorney in deciding whether to give up the potential element of surprise by filing the articles in advance, rather than revealing them during cross. Filing the articles will likely put the expert on notice of contradictory research which they ought to consider in offering their opinions.)
-Are you familiar with the (name book, text or journal which is a leading publication in the field the expert is testifying about)?
-That (book, text, article) is a well respected publication in the (field they are testifying about) is it not?

-Are you familiar with an article written by (name author) entitled (name title) published in the (name journal)?
-The author of that article is respected by other professionals in the field of ...?
-That article was published in a professional journal which is subject to peer review isn't that correct?
-Would you agree that this article is well accepted in the scientific community of professionals dealing with this issue?
-That article says ... (read relevant portions of the article highlighting the statements in the minds of the jury. An even better method is to have those statements blown up as a visual aide so the jury can read along with you.) Do you agree or disagree with this point (or conclusion) from this article? Or, do you agree with author ___ when they write ...? If the expert says that they disagree then further questions can be developed discussing the importance of the peer review process, and how this process suggests that other professionals deemed the article worthy of public distribution because of its contribution to the body of knowledge on the topic. For example, "In journals using a peer review process, the editorial board of the journal selects other professionals who they believe to be sufficiently trained and knowledgeable in the subject area to review articles and offer opinions before it is published, isn't that right?" "The fact that an article goes through this process suggests that other respected professionals who serve as editors for the professional publication found the article to be worthy of distribution in order to educate other professionals does it not?"
-Did you consider this article in formulating your opinions? (If the answer is no, a follow up question can be posed asking them whether they would change their opinion now in consideration of this article. If the answer is yes, then they should again be asked to explain why they discounted the position stated in the article)

7. You would agree that this literature supports a different position or conclusion than the one you are offering by your testimony?
-You would agree that any professional consideration of this issue should include consideration of the points raised in this article (or these articles) isn't that right?
-So what you're telling us is that despite this body of scientific literature you are maintaining your position which is contrary to that literature?
-Would you say that such literature places any qualifications or limitations on your own opinions? (See Code 7.04)
-You would agree that other professionals would not ignore or discount this literature in formulating opinions on this topic?

8. Doctor, you are familiar with the APA Code of Ethics are you not?
-Those ethical provisions govern your testimony here today don't they?
-Specifically Code provision 3.01 covering public statements includes providing testimony in court correct? (Read specific Code provision)
-And the Principles of the APA Code provide guidance to psychologists on how they are to conduct themselves before courts of law, do they not?

-Specifically Principle B of that Code provides that "Psychologists seek to promote integrity in the science, teaching and practice of psychology. In these activities psychologists are honest, fair, and respectful of others...they do not make statements that are false, misleading, or deceptive."
-You are familiar with Code provision 3.03 Avoidance of False or Deceptive Statements which provides that "Psychologists do not make public statements that are false, deceptive, *misleading* or fraudulent, either because of what they state, convey, or suggest or because of what they *omit*...?"
-And you are also familiar with Code provision 7.04 regarding Truthfulness and Candor which provides that "In forensic testimony and reports, psychologists testify truthfully, honestly, and candidly and, consistent with applicable legal procedures, describe fairly the bases for their testimony and conclusions. Whenever necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions."

9. Doctor you acknowledge these ethical provisions govern your testimony here today don't you?
-You further acknowledge this literature which I have just reviewed with you supports a contrary position than the one you are offering?
-Can you tell this jury when it was you were going to disclose this body of literature?
-When was it we would have learned of that information if I hadn't brought it out on cross-examination?
-Any explanation by the witness can be countered by further questions. For example if the witness says I would have provided it on direct if asked, the witness can be asked whether the Code doesn't impose on them an affirmative obligation to provide this information to the fact finder. If the opposing attorney asked no questions on cross this information would never have come out. If the opposing attorney was not familiar with the literature on the other side of the issue, and capable of asking appropriate questions, this information again would not have been revealed.

10. A variety of questions can also be developed dealing with the Code provisions under the subcategory for Evaluation, Assessment or Intervention, sections 2.01 to 2.08. Although the application of psychological research findings to children is not technically an "assessment" the principles developed under these provisions can be applied by analogy to this situation. For example, section 2.01(b) states that "psychologists' assessments, recommendations, reports...are based on information and techniques (including personal interviews of the individual when appropriate) sufficient to provide appropriate substantiation for their findings." Statements in court testimony or evaluation reports applying children's memory and suggestibility research arguably fall under this provision. In most circumstances, the child victim will not have been subjected to any assessment techniques, including IQ and developmental testing, assessment of language capabilities, assessments for trauma, etc.. Such assessments would potentially provide a more informed basis for expert

testimony about how this particular child victim might have responded during the interview process. The lack of such personal assessment again raises limitations to the application of memory and suggestibility research results to the individual child. The remaining sections of this subcategory similarly discuss limitations for application of assessment techniques in light of various factors, including the individual's gender, age and other personal characteristics. All of the points raised above regarding why the application of research on children's memory and suggestibility is problematic in the context of an individual case, or with a particular child, also carry over and implicate these ethical provisions. In the event the expert acknowledges during cross-examination the application of these ethical provisions, and the corresponding necessity for disclosure of the limitations in applying this research, additional follow up questions as suggested by #8 and #9 above can be pursued.

Expressive Therapy for Healing Victimization

Presented by

Sharon A. McGee, MS, LPC

Expressive Therapy For Healing Victimization

Expressive therapy encompasses a wide variety of techniques including art, dance, music, play and drama. It is not simply drawing a picture. Expressive therapy techniques allow us to help a child express what is inside them. It allows a child an avenue to tell us what is going on inside them or what happened to them without having to just say it. Playing can also get the child back in touch with being a child even though they have been through trauma. Expressive techniques are not limited in their use. We can use these techniques for almost any issue that presents itself. Furthermore, some of these techniques can be used with adults as well.

"The people who come to see us bring us their stories. They hope they tell them well enough so that we understand the truths of their lives."
Robert Coles, The Call of Stories

Objectives

- Become familiar with what expressive therapy is and how it can be applied.
- Learn the essential tools used in expressive therapy techniques.
- Participate in and learn numerous expressive therapy techniques that can be used with children, teens and adults.
- Explore our own creativity and how we can use it with our clients.

Sharon A. McGee • Therapeutic Options • 527 Interstate Park Drive • Montgomery, AL 36109 • (334) 213-0801 • website:http://members.aol.com/this1

Suggested Reading

For Therapists

Bridging The Silence: Nonverbal Modalities In The Treatment of Adult Survivors of Childhood Sexual Abuse
by Susan Simonds

A Shining Affliction
by Annie G. Rogers, Ph.D.

The Healing Power of Play
by Eliana Gil

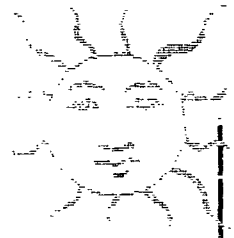
Therapeutic Stories
by Nancy Davis

Too Scared To Cry
by Lenore Terr

Therapeutic Use of Child's Play
by C.E. Schaefer

"Take care when you speak to me I might listen." Tess Gallagher
Moon Crossing Bridge

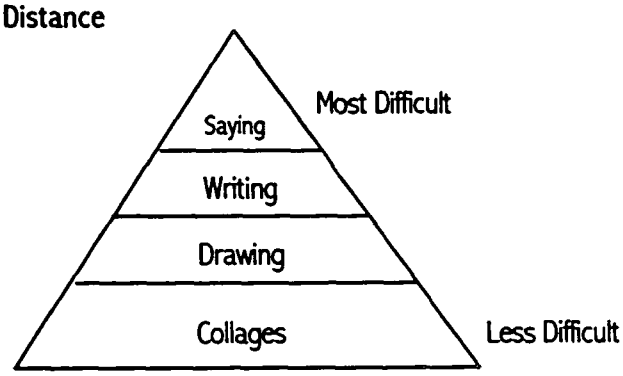
Things to Consider . . .



- What is my personal style?
- How much do I know about expressive therapy?
- What is the difference between expressive therapy and art therapy?
- Learning and Processing Styles

Auditory:	Rely heavily on what they hear. Prefer listening to reading; music is outlet.
Visual:	Like to read. May take notes, journal write; draw.
Kinesthetic:	They sit and look preoccupied but do take in information. May take longer for them to process, so go slower. Their work may not make sense to us but it does to them.

- Provide Distance



Start with the least difficult and overwhelming types of therapeutic activities and slowly move to more intense types of activities.

Suggested Supplies

All of these are suggested supplies which are useful with children.
Some can be used with teens and adults.

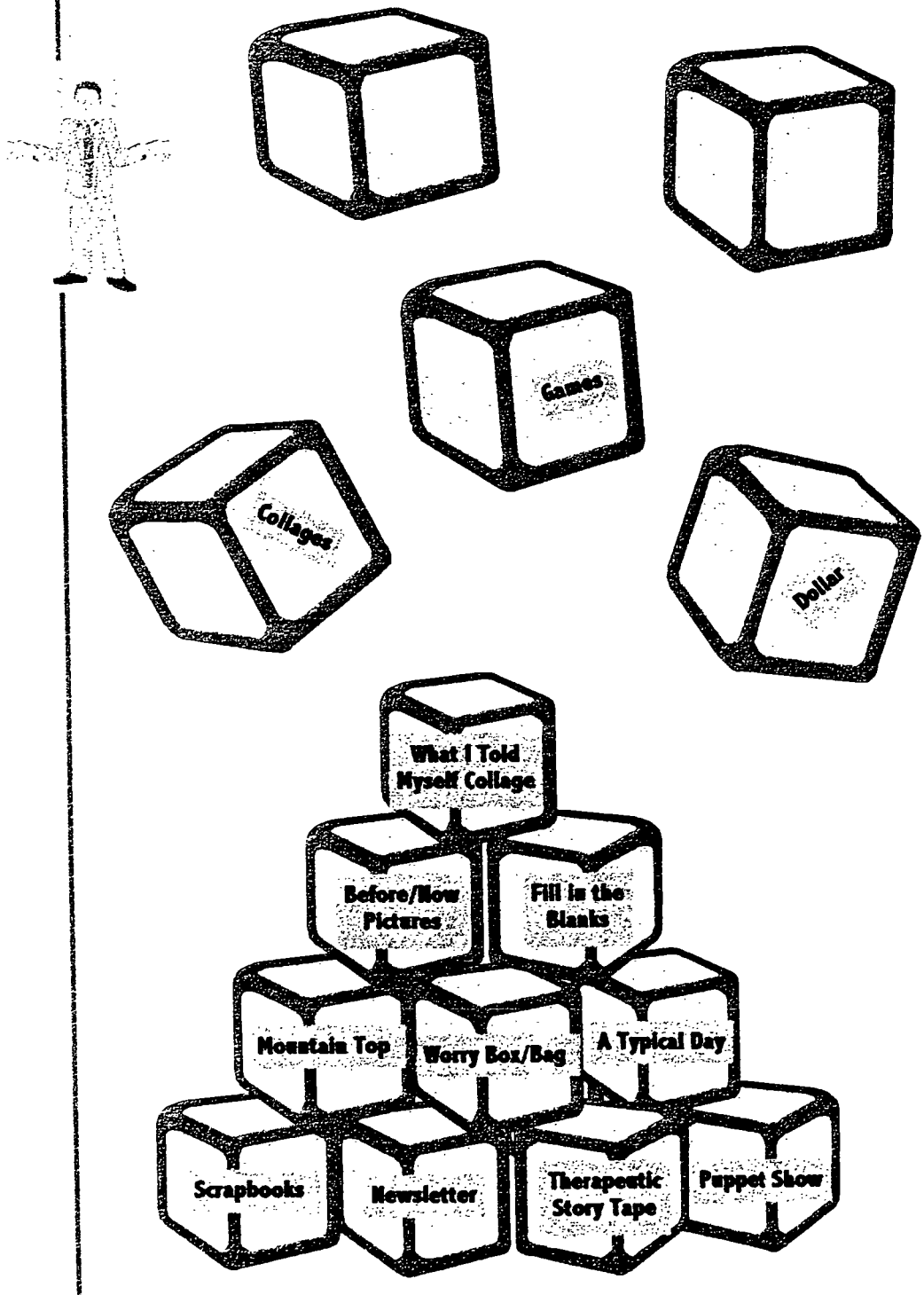
Recommended Games

- Uno
- Candy Land
- Connect Four
- Family Happenings*
- The Great Feelings Chase**
- Survivors Journey*
- My Two Homes**
- Ungame
- Checkers

* Distributed by Kidsrights 1-800-892-KIDS

** Distributed by Child's Work Child's Play 1-800-962-1141

What Can We Do?



Notes

Interviewing the

Reluctant Child

Presented by

Daniel Jarbo, MA, LPC

Interviewing the Reluctant Child

Instructor - Dan Jarboe, MA

I. Review of the Research: Understanding the nature and magnitude of the problem
Child sexual abuse reporting/disclosure patterns -

A. False denials

B. False retractions

C. Delayed disclosures

D. Factors influencing disclosure

II. Important Considerations when Beginning

A. Child's readiness, perception of said experience, and attitude toward the interview

B. The right climate and interviewer mind-set

C. Soliciting cooperation: the "one-down" position and the need for "assistance"

III. Is Information is Being Withheld? Assessment techniques & considerations

A. Assessment of 1) previous outcry or suspicious statements, &
2) Other corroborative evidence (ie., Sexualized behavior, other significant symptomology, offender confession)

B. Assessment and reduction of fears / shame

C. Identifying and interpreting reluctance

D. Other helpful questions to consider

IV. Strategies Useful in Collecting Information

A. Managing distress: a critical task
1) "Where?" before "What?"
2) Other "easier" questions
3) Approach and avoid

B. Alternative vehicles for communication

C. Back-door strategies: introducing a shift in focus

D. Working with older children

E. Being thorough

F. Additional techniques

V. Knowing When to Quit

A. Sensitivity to interview fatigue

B. Responding to retractions

C. Ethics and limitations

Effective Treatment for Traumatized Children: What We Know About What Works

Presented by

Lucy Berliner, MSW and
David J. Kolko, PhD

Components of Trauma Specific Treatment

- Education re: nature and consequences of abuse/offenders
- Encouraging expression of abuse-related feelings
- Identification/correction of distorted cognitions
- Teaching anxiety management/active coping
- Gradual exposure
- Promoting abuse response skills
- Enhancing support system/parental capacity

Abuse Specific Treatment

- Abuse specific/supportive = improvement in child behavior per parent report
- Abuse specific/less structured = improvement in parental support
- Abuse specific x recipient/routine community service = child behavior improvement per parent report/parent recipient; child pts sx improvement per child report/child recipient

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Western Psychiatric Institute and Clinic
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Child Physical Abuse

Child and Parent Therapy Outcome Studies

Child: Day TX, Social Skill/Play (3), Cognitive-Behavioral TX
* Developmental scores, peer social interactions, adjustment
* Modest change in Abuse (1) and P-C Adjustment (1)

Parent: Behavioral Skills Training or CBT (6)
* Parenting skills, Child behavior, Interactions
* Some reduction in abuse, Better P-C relationship

Family Therapy Outcome Studies

Family-Ecological Services (2), Family Therapy (2)
* Parental skills, P-C interactions, parental control, coercion conflict, cohesion
* Mixed effects on Abuse, placement

Summary of Treatment Effects

Few studies targeting children; None in groups
Fewer than 10 controlled studies
Child Gains: Social behavior & developmental scores (young); Aggression; other symptoms (older)
Family Gains: Parenting skills, control, distress; Conflict/cohesion, paret-child interactions
Follow-up: Some skills and outcomes;
Recidivism: Mixed

Lessons from a Clinical Trial: What to Do

Use multiple informants & construct measures
Comprehensive assessment -- child, parent, family, social;
ind/env risks, sequellae, resources/skills
Understand Family Context -- ethnic, social, psych'l, financial
View of violence, child-rearing practices, poverty,
parental distress, drugs, family instability
Conduct (some?) work in home/community
Monitor treatment carefully -- does client/therapist get it?
Make treatment flexible, individualized, & responsive
-- participants; individual vs. family-based; "matching"
-- format, site, comprehensiveness, timing

Other Lessons

Push limits in assessment -- especially "sensitive" topics (PTSD)
Establish Positive Orientation to Treatment
Denial/disgust (resistance) --> poor motivation/attrition
Address motivation and view of abuse (responsibility vs. denial)
Offer adequate duration & range of services (individual & family)
Balance Family Change Efforts
Function (processes) vs. Structures (hierarchies)

Cognitive-Behavioral Treatment

Perspective on Psychological Abuse & Violence:
Understanding the Child's Experiences
    Emotional/Psychological Abuse
    Normalization of Feelings
Exposure to Abuse Incident Cues
    and Circumstances/Consequences
Coping Ability -- behavioral/cognitive
Anger expressiveness/control
Safety Plans
Social competencies
Social Supports

Parent and Family Interventions

Parenting & Developmental Expectations
Distortions
Parenting Skills -- Behavior Management
Problem-solving
Communication skills

Community Treatment

Monitor Treatment Administration -- carefully and regularly
    Does client get it?...does therapist get it?
Assess use & impact of physical force
Collect observations on family functions/relationships
Document actual skill improvements
Assess role of existing support systems & other interventions
Evaluate flexible protocols -- responsive to "life" events

Building Resilience in Child Protection Professionals

Presented by

Mark Horwitz, MSW, JD

CAUSES OF PSYCHOLOGICAL TRAUMA

Psychological trauma can occur when a person's ability to manage events in her life is overwhelmed by the occurrence of a particularly challenging or unfamiliar event. The following are definitions of psychological trauma.

> Psychic trauma occurs when an individual is exposed to an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety and instinctual arousal.
>
> Eth and Pynoos[1]
> pg 38

> Psychic trauma is the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations.
>
> Terr[2]

> Traumatic events...overwhelm the ordinary human adaptations to life.
>
> Herman[3]

Psychological trauma theory recognizes the role of distressing life events in the development of many of the psychological problems people suffer from. Recovery most effectively occurs in the context of a society and a set of personal relationships where the reality and the injustice of traumatizing, often abusive, events are acknowledged. And before any recovery can be expected, the traumatizing events must cease. Child protective social workers play a key role both in the social acknowledgement that child abuse occurs and in guaranteeing that efforts are made to ensure that these children are safe in the future. Mental health professionals cannot help children recover from the traumatic effects of abuse experiences if the abuse itself has not stopped. Protective workers thus play a critical role not only in ensuring that children are safe from abuse but also in the effort to address the psychological trauma which results from child abuse and neglect.

Psychological trauma **can** occur when a person's coping abilities are overwhelmed. But it's important to remember that having one's abilities overwhelmed is also a normal developmental process. We often learn and grow by being forced to "stretch", to develop new capacities which help us address new tasks. Being overwhelmed in and of itself is not necessarily traumatizing. The trauma effect can occur when we are **overly overwhelmed**, and usually when the event causing the trauma is a negative incident which we would hope would never have occurred.

Ronnie Janoff-Bulman[4] views trauma as the result of shattered assumptions about ourselves and the world. Janoff-Bulman reasons that we develop assumptions about ourselves and the world which allow us to build a life with purpose, coherence and meaning, and that traumatic events tend to shatter these assumptions. She posits that the following are key assumptions which, when shattered, can lead to psychological trauma.

ASSUMPTION OF INVULNERABILITY

WORLD AS MEANINGFUL

POSITIVE SELF-PERCEPTIONS

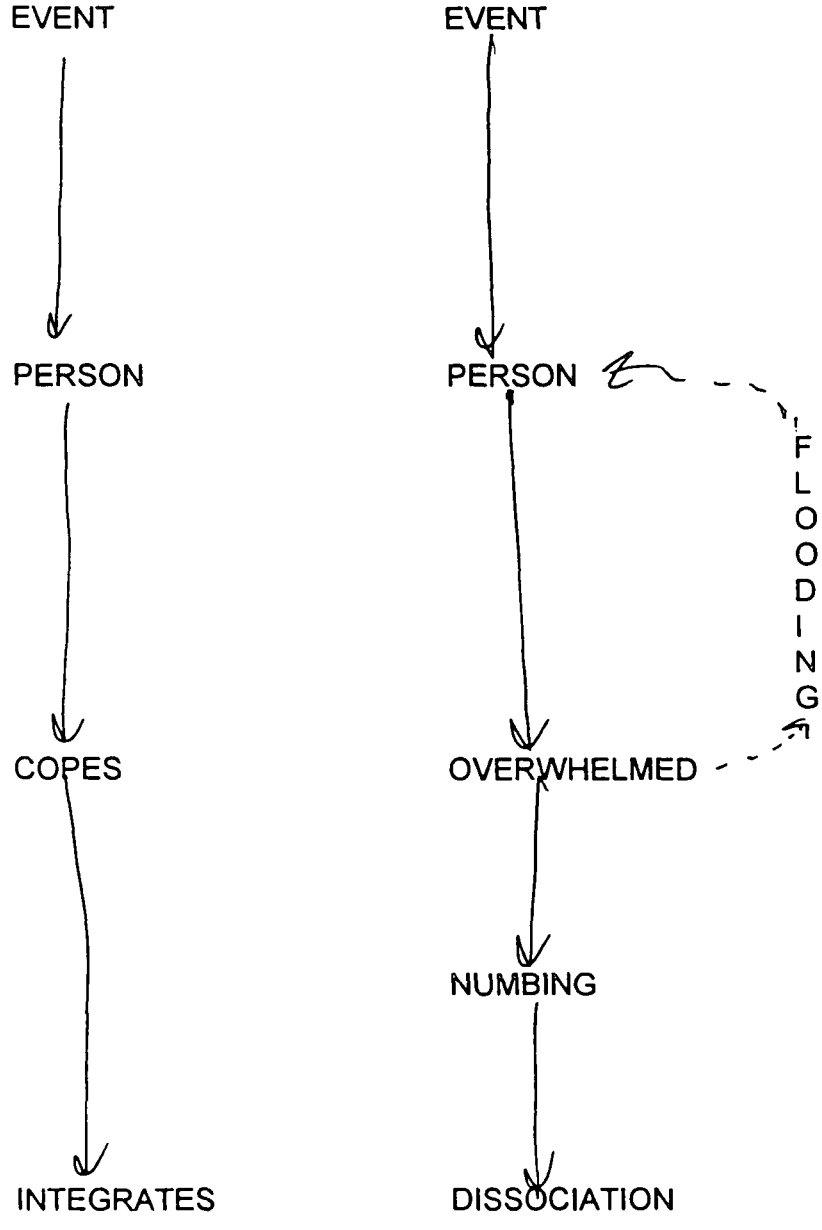
EFFECTS OF PSYCHOLOGICAL TRAUMA

People develop psychological means of protecting themselves when overwhelming events occur. Often the overwhelming material gets pushed away, through the psychological mechanisms of **numbing, dissociation and denial.** But these thoughts or feelings are seldom pushed away completely, and they tend to reappear in the form of **flooding, intrusive thoughts** and **repetitive behaviors.** The effects of psychological trauma can be broken down into the **numbing** and the **flooding** types of responses.

Dissociative states, a more extreme version of psychological numbing, can be a healthy and helpful response in many situations. In extremely pressing situations, such as intensive combat exposure or when responding to a major disaster, it is adaptive to put aside feelings which might distract one from completing a difficult task. And when there is no task to complete, as in the case of torture or abuse victims, the helplessness, pain and indignity of their dilemma invites a dissociative response as a way of creating emotional distance from the event. But while these numbing and dissociative responses can be useful and adaptive, they also can become debilitating when a person begins generally to respond to life events with these mechanisms.

Life experiences which are warded off through numbing or dissociation remain with a person. They tend to reemerge through flooding mechanisms, often set off by triggers. **Flooding** refers to **intensive remembering, through intrusive thoughts or feelings**, of traumatic events which previously were pushed away from conscious experience. **Triggering stimuli**, which are not harmful in and of themselves but rather evoke memories of an earlier critical incident, operate to set off painful, confusing responses. Flooding responses can be helpful in that they encourage a person to integrate past experiences, yet hurtful in that they can be the source of constant and often severe retraumatization.

A simple version of the operation of numbing and flooding mechanisms is graphically represented below.



WHAT HELPS AFTER PSYCHOLOGICAL TRAUMA HAS OCCURRED

Help for the effects of psychological trauma takes many forms. Psychotherapy can provide a useful forum for sorting out both details of the memories and effects of the critical event, and for developing coping strategies. Most of the recovery and healing which can take place after trauma has occurred happens in the daily life of the traumatized person. A person who has been traumatized must learn to live in the world anew, to rebuild safe and working relationships with self and others. Traumatized children, especially those traumatized by abuse or abandonment within their families, are especially vulnerable to the negative effects of trauma. They may have few established, effective coping skills to fall back on, and their young, emerging personalities can be greatly shaped by the fallout from the traumatizing event. Children need opportunities to develop the relationships and coping skills which will allow them to stay attuned to themselves, connected to others and motivated to function and thrive in the world around them.

Healing from psychological trauma occurs in three stages, stages which a person may cycle through a number of times as the negative effects of the traumatic event recede.

GET SAFE

No one heals until they first are made safe from further harm. In the safety phase of trauma recovery it is important to **stop the abuse** or other events which are causing the trauma. People **focus on the immediate crisis** during this period, in an attempt to regain control of their lives. Professionals help clients **access services** which will keep them safe and help them rebuild their lives. Clients need help in **limiting their exposure to evocative events,** events which are similar to the traumatic event and might evoke negative responses. People need **nurturance** and care during this period. They also need to **contain behaviors**, such as aggression or substance abuse, to prevent their situation from becoming worse.

GET UPSET

Our first goal when children are being traumatized by abuse is to ensure their safety. Once this has been achieved, it is only natural to want them to get it together, to feel better and to heal. And children sometimes do initially present in a more positive way following removal from an abusive situation. But to fully recover from the effects of trauma people usually need to get upset, in a variety of ways, over a substantial period of time.

Talking, both to remember and to reexperience, is a key component of trauma recovery. Trauma victims need to tell their stories, to create a **narrative** of their experience which assists in managing the trauma effects and in rebuilding a new sense

of self and the world. People might not want to talk, because of fear of not being believed or a wish to avoid the pain which comes with remembering. But talk, in a controlled setting, promotes **integration** of the material and **mastery** over it. A **controlled setting** is a relationship in which a person will be heard and validated, and assisted in talking about the traumatic experience and effects in small, manageable pieces.

But talking about these memories and experiences can be upsetting. Children may reexperience traumatic events in ways which greatly distort their current relationships and cause their behavior to be volatile and violent. Adults, including parents, foster parents, psychotherapists and social workers, would like to see children be content and well-behaved. While this is an attainable goal for most children, there is almost always a passage which traumatized children must make before this degree of calm can be achieved. Optimally, we want to help trauma victims be neither the overly-compliant child who is numbing her feelings nor the overly-aggressive child who is perhaps being flooded with unmanageable memories and affect. Children have the greatest opportunity to heal when they are in a setting which encourages them to be genuine about their pain while containing the overwhelming aspects of their experience.

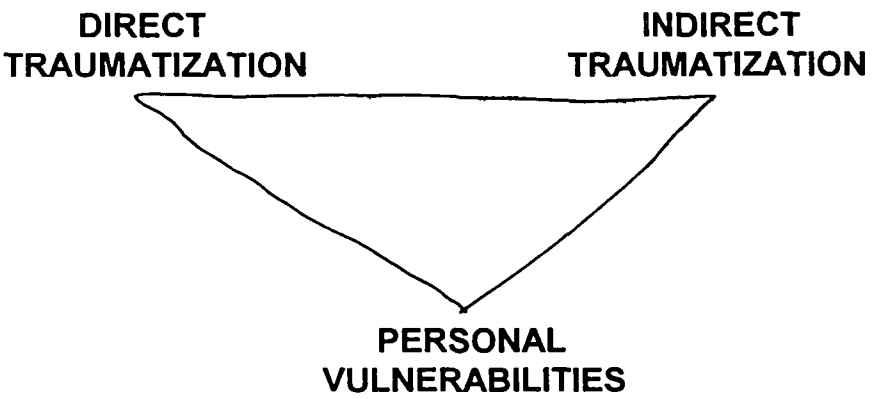
When a child is having a difficult time in a placement, be it a home, foster home, residential or hospital setting, our first reaction may be to wonder if the child is safe in the placement, if this is really the right placement for this child at this point in time. This instinct, to want to ensure that a child is safe, is a useful thing. We need to be able to distinguish, however, between the "upset" which indicates a lack of safety and perhaps calls for the implementation of a new plan, and the "upset" which indicates the gradual, painful working-through of traumatic memories and experiences. This is a process which requires thoughtful **reflection** and **open communication** between the various members a child's treatment team, including parents, caretaker, social worker, teacher and mental health provider.

GET IT TOGETHER[5]

Getting upset about the event which has caused a trauma ideally leads to being able to "get it together", to move on in life. Trauma symptoms may exist for many years after a traumatic event has occurred, and it is important to **"know thyself"**, to be able to recognize symptoms as they appear and to manage them. People need to **build connections with others** as a way of minimizing stigma and isolation and remaining in the stream of life. If assumptions about self and others have been shattered by the traumatic event, these **assumptions need to be reworked**, allowing the traumatized person to rebuild viable expectations in their life. In the process of rebuilding these assumptions, **meaning is reestablished** in a person's life. People also need to take care of themselves, to exercise, eat well, refrain from substance abuse and develop effective ways to express anger and sadness.

SOCIAL WORKERS AND PSYCHOLOGICAL TRAUMA

Social workers can be effected by psychological trauma. This trauma can best be understood by examining the effects of **direct traumatization** and **vicarious traumatization** on social workers, and by considering the role of **personal vulnerability** in traumatization.



DIRECT TRAUMATIZATION
CRITICAL EVENT DIRECTED AT A SOCIAL WORKER WHICH OVERWHELMS COPING ABILITIES AND CHALLENGES NOTIONS OF SAFETY, MASTERY AND MEANING

INDIRECT TRAUMATIZATION
CRITICAL EVENT DIRECTED AT A CLIENT RESULTS IN TRAUMATIC EFFECTS ON A SOCIAL WORKER, STEMMING FROM THE NATURE OF THE EVENT OR EMOTIONAL CONTAGION

RESPONSES SOCIAL WORKERS MIGHT EXHIBIT[6]

INTRUSIVE THOUGHTS	NIGHTMARES
SOMATIC SYMPTOMS	WITHDRAWAL
ISOLATION	ANGER
DEPRESSION	DECREASED MORALE
DIMINISHED CAPACITY TO WORK INDEPENDENTLY	DIMINSHED JOB COMMITTMENT

Resilience refers to the ability to weather the storm, to bounce back after a critical event with little evidence of psychological trauma. The following factors have been found to correlate with resilience in childhood.

INDIVIDUAL CORRELATES OF RESILIENCE[7]

AGE - VULNERABLE TO SEPARATION AGES 6 MONTHS TO 4 YEARS

TEMPERAMENT - EASY-GOING ARE MORE RESILIENT

IQ - GREATER SKILL, GREATER SENSITIVITY

INTERNAL LOCUS OF CONTROL

POSITIVE SENSE OF THE FUTURE

HUMOR

FAMILY AND COMMUNITY CORRELATES OF RESILIENCE[8]

ONE GOOD PARENT

POSITIVE ADULT IDENTIFICATION FIGURE

STABLE FAMILY

POSITIVE RELATIONSHIP WITH CARETAKERS

EXTERNAL SUPPORT

MEDIATING MECHANISMS

RISK REDUCTION

NEGATIVE CHAIN-REACTIONS

SELF-ESTEEM

OPPORTUNITIES

PERSONAL CHARACTERISTICS

COLLABORATION

ROLE CLARITY

RESULTS ORIENTATION

PSYCHOLOGICAL UNDERSTANDING

OBSERVATIONAL SKILL

ANALYTIC THINKING

STRATEGIC THINKING

INTERPERSONAL SENSITIVITY

COMMUNICATION SKILL

RAPPORT-BUILDING SKILL

COACHING & COUNSELING SKILL

PERSUASIVENESS

JOB COMMITMENT

SELF-AWARENESS

SELF-CONTROL

SELF-CONFIDENCE

FLEXIBILITY

SELF-DEVELOPMENT

From Bernatovich

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Child Protection Services and

Child Abuse Prevention

Presented by

Deborah Daro, PhD and
Jan Payne, MSW, LGSW

THE ROLE OF PREVENTION IN CHILD WELFARE PRACTICE

WELCOME

AUDIENCE CHARACTERISTICS

Number currently employed by CPS
Number having experience in working with CPS (examples)

PURPOSE

Today, want to focus on how we can foster a more collaborative and successful integration of CPS intervention efforts and community-based child abuse prevention efforts.

In the past, this partnership has been hampered by

A. Defused prevention programs -- each community was different so it was difficult to set uniform standards. Everyone had to recreate the wheel

B. No legislative incentives for CPS to expand scope of work.

Payment for foster care was open ended
Payment for family support/family preservation was fixed
Training issues focused on investigation and "taking a case to court"

C. And lots of work to do with the treatment population

High numbers of reports
Bad press regarding fatalities
Stable or decreasing budgets

While many barriers and challenges exist to forging a new relationship between CPS and prevention, current conditions make it particularly fruitful to begin this discussion NOW.

POINTS TO COVER THIS MORNING

Want to discuss several items with you this morning.

I. WHY IS THIS A GOOD TIME TO BE TALKING ABOUT THIS ISSUE

Shifts in prevention
Shifts in legislative leadership
Shirts in child welfare realities.

II. SPECIFIC ASPECTS OF CHILD WELFARE PRACTICE WHICH ARE GOOD CANDIDATES FOR RELATIONSHIP BUILDING

Reporting system
Case planning process
Family Preservation/Reunification Efforts

III. MOVING FORWARD

Individuization of services
Allow/encourage local experimentation
Open funding streams
Expand range of partnerships
Monitor progress
Learn from mistakes/capacity to change

TOPIC I: WHY NOW

A. Healthy Families America - six year old initiative to provide support to all new parents, particularly those facing the greatest challenges -- is moving up to scale

300 sites in 38 states and D.C.
All states involved in planning process

While not uniform, does suggest prevention systems are looking for similar and a consensus is developing on how to structure prevention

B. Passage of the Family Preservation and Family Support Act in 1994

$60 million in FY1994
$225 million in FY1995
$240 million in FY 1996
$255 in FY 1997

All states needed to do planning on how to accomplish the dual mission of family support and family preservation (or treatment and prevention).

While disagreement on how balanced the distribution of these funds is between these dual objectives (advocates on each side of the argument claim the other side is getting all the money), fund DOES REPRESENT NEW REVENUES AND A COMMITMENT TO PLANNING

With reauthorization coming up in FY 1998, advocates need to stop arguing and start showing that this policy shift has been useful and should be continued.

C. Current system is not getting the job done, the number keep rising

High number of reports.
Changes in the characteristics of reports/number of cases involving sexual abuse.
Child fatalities and their characteristics
Why do these cases occur
Program lessons from these casual patterns
-- need diversified response system
-- need to formally link prevention and treatment

TOPIC II: WHAT DOES PUBLIC AND CHILD WELFARE ADMINISTRATORS THINK OF EXISTING REFORMS.

A. The public's perception of child welfare practice

Asked a series of questions and it is interesting to note the patterns of response

B. In the most recent survey, asked administrators what they thought of a variety of reforms/interventions.

As this table illustrates, highest confidence in family preservation reforms and children's trust funds (proxy for prevention).

Least pleased with prosecution and privatization of services

TOPIC III: REPORTING SYSTEM

A.. CURRENT OPERATION

Seeks to substantiate an allocation
Seeks to determine blame/responsibility
Seeks to avoid the worst outcomes
Serves as a gateway to too narrow a range of protective services

B. INCORPORATING PREVENTION FOCUS

Seeks to assess a child's risk for harm
Seeks to support children and their parents
Seeks to achieve the best possible outcomes for children
Serves as the gateway to broad system of community support

TOPIC IV: CASE PLANNING PROCESS

A. CURRENT REALITY

Limited array of service options available to caseworkers
Services often determined by what system has to offer rather than need
Outcomes measured by compliance with court orders -- often limited to "process" indicators of success

B. INCORPORATING PREVENTION FOCUS

Offers multiple response avenues
- Voluntary engagement
- Family arbitration
- Court intervention

Wide range of therapeutic and support services
Outcomes measures by changes in parental capacity or child well being

TOPIC V: fAMILY PRESERVATION/REUNIFICATION EFFORTS

A. CURRENT REALITY

Offered when a child is at risk for maltreatment
Foster care placement viewed as a case failure
Conceptualized as a short-term, limited intervention

B. INCORPORATING PREVENTION

Offered when a child is at risk for maltreatment
Seeks change in a broad range of domains
- Parenting knowledge/skills
- Child development
- Social support
- Parent-Child interactions

Length of engagement determined by family's level of need

TOPIC VI: MOVING FORWARD

Field, both prevention and treatment need to change and move forward. Possible areas of change include:

Individuization of services
Allow/encourage local experimentation
Open funding streams
Expand range of partnerships
Monitor progress
Learn from mistakes/capacity to change

Frank Farrow
with
The Executive Session
on
Child Protection

JOHN F. KENNEDY
SCHOOL OF GOVERNMENT
HARVARD UNIVERSITY

Funded by
the Edna McConnell Clark Foundation and
the Annie E. Casey Foundation

EXECUTIVE SUMMARY

Child Protection: Building Community Partnerships

"Getting From Here to There"

Across the country, there is a growing consensus that states and communities need to change the way that they protect children. Alarmed by steady increases in child abuse and neglect reports and by a child protective services (CPS) system that is struggling to safeguard children, professionals, politicians, and the public alike are calling for changes in child protection.

In an effort to craft a more effective approach for keeping children safe from maltreatment, the John F. Kennedy School of Government at Harvard University convened a working group of leading public and private child welfare administrators, elected officials, judges, advocates, academics, and other experts in the field. Funded by the Edna McConnell Clark and the Annie E. Casey Foundations, this group, the Executive Session on Child Protection, met regularly over the past three years in a series of intensive three-day meetings to share and examine new work in the field, and the experience of its members. The group's efforts are captured in a series of working papers that describe a comprehensive new approach for protecting children. The lead paper, written by Frank Farrow with the Executive Session, is *Child Protection: Building Community Partnerships.*

The working group proposes that rather than one agency—the public child protective services agency—bearing sole responsibility for protecting children, a broader array of parents, public and private agencies, organizations, and individuals should join together to carry out this fundamental public responsibility. The heart of this improved system is a community partnership for child protection.

A community partnership is a way of extending "who's responsible" for child safety as well as a way of providing more rapid, intensive, and effective responses when a child is in danger of being abused or neglected.

This vision is not utopian. Cities and counties as diverse as Cedar Rapids, Louisville, Jacksonville, and Los Angeles are developing community partnerships now. They are investing in new neighborhood-based services to identify risks of abuse and neglect early on. States such as Missouri, Michigan, and Florida are changing laws, practice, and policies to encourage these new efforts. The ingredients for a more effective system—from better frontline practices to new statutes—are already being developed and demonstrated around the country.

"Getting From Here to There"

Drawing on the experience of these communities and states, the Executive Session has mapped out a series of "do-able" steps for building community partnerships. This process of change begins with the CPS agency and new partners joining together in the mission of child safety. Once this partnership is established, states and communities create neighborhood-based services that reach families earlier, offer a wider range of help, and keep a keener eye on children's safety than the current system can. This well-organized partnership ensures that many people—parents, neighbors, schools, public and private agencies, police, churches, synagogues, mosques, boys and girls clubs, and others—work together to promote child safety.

Starting points and the degree of change will vary across states and communities. There are, however, seven stages through which states and communities may progress:

1. **Agreeing on the direction for change.** Reaching out to the public makes it more likely that the partnership will be accepted and sustained. An essential first step for CPS administrators, legislators, and other policy makers is to recognize that the CPS agency alone cannot successfully protect children.

2. **Starting the partnerships.** Partners should include all the people and organizations in a community that are required to keep children safe. Chief among these are parents. And while all partners are important, protecting children requires that schools, substance abuse prevention and treatment providers, the police, domestic violence service providers, and welfare services be part of this new agency from the start.

3. **Creating differential responses to the varied needs of families for child protection.** CPS agencies must be able to respond to children's safety needs in a way that makes sense for each situation. When abuse and neglect are severe, and coercive services and an investigation are essential, cases are assigned to an "investigative" track. However, when children are not at immediate risk and families will benefit from voluntary services, needs can be met through a second track that emphasizes a comprehensive assessment of family strengths and needs.

4. **Developing comprehensive neighborhood-based supports and services.** Effective neighborhood-based services requires the use of family networks, friends and other informal supports, the commitment of a wider array of formal services, and a willingness to change the way public services are now organized.

   Drawing on family networks and other informal resources is as important as expanding formal services. These networks, often including friends, relatives, and neighbors, are closer to and more trusted by struggling families than are most traditional formal services. Equally important is the need to reorganize service delivery. Moving services into neighborhoods and creating teams of public agencies and community resources makes services more accessible. Having a community partnership for child protection that focuses on each specific community builds bonds of accountability, trust, and knowledge between service providers and community residents.

5. **Transforming public child protection agency services.** CPS agencies must change their internal policies and practices while playing a leadership role in creating and sustaining the community partnership. The mainstays of practice become (1) using more comprehensive assessments, (2) engaging families and natural networks of support, (3) understanding the dynamics of substance abuse, domestic violence, and other risks to children, and (4) teaming with colleagues in other systems and the community.

6. **Shifting intake and follow-on services for lower-risk cases to a community-based system.** A well-established community partnership for child protection creates the possibility that some of the families now served by the CPS agency may be served by other members of the community partnership, without formal CPS involvement. This reduces the workload that is now overwhelming CPS agencies.

7. **Instituting community governance and accountability for protecting children.** Even as communities begin to build partnerships, they must ensure crystal clear responsibility for the safety of children, for the effectiveness of the system as a whole, and for generating and acting on data produced for the purposes of accountability. As partnerships mature, they may organize formal boards that assume responsibility for keeping children safe.

Who provides leadership for the partnership? Many agencies can, but CPS agencies remain particularly important. They will now act as the catalysts, organizers, and leaders in the development of community partnerships. Moreover, they will directly oversee the initial response to maltreatment reports (even though they may not provide that response itself); they will provide protective supervision for highest-risk cases; and they will supervise foster care and adoption services for families for whom voluntary services are not sufficient, and for whom the oversight and/or custody of the CPS agency is required.

The Executive Session recognizes that change will be difficult; current child protection approaches are mandated in federal and state law and are deeply ingrained in policy and practice, tens of thousands of caseworkers have been trained in this approach, millions of dollars are spent annually to support CPS, and the political stakes are high.

This should not discourage communities from embarking on this cause. The cold reality is that if states and communities do not re-engineer their CPS systems now, they may find themselves hopelessly behind as they try to meet the needs of endangered children and struggling families. Even cautious forecasters predict welfare reform will have a significant impact on the welfare of children.

Moreover, the reward for those who do embark on this course will be the capacity to move promptly and aggressively when children's safety is threatened and, eventually, to reduce the incidence of maltreatment. Furthermore, these steps need not be completed all at once; communities can tackle parts of this work and still improve child safety and agency performance. In the view of the working group, what is most important is to get started now. □

Sexual Assault in Adolescents

Presented by

Kevin Olson, MD

Adolescent Victims of Sexual Assault

Kevin Olson MD

Reported Incidence: 1986 - 37.5 rapes per 100,000 in US
1994 - Rate for females - 72/100,000
National Adolescent Health Survey: 17% to 30% of highschool students reported attempted rape
Survey of 18 to 22 year olds in a Family Planning Clinic 39% of women and 16% of females reported at least one episode of forced sexual intercourse

- Reporting: 39 - 90 % go unreported
  Arrests made in 50% of reported rapes
- Convictions:
  21 % of adolescent victims agree to discuss prosecution
  Arrested - 2/3 prosecuted
  Prosecuted - 47% found guilty
  16 convictions per 100 reported rapes

Demographic characteristics:

Age of rapist: 40% are 16-20 years old
26% are 20-24 years old
Age of victim: 50% are less than 18 mean age 15
Sex of rapist: 81% male, 19% female
Sex of victim: 96% female, 4% male - male rape including gay rape is likely to be much higher
Relationships: 60% are known "date" or acquaintance rapes
Statutory rapes are reported more commonly when perpetrator is older
Time of assaults: Higher in summer, weekends, 8pm-2am
Time of presentation: avg. 11 hours post assault. Most acute exams done within 24 hours of assault.
Weapons used in 30% of assaults. Weapons include knife, gun, choking, fists
Payor Mix: Private/HMO (30%), Medicaid (25%), None (43%), Other (2%)

Psychological effects of rape and the examination:

1. The acute signs of the rape trauma syndrome are: disorientation, hysteria, stoicism, anxiety, tearfulness. Victims in this state may present in a very controlled manner, seeming apparently calm or subdued. Don't associate affect with credibility.
2. Uncommon to see anger
3. Acknowledge that the victim's fears are valid, and that things in her life may be very difficult subsequent to disclosure

4. It may be necessary to ask more direct and focused questions when the victim is having difficulty providing a narrative response
5. It may be necessary to confront the family members if you feel that they are blaming the victim, and help clarify the dynamics of what occurred.

History

1. Time between assault and exam
2. Manner of assault
3. Complaints of pain, presence of blood
4. Date of last menses
5. Use of contraceptives
6. Actions after of assault (e.g. brushing teeth, showering)

Sexual history: 40% have had consensual activity
18% had been pregnant
19% prior sexual assault

Preparation:

1. Privacy
2. Trained examiner (e.g. SANE examiner)
3. Detailed examination protocol
4. Presence of companion
5. Explain the exam and reasons for different procedures. Use a diagram
6. Victim advocate or child life specialist for emotional support
7. Give victim control and choices during the exam

Physical examination

1. Do rape kit if exam is within 72 hours of assault. Always swab vagina even if exam is normal.
2. Follow all necessary steps for forensic evidence collection as outlined in rape kit.
3. General physical exam looking for other injuries like grab marks, bruises, human suction marks
4. Examine with a colposcope if possible and photograph injuries
5. Careful exam of external genitalia looking for labia and hymenal injuries.
6. Apply toluidine blue to posterior fourchette, fossa navicularis and anal verge.
7. Examine with Woods lamp for sperm fluorescence
8. Run hymenal edge with a wet Qtip
9. Foley catheter- 14 french with 30cc balloon used to gently stretch estrogenized hymenal folds.
10. Knee chest position only if hymen cannot be well visualized in supine position or with Foley catheter
11. Speculum exam looking for vaginal tears and cervical contusions
12. Do not perform hymenal measurements

13. Make sure that specimens are air dried. Number for air dryer company:
14. Detailed documentation of findings

Physical findings:

Types of assault:

- vaginal penetration - 88%
- rectal penetration - 21%
- fellatio - 20%
- cunnilingus - 17%

Evidence of injury: 60-70% in acute exams

1. Most common finding is a normal exam
2. Posterior fourchette most frequent area to see an injury during acute exam
3. Areas of absence of hymenal tissue,
4. Complete hymenal transections most frequent at 6 and 8 o'clock locations
5. Hymenal echymosis/contusion, vaginal tears, cervical contusion
6. Most common suspicious finding were single hymenal notches at 6 and 9 o'clock position
7. Anal tears - common for adolescents not to report anal penetration
8. Positive pregnancy test
9. Sperm present in vagina
10. Healing occurs rapidly

Classification of physical findings - see Adams reference
Strongest predictors for physical findings:

1. Exam within 72 hours
2. Presence of blood
3. Complaint of pain

Rape drugs

Alcohol and drugs used in over 30% of victims
When to suspect:

- Victims appear intoxicated similar to ETOH appearance
- Victim wakes up partially undressed in a bed or strange place

Deaths and life threatening overdoses have been reported

1. Flunitrazepam (Rohypnol) not sold in the US
   - Peak sedation in 1 - 2 hours and may last for 8 to 12 hours
   - anterograde amnesia
   - 2 mg tab dissolved in a beverage. Colorless and odorless
   - urine specimen must be analyzed specifically for flunitrazepam. Remains positive for up to 72 hours Call Hoffman- La Roche 1-800-608-6540 for help on urine sample analysis
2. Gamma hydroxybutyrate (GHB)
3. Ethanol

Diagnostic Tests:

1. Consider GC culture from throat, rectum, endocervix
   Chlamydia culture from rectum, and endocervix
2. Wet mount or pap smear for sperm, trichomonas, yeast.
3. RPR repeat in 6-8 weeks
4. Urine pregnancy test
5. HIV testing in months. At time of exam if sexually active

Treatment

1. Remark on normal findings
2. Review finding with victim if desirable
3. Emergency Contraception:
   - Offer Ovrall - 2 pills at time of visit and 2 in 12 hours. Also prescribe an anti-emetic to with the pill

4 Treat significant trauma. Most hymenal injuries heal well without surgical intervention

5. Tetanus toxoid
5. Cefixime 400mg, Azithromycin 1 gm po, Flagyl 2gm po
6. Hepatitis B vaccine
7. Psychological support with detailed discharge instructions for medical follow up. Dependent on STD testing and pregnancy prophylaxis

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Munchausen Syndrome

by Proxy

Presented by

Randell C. Alexander, MD, PhD

MUNCHAUSEN SYNDROME BY PROXY

I. Definitions
   A. Syndrome: Greek origin -- *syn* (with or together) and *dramein* (to run). A running together of signs and symptoms.
   B. Signs: What can be observed
   C. Symptoms: What the patient complains of
   D. Munchausen syndrome: The fabrication of symptoms and/or signs by the patient.
   E. Munchausen syndrome by proxy: The fabrication of symptoms and/or signs by a caretaker with respect to a child.

II. History of Munchausen Syndrome by Proxy (MSBP).
   A. Munchausen syndrome first described by Asch in 1951 for adults who fabricated symptoms about themselves and/or produced signs of illness. Presented for medical care, but did not inform medical personnel of the deception. The fantastic confabulations reminded him of Baron Von Munchausen -- a European teller of tall tales.
   B. Munchausen syndrome patients have multiple hospitalizations, doctor visits, and medications -- all on the basis of deception (i.e. nothing wrong in the first place).
   C. Guinness Book of Records (1993):
      William McIloy (b. 1906) cost Britain's National Hospital Service about $4,000,000 over 50 years. 400 major and minor operations, 100 different hospitals using 22 aliases. Longest period out of hospital = 6 months. "In 1979 he hung up his bedpan for the last time, saying he was sick of hospitals, and retired to an old people's home ... where he died in 1983."
   D. Roy Meadow in 1977 first coined the term "Munchausen syndrome by proxy" to describe the perpetration of the deception in regard to the child, not the patient.
   E. Donna Rosenberg (1987) wrote about the "web of deceit" -- an extensive literature review.
   F. Levin and Sheridan (1995) editors of first comprehensive professional book about MSBP.

III. Specific Definition of MSBP (Alexander et al., 1990)
   A. Apparent illness or health-related abnormality which the caretaker concocted or produced.
   B. Presentation of the child for medical treatment.
   C. Failure by the perpetrator to acknowledge the deception.
   D. Exclusion of simple child abuse/neglect and simple homicide.
   E. Note: Rosenberg adds that the symptoms go away when the child is completely removed from the perpetrator. However, this is an effect -- not a definition per se.

IV. Epidemiology
   A. Crude estimate of about 2-4 cases per million general population (about 6-10 cases in Iowa per year? 500-1,000 cases nationwide per year?).
   B. Are there cases which are missed because the perpetrator does such a good job of deception that they are never caught?
   C. Several hundred cases published in literature -- hard to publish any other cases unless something really unique.
   D. Production of signs/symptoms in about 70% of the cases.

V. Presentation
   A. Various symptoms, signs and laboratory findings
      - Abdominal pain
      - Anorexia (loss of appetite)

- Apnea (cessation of breathing)
- Arthralgia (painful joints)
- Arthritis (swollen joints)
- Ataxia (dyscoordination)
- Bacteruria (bacteria in urine)
- Biochemical chaos
- Bleeding from ears
- Bleeding from other sites (nasogastric tube ileostomy)
- Bleeding tendency
- Bleeding from upper respiratory tract
- Bradycardia (slow heartbeat)
- Cutaneous abscesses (skin infections)
- Cyanosis (turning blue)
- Cystic fibrosis
- Dehydration
- Developmental disabilities
- Diabetes
- Diaphoresis (sweating)
- Diarrhea
- Easy bruising
- Eczema
- Edema (peripheral)
- Epistaxis (nosebleeds)
- Esophageal burns
- Feculent vomits
- Fevers
- Food allergy
- Glycosuria (sugar in urine)
- Headache
- Hematemesis (vomiting blood)
- Hematochezia or melena (blood in stool)
- Hematuria (blood in urine)
- Hemoptysis (coughing blood)
- Hyperactivity
- Hypernatremia (high blood sodium)
- Hypertension (high blood pressure)
- Hypoglycemia (low blood sugar)
- Hypokalemia (low blood potassium)
- Hyponatremia (low blood sodium)
- Hypothermia (low body temperature)
- Immunodeficiency (body can't fight germs)
- Irritability
- Lethargy
- Leukopenia (low white cell count)
- Morning stiffness
- Nocturia (urinating at night)
- Nystagmus (jerking eye movements)
- Personality change
- Polydipsia (drinking a lot)
- Polymicrogial bacteremia (more than one germ in blood)
- Polyphagia (eating a lot)

- Polyuria (urinating a lot)
- Prolonged sleep
- Pyuria (pus in urine)
- Rash
- Renal failure (acute)
- Seizures
- Septic arthritis (infected joint)
- Shock
- Unconsciousness
- Unimicrobial bacteremia (one germ in blood)
- Urination from umbilical micropenis
- Urine gravel
- Ventricular tachycardia (abnormal heart rhythm
- Vomiting
- Weakness
- Weight loss

Reference: Rosenberg DA. Web of deceit: A literature review of Munchausen syndrome by proxy. *Child Abuse & Neglect.* 1987;11:547-563.

B. Frequently cases are described as "one of a kind," "I've never seen anything like it," "this case doesn't make sense." Often medical remedies that usually work, do not.

C. Case example:
A 33 month-old boy was brought to the ER by ambulance for the 10th time in 5 months. The mother reported that the boy was not breathing and/or had a seizure. These episodes occurred approximately 4:30 PM every third Tuesday. The mother was the only one to witness the onset of the spells, and frequently would be administering CPR when the ambulance arrived. Extensive medical testing over the years (about 20 hospitalizations) yielded no definite cause. MSBP was beginning to be suspected in another state, but the family moved before action could be taken. One physician performed a 24 hour EEG which was inconclusive, but still continues to believe that the child has some rare (possibly undescribed) medical problem. Placed in foster care, no spells were ever observed again. The mother was convicted of felony child endangerment.

Discussion points:
1. What tipped the physicians as to the diagnosis?
2. What categories of child abuse apply in this case?
3. What aspects of this case are most typical of MSBP? Which are not?

VI. Characteristics of the Perpetrator
A. Nearly always the mother (more than 95%). Sometime a female caretaker. Rarely a father (first case was described in Iowa).
B. Many have some sort of health background (who better to mount a credible deception?).
C. Often (but not always) are described as the last person you would suspect.
D. May enjoy being in the hospital, constantly present, knows the nurses and other patients.
E. In retrospect, sometimes they are unusually calm when a major crisis is happening to their child (e.g. CPR).
F. When confronted, they nearly always maintain their denial -- even in the face of direct evidence such as a videotape.
G. Psychological testing usually normal.
H. May have Munchausen syndrome themselves. If so, beware of strong association with suicide.

VII. Characteristics of the Family

A. Father
   1. Probably present more often than the population average would suggest
   2. Often described as distant, secondary to mother, little involvement.
      a) This may be partly unfair. Mothers bring in most children for medical care in this culture.
      b) If mother is a health professional besides, father has further reason to let her take the lead.

B. Extended family
   1. Increasingly, cases discovered of mother being victim of MSBP (intergenerational).
   2. Families often supportive of the mother in her denial

C. Community
   1. MSBP does not happen unless a doctor is found who can be fooled (any can for some period of time). Often the doctor will go to bat for the mother beyond that support shown for other patients.
   2. Once discovered, mother may enlist her lawyer to crusade for her. Argument almost always is that the doctors do not understand that the mother exaggerates ("she doesn't know medicine as well as you").
   3. May enlist the CPS worker, legislator, etc. in her efforts to deny. All part of the pathology of this behavior.

VIII. Dynamics of MSBP

A. Common final pathway: mother using the child in a cold, calculated way to further her own ends.

B. Always a combination of physical abuse (by omission) -- using the doctors as "hit men" to poke with needles, perform surgery, etc. -- and medical neglect (improper supervision, failure to attend to the child's medical needs).

C. Types of motivations (may be others):
   1. Mother wanting to be in the hospital. Liking the action. Child is the ticket.
   2. Mother wanting to fool the doctors. A game.
   3. Mother escaping the father.
   4. Mother trying to get the father's attention (e.g. MSBP during Operation Desert Storm in Iraq. Father returns on medical emergency basis).
   5. Mother using MSBP as respite.

   Case example:
   A mother comes to the ER with her 12 month-old son complaining of apneic spell. Ten previous ER visits, with multiple hospitalizations. Previous testing is negative and no spells ever noted by anyone other than mother. On apnea monitor at home. In the process of being sent home again, she comes out of the room saying that her child is bleeding on the diaper. Female resident notes that it is rouge. Timeline showed that whenever father went out of town for 3-4 days for work, mother would show up in ER with claim of child's apnea.

D. Not to be confused with exaggerations which are common in Pediatrics (MSBP is a deception). If parent is hallucinating, MSBP is not the issue.

IX. Diagnosis

A. Who makes the diagnosis?
   1. Pediatricians and family practitioners (MSBP first described by pediatrics, and most of literature still in pediatrics).
   2. Best confirmed by Forensic Pediatrician (child abuse specialist).
   3. A medical diagnosis -- not to be diagnosed by non-medical personnel (although suspicion is okay).

4. Since it is a medical diagnosis, CPS worker must "found" the report in absence of contradiction by Forensic Pediatrician.

B. Role of psychology/psychiatry in diagnosing MSBP
   1. MSBP refers to the behavior. It is not a mental health problem of the mother or the child as such. It is an interactional deceptional problem, not something which shows up on individual testing.
   2. No test for MSBP. Nothing correlates with MSBP, except recent reports from England that "borderline personality disorder" is over-represented.
   3. Psychiatry generally NOT as knowledgeable about MSBP and is less expert than pediatrics.
   4. MSBP describes actions -- not personalities. Do not use profile of perpetrator to diagnose a case (false negatives and false positives).

   Case example:
   A two year old has fevers of unknown origin. Cultures of the blood show water-borne organisms not normally seen in infections. The organisms are often mixed and vary from infection to infection. None of this makes sense. The mother is caught by a nurse coming out of the bathroom one day with something in her hand which she was hiding. Doctors diagnose MSBP with some sort of surreptitious injections. Sent to a psychiatrist by the court, the mother has a normal MMPI, is not depressed, is defensive, and tends to exaggerate. The psychiatrist states that she does not believe that the mother has MSBP based upon the testing.

C. Protocol for identification
   1. Knowledge of the syndrome.
   2. A high index of suspicion when cases "do not make sense".
   3. Extensive review of old records May need to use insurance/Medicaid to track all the doctors, hospitals, and pharmacies used.
   4. Toxicology screen for some cases. Examples: Ipecac, Ex-Lax, Valium.
   5. Timeline. (Very important!!)
   6. Surveillance in a controlled hospital setting in some cases. (MSBP is NOT a diagnosis of exclusion -- it can be make on pattern alone and does not require hospitalization in many cases.) The risk may actually increase somewhat when hospitalized as the caregiver attempts to give more convincing "proof" of the claims. The witnessing of produced signs or symptoms is helpful. The absence of signs/symptoms when monitored continuously is also helpful in making the diagnosis.

X. Protocol for Initial Treatment
   A. Child abuse report.
   B. Emergency removal to foster care.
   C. Juvenile court involvement (possibly criminal court).
   D. Psychological testing of caregivers. This is to determine any learning disabilities, mental impairment, thought or emotional disorder which impacts upon service delivery. NOT to diagnose MSBP.
   E. Consult with Forensic Pediatrician.

XI. Outcomes
   A. About a 10% risk of death in published reports.
   B. Psychological morbidity in the victims is high/universal. May adopt Munchausen behaviors themselves. Impairment of most basic level of development -- basic parental trust.
   C. Legal system often has difficulty understanding such cases and may not respond appropriately.

D. Prognosis is extremely poor. Although many children return to the family and survive, there is no convincing case in the professional literature demonstrating successful treatment. How would you measure it in an engaging, charming mother?

XII. Legal Issues

A. Serial abuse (Alexander et al, 1990).
   1. Estimated a minimum of 25 - 35 % of cases may involve other children in family
   2. Usually mother commit MSBP to one child at a time.
   3. Tend to use the same type of presentation from child to child.
   4. In cases of serial MSBP: higher fatality rate, more children involved, marital difficulties, high incidence of maternal psychiatric histories (cause vs. effect?), Munchausen syndrome in the mothers themselves.

B. Treatment (if attempted)
   1. Genuine admission to all the deceptions.
   2. Identify antecedents of these behaviors.
   3. Correct these antecedents.
   4. Monitor the situation closely.
   5. Keep children with same doctor -- one who understands and accepts the diagnosis.
   6. Any therapy with the mother (and father) should be by a therapist who knows and accepts the diagnosis and will not be easily fooled.
   7. No successful case known. Doubt it will work.

C. Videotape and other monitors
   1. Apnea monitors with event recorders are very helpful in determining what is going on in questionable cases.
   2. Videotaping in a hospital is rarely needed for diagnostic purposes. Videotaping is <u>not</u> a gold standard for "proof."
   3. Covert vs. overt taping.
      a) Check with hospital attorney.
      b) Often leaving the video camera in the room will work as it is soon forgotten.
      c) What is the legal liability if no one is watching when the abuse is committed?

Issues for Recently

Established CACs

Presented by

Anne Lynn

CAC COMMON ELEMENTS and UNIQUE OPTIONS

- **Neutral Child-Appropriate Facility**
- **Multi-Disciplinary Case Review**
- **Joint Investigations/Interviews**
- **Medical Examination and Evaluation***
- **Mental Health Treatment***
- **Case Tracking**
- **Specialized Training for Staff and Disciplines**

(OVH 3-5)

CAC ORGANIZATIONAL COMPONENTS

- **Private Non-Profit Status or Government/Agency Sponsership**
- **Interagency Agreements and Protocols**
- **Designated Staff Assigned to the Program**
- **Volunteer Screening, Training and Supervision**
- **Policies and Procedures for Safety, Confidentiality, and Service Provision**
- **Malpractice and Liability Insurance for Staff, Volunteers, and Clients**

(OVH 3-6)

RESOURCE DEVELOPMENT:

a comprehensive plan which includes sources for:

- People
- Skills
- Time
- Energy
- Expertise
- Space
- Materials
- Equipment
- Community Good-Will
- Partners
- Money

(OVH 3-7)

INTERAGENCY AGREEMENTS AND PROTOCOLS:

- **To coordinate intervention**
- **To establish and formalize cooperation**
- **To solidify commitment to CAC approach**
- **To detemine consensus**
- **To address concerns**
- **To open communication**
- **To gain agreement**

(OVH 3-8)

STEPS FOR GETTING STARTED

- Convene Task Force/Steering Committee
- Recruit Key Agency and Community Leadership
- Conduct Community Needs Assessment and/or Feasibility Study
- Determine Scope of Service
- Develop Vision/Mission/Goals
- Identify Local Resources

(OVH 3-1)

KEY ELEMENTS OF TASK FORCE / WORKING COMMITTEE

- Membership
- Leadership
- Size
- Facilitator/Convener
- Focus

(OVH 3-2)

NEEDS ASSESSMENT

Used to determine if the incidence of a particular problem justifies intervention to redress the problem.

- Defines the scope of the problem
- Illustrates a child's movement through all systems
- Defines need for collaboration on cases
- Results can be used in Feasibility Study

(OVH 3-3)

FEASIBILITY STUDY

Used to decide whether a community has the interest and resources to develop a specific program successfully.

- Helps to cultivate support for the CAC
- Will be valuable for later CAC planning, fund raising and evaluation efforts

(OVH 3-4)

Creatively Corroborating the Victim: Using Search Warrants and Pretext Phone Calls in Child Abuse Cases

Presented by

Nancy Lamb, JD and
George Ryan, Investigator

PROBABLE CAUSE STATEMENTS FOR SEARCH WARRANTS

1. Pedophiles are men or women who are sexually attracted to children- Ped, meaning children and Philia, meaning the attraction to.

2. Pedophiles can receive sexual gratification from the actual physical contact with children or may receive sexual gratification from fantasy items such as props and pictures (i.e., toys, dolls or children's books).

3. Pedophiles are extensive collectors of sexually explicit materials such as tapes, photographs, child pornography magazines, video tapes, movies, slides or books which can be used for sexual gratification.

4. National statistics indicate 80% of pedophiles were sexually abused as children.

5. Pedophiles usually commit their first offense of sexually molesting a child near the beginning of their adolescence.

6. Pedophiles usually molest more than one victim in their lifetime. A typical pedophile will sexually abuse 380 children in a lifetime (ABEL, 1986 Study, National Coalition Against Pornography).

7. Pedophiles usually do not dispose of or destroy their collections of child pornography and other sexually explicit materials. These items are "personal souvenirs" and "collections" that may have taken years to collect. They will do anything possible to build their collections and they will take much personal pride in their collections. These collections can be preserved for years and years, often stored in uncommon hiding places to protect them from being discovered (i.e., inside walls, false ceilings).

8. Many pedophiles will go to extremes to hide and protect their collections, even using bank safety deposit boxes and computer programs.

9. Pedophiles usually have a gender preference as well as an age preference of their victims. Pedophiles may also have a physical preference such as hair and eye color.

10. Pedophiles will engage in certain sex acts that actually give them sexual gratification. Certain sex acts that turn one pedophile on may turn another pedophile off (i. e., oral sex and anal intercourse).

11. Many pedophiles will volunteer their services as scout leaders, football, baseball, or soccer coaches, day care providers, big brothers or big sisters, or other organizations that will give them legitimate and easy access to children.

12. Pedophiles often correspond with one another to share and tell their sexual experience with each other. To fulfill this need they actively look for another pedophile (friend) they can relate to and trust with their secret.

13. Pedophiles will often keep diaries and ledgers of their sexual experiences in order to "relive" their experiences.

14. Pedophiles are extensive "keepers", using everything from simple notebook paper and/or calendars with victims names listed, to computer printouts and programs of their victims. These records may include physical descriptions and addresses of victims, what sex acts they engage in, how well they perform the sex acts, where the victims were picked up and how many or how often the victim was molested.

15. Pedophiles may cut pictures out of magazines, newspapers, books, and department stores catalogs of children wearing bathing suits, training bras, and underwear.

16. Pedophiles usually use a camera to develop their own pornography. They often do their own film developing and reproduction to help protect their operation.

17. Pedophiles often maintain names, addresses, phone numbers, and lists of persons who have similar sexual interests.

18. Pedophiles at times use "props" such as sexual aids, dildos, and vibrators in the seduction of their victims.

19. Pedophiles will also keep collections of adult and child pornography available to help lower the inhibitions of their victims.

20. Pedophiles will use the inhalant "anyl nitrate" to enhance their sex drives.

POTENTIAL PROBLEM AREAS OF THE SEARCH WARRANT

1. **Information must be correct. If the affiant includes misleading information, credibility may be compromised.**

2. **The affiant must have sufficient expertise in the investigation of child sexual abuse cases.**

3. **Avoid terms such as pedophile or pedophilia. These are diagnostic terms. Law officers should stay with generic law enforcement terms such as child molester.**

GENERAL TIPS
ON LOCATING EVIDENCE DURING YOUR SEARCH

1. Be nice to your suspect. Often they will tell you about their collection hiding spots.

2. Ask your suspect about other areas under his control: safe deposit boxes, rental storage units, boats, planes, offices, and other areas. Either obtain a consent search or supplemental search warrant for the areas your suspect lists.

3. Be **PATIENT**. If a suspect believes your search team is rushing, he will hope your team will miss the items. However, he will often give up hope if you let him know that you will be there as long as it takes.

4. Be **CONFIDENT**. Ask your suspect "Where the pictures of children are kept", not "whether or not they have them".

5. Be **THOROUGH**. Instruct your search team that hiding places... and your finding them, are only limited by the imagination of the pedophile. Conduct a thorough search. Look for evidence of rental storage or safe deposit boxes.

6. **COMMUNICATE**. Statements made by the suspect can aid your search team in zeroing in on evidence. Evidence uncovered by your team can be invaluable in aiding your suspect interview. Prior to a search, instruct your interview and search teams to communicate.

DEVELOPING THE OFFICER'S EXPERTISE

The process should include as many of the following possibilities as are pertinent to the officer:

- Number of assignments to sex crimes
- Number of years in law enforcement
- Number of years working in child sexual abuse investigations
- Pertinent professional memberships
- Number of cases investigated
- College Degrees
- Training in the area of child sex crimes
- Number of confessions obtained
- Number of child interviews
- Number of child sexual abuse criminal warrants obtained.

REASONS TO OBTAIN A SEARCH WARRANT

TO SEIZE CORROBORATING EVIDENCE:

- Verification of offenders' house furnishing and physical characteristics
- Any photography equipment
- Any developing or printing equipment
- Names/addresses of victims
- Collections, books, magazines, toys, or other unique items that a child would play with
- Items left by the child with the offender
- Blood samples
- Suspect's bank records, checks written to victim
- Phone records

TO SEIZE CONTRABAND:

- Narcotics described by the victim as provided by the offender.
- Weapons used by the offender to threaten or injure a child

Sorting Out Sexual Abuse Allegations in Context of Divorce and Custody

Presented by

Seth L. Goldstein, Esq.

INVESTIGATION AND PROSECUTION CHILD SEXUAL ABUSE ALLEGATIONS IN CUSTODY/VISITATION CASES

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DISCUSSION NOTES AND DETAILED OUTLINE

Intended for anyone involved in investigating or developing a child sexual abuse allegation for court, this lecture will provide investigative case management techniques, strategies, and sources for identifying offenders and victims, establishing corroboration, determining criminal intent, collecting evidence, and preparing a case for trial. Cases involving child custody and visitation issues have special issues that must be considered to assure the allegation is valid and that defenses that are not valid are anticipated.

Traditional investigations focus mainly upon the child and offender when investigating child sexual abuse. In custody and visitation cases, the focus must more heavily bear upon the reporting parent (RP). This focus must seek to isolate the child and the evidence from the RP to assure, to the best degree possible, that there is no improper influence or direction attributable to the RP in the child's account of events and/or the evidence.

It must be stressed that there is no difference between a custody and visitation related case and that of any other investigation. It is when investigators treat these cases differently that problems develop. The same investigative practices used in every other case must be considered and/or utilized.

Special concentration should be devoted to certain efforts in these cases that will produce a greater likelihood of dispositive (determinative) evidence. This lecture is intended to discuss these concerns.

The material presented in this course consisting of suggested guidelines, procedures and investigative practices, is a compilation of successful and standard practices from various sources. They are offered as suggestions and possible alternatives for consideration in individual cases. Before employing any of these practices or procedures, the student should first consult with local policy and interpretation of law and rules.

INSTRUCTIONAL OUTLINE

I. DEFINITIONS
II. FALLACIES
III. BACKGROUND
    1. Magnitude
    2. Sources of victims
    3. Seduction methods
    4. Organized groups/underground
    5. Pornography and other literature
    6. Violence

IV. DYNAMICS OF THE OFFENSE
    1. Why the child gets involved
    2. Response to the crime
        a) By the victim
            A. Child sexual abuse accommodation syndrome
                1. Secrecy
                2. Helplessness
                3. Entrapment and accommodation

4. Delayed, conflicted, and unconvincing disclosure
5. Retraction
b) By the public Distrust because of CSAAS.

3. Victim characteristics
a) Non-offending parent characteristics.
4. Offender characteristics

V. MO FACTORS
1. Contacts
2. Methods of sexual pursuit
3. Style of seduction
4. Photographs
5. Pornography
6. Drugs and alcohol
7. Reasons why child will disclose
a. Window of disclosure
1. Safety
2. Fear
3. Anger

VI. INVESTIGATION PROCEDURES AND CONSIDERATIONS IN CASE MANAGEMENT

1 TEAM APPROACH
1. Multi\disciplinary team
A) roles carefully defined
B) eliminate need for multiple interviews
C) Never delegate to untrained person

VI.2 PRELIMINARY INVESTIGATION CONCERNS
1. Is it possible to prevent contamination by witnesses and involved parties talking to one another or is there a chance of alliances being drawn once the "secret" is out?

2. Is it possible to secure an admission or confession on the part of the offender before he learns of the investigation and tries to intimidate the child or witnesses or begins to confabulate a story?

3. Is it possible to prevent the destruction of evidence by the offender or his supporters (often the non-offending parent) before he learns of the investigation?

4. Is there any medical evidence available?

NATURE OF RESPONSE
1) Should be conducted in person.
2) Should depend upon the manner in which the case is generated, the scope, and nature of the case.

VI.3 SENSITIVITY OF RESPONDING INVESTIGATOR(S)
1) Must be sensitive to the needs of all concerned in the family.
A. Use of professional support people such as rape crisis or victim witness workers may help to facilitate this if they are brought to the initial contact with the investigator.
B. If there are multiple victims in a single case, consideration of sending the children to different therapists may be in order.
2) Recognize parents confidence is necessary. Loss will compel them to go out on own and investigate, thereby discrediting anything they come up with.

VI.4. CONCERNS IN INTERVIEWING VICTIM(S) AND ALL POTENTIAL WITNESSES

1) Each witness should be interviewed separate and away from any others. Especially with Intra-familial cases.
2) Never tell a child specifically what another child has said about the abuse.
3) If the abuse occurred in a school or other organizational setting, not only should the other students in the child's' class or group be interviewed, but, those in past classes should be considered. Present past staff members should be interviewed.
4) In any incest case the siblings of the victim should be interviewed, both those who currently live in the home and those who don't.
5) Any and all residents of a home where an incest case occurs should also be identified and interviewed, in particular, the Reporting Parent.
6) Just as in extra_familial cases, examine the characteristics of the victim(s) and try to "profile" who the offender would target.
7) Relatives and neighbors should be interviewed. Here are some questions to ask:
    A. If the victim reported the molestation to anyone, what specifically did the child say? What did the person say to the child - was there any observed effect?
    B. What was the victim's demeanor when he/she made the report of the molestation?
    C. What is the witness' relationship to the suspect? Look for bias/collusion.
    D. What is the witness' attitude toward the suspect and toward the allegation that the suspect has committed acts of child molestation?
    E. What is the witness' attitude toward the victim, e.g. does the witness believe the victim to be a truthful child? If not, what does the witness perceive as the motive of the child to fabricate?
    F. Have there been any behavioral changes in the suspect or the victim (see characteristics below)?
    G. What is the attitude of the child toward the suspect?
    H. What is the attitude of the suspect toward the child?
    I. Have there been any recent or ongoing problems between the child and suspect? Or, on the other hand, has the suspect shown any unusual interest in the child?
    J. Has there been any change in the victim's performance or conduct at school?
    K. Has the child complained of pain or soreness, particularly in the vaginal or anal areas?
    L. What has the child's medical history been?
    M. What is the name and address of the child's physician? (This information will facilitate the subpoenaing of the child's medical records.)
    N. What schools has the child attended during which years? What are the names of the child's teachers during those years? (This will help establish the period of the molestation and will facilitate the subpoenaing of the child's school records if necessary.)
    O. What opportunity did the suspect have to commit the crimes at the times alleged? Did the suspect have access to the child? Is the child frequently alone with the suspect?
    P. When and where did the incidents reported by the child occur, i.e. if the child reports that she was molested while the family was at the beach, when did the family go to the beach, who was present, where was the beach? If the child reports that he/she was molested while the suspect and the victim were together in the back yard, when were they together in the back yard?
    Q. What are the drinking and drug habits of the sus\-pect?
    R. Is there any conflict in the home? Is the child aware of it?
    S. Is the child aware of what the report of molestation might have on his/her living or custody arrangements?
    T. Has the suspect ever previously been accused of child molestation? When, where, and by whom?

U. Has the child ever been molested previously or made any allegations of molestation in the past?
   a) When, where, and to whom?
   b) Does the child know anyone who has made such allegations?
   c) If so, what are the circumstances of that incident?
   d) Is the child related to or friends with the person who reported that incident?

V. Where did the child acquire any awareness that the child may have of sexual matters and is it possible that the child was exposed to anything like what he describes?
   a) Is there a possibility that the child is partic\-ipating in sexual activity?
   b) If so, with whom?
   c) Are there sexually explicit matters in the home?
   d) Does the family watch the "Playboy Channel" or other cable type of pornography station?
   f) Does the family have a video recorder and does the child have access to it?
   g) Has the child had opportunity to observe sex acts of other family members?
   h) If the child describes sexual intercourse, oral copulation, sodomy or other bizarre sexual practices, has the child ever been in a position before to observe such activities?
   I) Is the suspect inclined toward` such practices? (specific sex acts; practices with non-offending parent/previous sex partners.

W. If the child describes the use of foreign objects, e.g. Vaseline, condoms, pornography, etc., are there such items in the home?

X. Has the witness/relative noticed any of the following behavior at any time during, after, or presently, by the child?:
   a) Overly compliant behavior
   b) Acting_out aggressive behavior
   c) Pseudo mature behavior
   d) Hints about sexual activity Look for drawings, re-enactments, sexual play with peers, younger siblings.
   e) Persistent and inappropriate sexual play with peers or toys or themselves, or sexually aggressive behavior with others
   f) Detailed and age inappropriate understanding of sexual behavior (especially by young children)
   g) Arriving early at school and leaving late, with few, if any absences.
   h) Poor peer relationships and the inability to make friends
   I) Lack of trust, particularly with persons who are important in the child's life
   j) Nonparticipation in school and social activities
   k) Inability to concentrate in school
   l) Sudden drop in school performance
   m) Absolute "perfect" child
   n) Extraordinary fear of males (in case of male perpetrator and female victim)
   o) Seductive behavior with males (in case of male perpetrator and female victim)
   p) Seductive behavior with females (in case of female perpetrator and male victim)
   q) Running away from home
   r) Sleep disturbances
   s) Withdrawal
   t) Clinical depression
   u) Self destructive behavior (self_inflicted inju\-ries, etc.)
   v) Suicidal feelings

Y. What are the sleeping arrangements in the house\-hold

VII. ANTICIPATION OF DEFENSES AND COUNTER MEASURES

VII.1 IDENTITY

a). Fingerprints
b). "Rape kit" evidence
c) Unique descriptions of offender's person, home or car

VII.2. ITS A FALSE REPORT

PRIMARY TYPES OF REPORTS:

1. Those where there is a sincere, legitimate and valid allegation made which is true because the abuse actually occurred.
2. Those where there is a sincere, legitimate, and valid allegation made which is a misinterpretation of some behavior or statements made by the child.
3. Those where there is a deliberately malicious false allegation made.

BREAKDOWN:

a) The totally false report which has no merit at all. Maliciously made.
    1. Initiated by: parent/adult or child
b) The partially false report. Actually happened, but something not correct.
c) Misinterpreted actions on the part of the offender. Genuine belief, incorrectly based.
d) Pied Piper effect (children following interviewer's (Mom's/Dad's leading questions/directions).
e) Displaced assignment of responsibility (child was molested, but by a different person).
f) Second party reports (a third party suspects abuse).

The investigator should consider the following factors in assessing his case.

1. Can the child describe events/acts to which (s)he wouldn't ordinarily be exposed?
2. Does the child describe characteristics consistent with abuse with idiosyncratic detail such as the style of seduction or manner in which the crime was committed, i.e.:?
    A) Says the offender told him it was a secret.
    B) Says the offender called it sex education.
3. Is it physically possible or feasible for the things to have happened which the child(ren) describe?
4. Do the things the child describes exist?
5. Does the child show the emotions and characteristics which generally accompany disclosure?
    A) Tears
    B) Fear
    C) Anger
    D) Avoidance behaviors
    E) Reluctance to discuss intimate details
    F) Nervousness
    G) Anxiety
    H) Discomfort
    I) Sadness
6. Does the child exhibit incredulity at questions regarding the intimate or distasteful aspects of the crime which he would have experienced had it happened to him?
    A) Semen in the mouth
    B) Oral copulation of vagina or anus
7. Does the child exhibit any characteristics of the false reporter?
    A) A bright adolescent.

B) Has an axe to grind with the offender.
C) Is overly angry.
D) Alleges vaginal intercourse only with absolutely no other action.
E) Alleges overly bizarre behavior and acts which have little relationship to sexual stimulation.
F) Can't provide any details.

8. SPECIAL QUESTIONS FOR CONSIDERATION:
   A. Who did the child first disclose to?
   B. What triggered the disclosure?
   C. When did the first disclosure occur?
   D. How the original disclosure surfaced?
   E. Why the child is telling now?
   F. How many people Have talked to the child (and who are they)?
   G. Exactly what was said by the child to each of these persons?
   H. Exactly what was said to the child by these persons?
   I. How, if at all, the aforementioned may have affected what the child is now saying? What evidence is available to confirm or refute the allegation?
   J. What evidence is available to confirm what the child is saying?
   K. Are there any alternative explanations for the child's behaviors and what (S)he is saying?

VII.3. DIMINISHED CAPACITY OR INSANITY

1. To establish consciousness of guilt answer the following:
   A. Where does he contact the child when he finds him?
   B. Is it from behind the bushes or other type of con\-cealment?
   C. Does he try to conceal his face or identity in some way?
   D. Does he try to change his voice in some manner?
   E. When he molests the child, does he do it out in the open where everyone can see him or does he take the child into the bushes with him, around the corner away from everyone else, in his car to a remote location or does he turn out the lights so no one will see it?
      a) Act in front of others
         1. Thrill
         2. Automatic discrediting of claimant.
   F. After he commits the crime what does he do with the child?
      a. What does he tell the child? (secret/threat?)
   G. Does he tie up the child so they can't get away and report him before he gets away?
   H. Does he drop the child off in a place where the child can't possibly make a report because its in the middle of nowhere?
   I. Does he try to conceal the body or child after he leaves the child?
   J Where does he put the pictures he takes of the child?
   K. Are they in the same places his "family" photos are?
   L. Are they hidden away somewhere where only he can get them?
   M. What measures did the offender take to prevent his being discovered?
   N. Did he use an alias, postal box, a mail drop or remailing service?
   O. Did he give his own address in the correspondence or did he use a "coded" address when advertising?
   P. If he took pictures of children, where did he keep them.
   Q. Were they hidden or in a readily available location?
   R. What measures were taken to create a hiding place?
   S. Did he build a false wall, floor, or hidden storage area?
   T. What kind of camera equipment did he use?

U. Was it the type of film which develops immediately after taking the picture so no one would discover it in the developing process?
V. Was it video tape which requires no developing?
W. Does he develop and print his own film.
X. If he develops his film through a photo service, where does he have it done?

VII.4. ACTS DIDN'T HAVE NECESSARY INTENT
A. What did offender do before, during, and after act?
B. What did offender say before, during, and after act?
C. What kind of evidence was found in offender's possession? Child Erotica? Sexually explicit materials pertaining to children or activity with children?
D. Were there identifiable MO traits in the seduction of the child?
E. Are there any other children who had the same things happen to them?

VII.5. MISTAKEN AGE
A. Where did the offender pick up the child?
B. Where did the offender frequent?
C. What kind of activities did the offender and victim engage in? Where did they go together?
D. What are the ages of other people the offender asso\-ciates with?
E. What kind of statements has the offender made to others about the victim?

VII.6. CHARACTER
A. Why is defendant in the position he's in, IE: where/what has he been/done before? (Seek out former spouses/partners, determine if any or frequent moves)

VII.7. ALIBI
A. Does the suspect's account of the events check out?

VII.8. ULTERIOR MOTIVE
A. Witch Hunt
a) Vary assignments among investigators
b) Utilize different interviewers as much as possible
B. Misguided Investigator
a) Utilize several investigators from varying disciplines and backgrounds.
C. A Group of Disgruntled/Grudge Bearing/Hypersensitive Parents are making this up
a) Obtain as many victims as possible and distinguish when the children disclose how the report of the abuse came about (articulate lack of connection to previously disclosing children).
D. Malicious Report Created For the Purposes of Support\-ing Civiltion/Custody-Visitation
a) Try to convince parents to hold off on filing suit.
E. Kids Want Attention That All The Other Victims Received.
a) See #C above.
F. Children's accounts were contaminated by: police, therapists, doctors, nurses, the sun, the moon, etc.
a) See #C above.
b) Try to isolate victim from others by providing alternatives to seeing same therapist, doctor, investigator, etc.
c) So-called "Parent Alienation Syndrome"
d) Munchausen By-Proxy Syndrome
e) So-called "False Memory Syndrome"

XI. PROVING INTENT AND CORROBORATING THE VICTIM'S ACCOUNT

Corroboration may consist of:

A) Physical instruments or evidence of abuse.

B) Concurring accounts or observations of other witnesses.

D) Incriminating statements made by the offender. Such evidence may prove the act itself in a direct fashion or it may support the child's allegations through circumstantial evidence. In addition, this evidence can be used to demonstrate a propensity, inclination or abnormal sexual desire for children (a necessary element of the offense).

XII. CHECKLIST FOR QUESTIONING OF CHILD FOR CORROBORATION AND DETAIL

1. Did the child ever tell about the incidents and to whom. What did they tell them?
2. Have the child describe the offender, his home or car, in as much detail as possible noting unique or unusual observations of the offender's person (scars, birthmarks, etc.), clothing, house (furniture, decorations, linen, etc.) or vehicle.
3. Determine the number and specific acts committed by both the victim and the offender.
    A) Find multiple victims.
    B) Establish crimes with the same victim, but, different occasions.
    C) Establish crimes with the same victim, same incident, but, different acts.
4. Determine how the offender induced the child to perform or submit to the acts and exactly what words were used by the offender.
    A) examine the position of trust, dominance, and authority when looking at the child's perception of the events.
    B) establish this element the by asking the following questions:
        a) How does the child feel about the offender?
        b) What was he afraid of?
        c) Was he threatened? If so, with what?
        d) Why was the "secret" withheld? Like threats, the element of force may also enhance the charges. It may be established in several ways. In evaluating the degree of force look at these criteria:
            A) The age of the child.
            B) Size of the victim vs. the size of the offender.
            C) The sophistication of the child.
            D) Past violent acts of offender towards child or others that child is aware of.

5 Distinguish and establish dates and times of incidents.
    A) by the acts themselves.
    B) by time or location of the event.
    C) by the clothing which the child wore at the time of each event.
    D) by what was said during the different incidents
    E) by the activity before, during, or after, each event
    F) by the people who were present at the time.

6. Determine if pornography or drugs were used and if so, for what purpose (how), where it is kept, and have the child describe in detail for seizure.
7. Determine if the child was photographed, if the offender asked to take pictures of the child or if a photo was given to the offender.
8. Ask if the child saw any pictures of other children. Make attempts to identify the children after the search warrant is served and they are found.
9. Ask the child if the offender has a diary or computer.
10. Ask the child if any other children were present during any of the acts or at any other times.
11. Ask the child if he knows of any other adults who participated in the acts or associates with the offender.
12. Ask the child if he ever gave his address or phone number to the offender, and if so, in what manner it was recorded.
13. Ask if the offender ever went to the child's home or called the victim on the phone.
14. Ask the child if he saw any other child give their name or phone number and inquire if and how it was recorded.

15. Ask if the child played with any toys, read any books, magazines or played with or saw anything else which you might search for to prove the child was where he says he was.
16. Ask if the child left any belongings in the offenders place, home, car, etc.
17. Obtain a detailed account of the crime in the child's own words. Obtain specifics about the nature of the acts, IE:
    A) Did the child see semen and can he describe it
    B) Was the suspect's penis pointing straight down or straight out, etc.
18. Determine, as specifically as possible, if there was penetration of the vaginal or anal openings.
19. Determine if the victim experienced pain during the sex acts or afterwards.
    A) Did the child see blood in their underwear after the molestation?
20. Determine if the child reported that he hurt to anyone?
21. Determine if foreign substances or objects used, such as Vaseline, condoms, etc. If so, where were they obtained and placed after the act?
22. Determine if the child wiped off after the act and with what?
23. Determine if the child ever been molested by anyone else and, if so, by whom?
24. Determine the attitude of the victim toward the offender and if the attitude is one of dislike, is the attitude based on anything in addition to the molestations.
25. If there is any type of dissolution of marriage action or child custody proceeding in progress, determine what the child's understanding and involvement is of the proceedings and his attitude towards it.
26. If the report was delayed, try to have the child articulate the reasons why.

X. IDENTIFY ANY AND ALL CHILDREN OR ADULTS THE OFFENDER MAY ASSOCIATE WITH.

1. Consider opening separate cases when multiple offenders are named to prevent discovery from compromising new investigations.

XI. INTERVIEW OF OFFENDER WHEN NAMED

1. Prior to interviewing, record checks should be made for:
    A. Warrants;
    B. With other police agencies where the offender might have had contact or lived;
    C. With the state justice agency responsible for sex registration;
    D. With the child abuse registry or state intelligence unit on sexual assault cases;
    E. With the social services agency which handles child abuse;
    F. If appropriate, with any of the federal law enforce\-ment agencies which might have an interest such as the FBI, Postal Inspection Service or U.S. Customs.
2. Is a pretext confrontation possible?
3. Interview content:
    A. Does the statement made by the suspect:
        a) contain any admissions or confessions?
        b) corroborate the child?
        c) comport with that made by the child?
    B. How does the suspect:
        a) explain what happened
        b) explain or account for all of the defenses which follow?
        c) admit to being sexually aroused during the acts or by children in general?
        d) apologize to child?

XII. MEDICAL EXAMINATION

1. Have examination performed by forensic specialist in child sexual abuse examinations conducted with a colposcope and photographic documentation.
2. Ensure that the medical report jives with the information contained in the crime report
    A. In multiple victim cases try to get different doctors doing examinations for as many victims as possible.

SEXUAL ABUSE ALLEGATIONS IN DIVORCE AND CUSTODY CASES: FRUSTRATIONS OF INQUIRY

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Of the many cases handled by Child Protective Services, police, medical, and clinical professionals, no allegation is more difficult to investigate than sexual abuse arising in the context of marital discord. These cases cause more frustrations for investigators than any other because of lack of evidence, possible biases, and the acrimony between the parties. How does the investigator discern a true, valid, allegation from one which may be caused by a party's misguided, but honest, belief a child was abused or from a truly malicious complaint made solely for the purpose of gaining advantage in another court forum[1]. More specifically, a major concern of today's investigative agencies, wherein the watchwords are "do more with less," is how to properly address an allegation of sexual abuse in the context of impending, pending, or concurrent family law litigation?

One of the main problems is competent investigations of these allegations take an inordinate amount of time. Shrinking budgets and changing priorities have reduced staffing levels in investigative agencies. When there are fewer people to handle these investigations, time is in short supply. This is compounded when the child involved is young - too young to be able to articulate what has happened in one or two sittings — the minimum amount of time to spend with them in a preliminary phase of the investigation.

Police and social workers assigned to child abuse investigations are already inundated with cases that are difficult to prove when a child is accusing an adult. When added credibility questions surface in custody/divorce cases, it makes the cases even more likely to be unsubstantiated[2] or unfounded.[3] The special questions that must be paid particular attention to in these cases are:

1. Who did the child first disclose to?
2. What triggered the disclosure?
3. When did the first disclosure occur?
4. How the original disclosure surfaced?
5. Why the child is telling now?
6. How many people (and who are they) have talked to the child?
7. Exactly what was said by the child to each of these persons?
8. Exactly what was said by the persons that the child disclosed to?
9. How, if at all, the aforementioned may have affected what the child is now saying?

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[1] The most comprehensive resource now available on this issue is *Adjudicating Allegations of Child Sexual Abuse When Custody is in Dispute, A Model Judicial Education Curriculum*, National Judicial Education Program to Promote Equality for Women and Men in the Courts, New York, Ed., Schafran, Lynn H., 1996

[2] "Unsubstantiated" as used herein refers to the inability to prove whether a crime did or did not occur.

[3] "Unfounded" as used herein refers to a completed investigation in which the it is proven that no crime has occurred, or that it is highly improbable that a crime occurred, based on the evidence developed in the completed investigation.

10. What evidence is available to confirm or refute the allegation?
11. What evidence is available to confirm what the child is saying?
12. Are there any alternative explanations for the child's behaviors and what (s)he is saying?

These allegations often surface in circumstances that impugn the veracity of the disclosure and the stakes are high - an improper allegation may ruin the reputation of an unjustly accused person, yet, an unrecognized valid allegation may subject the child to continued abuse. For example, there may be an existing or pending custody/visitation order in place for some time, there may be a custody hearing or visitation issue to be settled or the divorce may soon be or have just been filed. Each of these situations is ripe for someone making up an allegation to get an upper hand in the litigation. Yet, there also are sound reasons why a child would disclose actual abuse which just occurred or has been ongoing.[4] Child sexual abuse is often validly disclosed first during highly volatile and divisive custody or visitation litigation. On one hand, a child who is separated from an offending parent and is faced with reuniting with that parent may finally feel frightened enough about returning to the abusive situation to trigger disclosure. On the other hand, a child who is finally removed from an abusive situation may feel safe enough to disclose. Yet another child may become angry enough at the abuser during the turbulent throes of divorce to tell what has been happening.

There is no denying that there have been malicious false allegations made in the circumstances of divorce or custody disputes, although the statistical probabilities of a false report are much less than most people commonly believe. Statistical reviews of the incidence of child abuse allegations arising in marital relations courts reveal that as few as two and as much as 10 percent of litigated cases involve claims of abuse.[5] That same study found that of the 169 cases reviewed, 14% were found to have been deliberate false allegations.[6]

A subsequent study, involving 9000 families, found a similar result in numbers of cases involving abuse allegations. It found a range of one-per-cent to a eight-per-cent involved sexual abuse allegations.[7]

As have other researchers, the California Judicial Council (CJC) investigation into such allegations found there were legitimate reasons why an allegation would be made, although it was later found no abuse actually occurred.[8] That same CJC report found that false allegations are not common, "although they sometimes occur."[9]

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[4]MacFarlane, Kee, *Sexual Abuse of Young Children*, Guilford, 1986, Ppg. 123-137.

[5] "Summary of Findings From the Sexual Abuse Allegations Project", Theonnes, Nancy, The Association of Family and Conciliation Courts Research Unit, Denver, Co., in *Sexual Abuse Allegations in Custody and Visitation Cases*, Nicholson, E., et al, American Bar Assn., Wash., D.C., (1988) at Page 4

[6]Bulkley, J., citing AFCC study Fn. 1, in *Think Tank Report: Allegations of Sexual Abuse in Child Custody and Visitation Situations*, The National Resource Center on Child Sexual Abuse, Huntsville, Alabama, (1989), at Page 17.

[7]"The Extent, Nature, and Validity of Sexual Abuse Allegations in Custody/Visitation Disputes", Thoennes, N, et al, in *Child Abuse and Neglect*, Vol. 14, Pg. 153 (1990).

[8]*Achieving Equal Justice For Women and Men in the Courts, the Draft Report of the Judicial Council Advisory Committee on Gender Bias in the Courts*, California Judicial Council, Administrative Office of the Courts, San Francisco (March, 1990)

[9]*Ibid*, at page 43.

There are basically three types of cases:

1. Those where there is a *sincere, legitimate and valid report and allegation* made which is true because the *abuse actually occurred.*
2. Those where there is a *sincere, legitimate, and valid report* made which is:
   a) a misinterpretation; or,
   b) a direct and correct report,
   of some behavior or statements made by the child, *but* there *was no abuse.*
3. Those where there is a *deliberately malicious false allegation* made.

In the first type of case there was abuse. In the second type of case, the two situations cause a report to be made where no abuse occurred. Sorting out the differences between these two situations present serious difficulties for investigators because there is a legitimate reason for the reported abuse. The child has done or said something that triggered the concern. Either it was misinterpreted or there is simply no known reason or attributable explanation why the child did or said what was reported.

Too often law enforcement and social services give short shrift to the distinguishing points between these three types of cases. When they encounter the difficulties and problems these cases present, they either stop and investigate no further or incorrectly jump to the conclusion there was a malicious motive. Therefore, the cases break down because they fail to make the critical *distinction of motive* between the first, second and third types of cases. That *motive establishes* the *difference between justified or innocent belief* and *a crime or risk* to the child.

The first and second type of case have legitimate motives, the third does not. In the first type of case, the child has been victimized and may be at risk of re-abuse. The second type of case presents a different problem. There may be no culpable pathology on the part of the parent in the case where the child has done or said something that was misinterpreted or there is no known reason why the child did or said them. On the other hand, in the third type of case where the motive is malicious, it may be prosecutable as a false report. More importantly, there may be a risk to the child. The child may be *emotionally abused* by the conflict which subsequently follows or may be unjustly harmed by the separation from the wrongly accused parent. This may be cause for the law enforcement agency or social services agency to move to protect the child.

The *real problem in all three types* of cases is that the *manner* in which the parent makes the *report and the allegation surface* is very much *alike in all of them.* The dilemma, then, has become how does the investigator determine which type of allegation has been made and whether abuse has or has not occurred?

We need a litmus test to provide a reliable screen for abuse. Wouldn't it be nice if it were possible to take the party's hand who is raising the allegation and place it over a machine which changed colors if the belief held by the parent was sincere and raised only for the purpose of protecting the child? Wouldn't it be nice if there was a piece of paper the child could chew and if the child was making up the allegation the paper changed color? Unfortunately, there are no such tests. There is only good investigative practice: use of successful procedures which establish proof in such a way as to support or refute an allegation of sexual abuse.

When a complaint is made, the police must be notified immediately. Interviews with the reporting party (not always the estranged parent) must be conducted and seek to identify the source of the disclosure and separate it from the supporting parent, if possible. For example, in one case a three-year-old child of divorced parents who were sharing custody of him was observed at his preschool drawing at a table. He was obviously experiencing discomfort kneeling over the table and so a teacher suggested he sit down. He replied

he couldn't because his "bottom" hurt, at which point the teacher asked if he wanted to go to the bathroom. The child again responded he couldn't because it hurt too much. When asked why, after some shifting and clear reluctance to talk, the child told of his father sodomizing him. Here, the disclosure came from the child independent of the supportive parent and was not volunteered, it was triggered by the teacher's concern for the child. It is these characteristics, coupled with the emotion, fear, and hesitancy, that made it credible. More importantly, it was identifying these characteristics through investigation which helped to support the child's claim and refute the claim of fabrication made by the offending parent.

Considering the posturing of the parties and influences exerted upon the child — witnesses, relatives, and others who the courts will use to evaluate the facts — proper investigatory steps must be taken immediately upon the receipt of the disclosure of abuse or any subsequent information gathered is likely to be of questioned value. Keeping all of the questions listed above in mind, four investigative concerns must be addressed simultaneously at this juncture in the investigation:

1. Is it possible to prevent contamination by witnesses and involved parties talking to one another or is there a chance of alliances being drawn once the "secret" is out?
2. Is it possible to secure an admission or confession on the part of the offender before he learns of the investigation and tries to intimidate the child or witnesses or begins to confabulate a story?
3. Is it possible to prevent the destruction of evidence by the offender or his supporters (often the non-offending parent) before he learns of the investigation?
4. Is there any medical evidence available?

The first is a time, space, and logistics problem. Are witnesses in such situations where they will call or talk to one another? Are there sufficient number of investigators who are able to quickly do interviews to nail down statements to prevent changes in accounts, perceptions or influences by involved parties?

The second is a matter of getting as much information about what happened and confronting the suspected offender as soon as possible. Denials are a common response investigators obtain when confronting the suspected offender. Therefore, the most successful technique an investigator can employ is one which will encourage the offender to tell the truth. This means he must not be threatened by the consequences of talking with the police or CPS worker. The most successful technique to accomplish this is the pretext confrontation, conducted by the child victim or, if too young or incapable, the non-offending parent or any party that the offender may trust.

This technique involves a recorded call or personal confrontation which is "wired."[10,11] The person places a call to the offender or meets him/her and confronts him/her with the specific acts committed upon the child. The objective is to provide an opportunity for the offender to admit the crime and to try to explain it away or try to convince the person not to tell about it. The main concern is the personal safety and mental state of the person doing the confrontation. In one case, a child called her father and told him she thought she had venereal disease from the sexual intercourse they were having. His response was that it was impossible, because she was the only one he had been having sex with. In another, a mother confronted the father about the sex he was having with his daughter by asking what she should tell the authorities who were now inquiring. The response she received was to "tell them it was a mistake, I shouldn't have done it."

The third concern is the securing and preservation of evidence. Considerations of the initiation of a

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[10] The conversation, whether an in-person confrontation or a telephone conversation, should be recorded.

[11] The laws of each state differ, so review privacy and wiretapping statutes before employing this practice.

confrontational recorded pretext-interview with the accused must be examined at the same time a search warrant is considered. Hard evidence consisting of corroborative facts in the form of concrete, tangible, evidence or admissions or confessions of the offender, must be sought in the earliest stages of an investigation. Besides a confession or admission from the mouth of the accused, there is nothing that can be more convincing than corroborating what the child has told. The clearest example of this is when the offender takes pictures of what he does (a frequently overlooked issue in incest cases). The phrase "a picture is worth a thousand words" must have anticipated the doubts cast upon children who accuse their parents of sexual abuse. However, even the slightest corroboration, consisting of finding the lubricant or condom the child claims was used, in the hiding place described by the child is very compelling.

Lastly, medical examinations should be conducted as soon as possible. The body often heals itself too fast for documentation. Therefore, immediate medical examinations with colopescopic, photographic documentation are a must in every case. Forensic medical evaluations should be conducted by medical professionals who are identified as forensic medical examiners in the child sexual abuse field. The fact that a person is a licensed medical professional does *not* mean that the person is a qualified forensic examiner.

Additional concerns arise in these matters. Backgrounds need to be done on all crucial witnesses and the accused. What connections do they have with the parties involved? What opportunities did the witnesses have to observe or interact with the child or the parties? What behaviors did they exhibit before the disclosure? What were the circumstances of the disclosure? What exactly was said? Who was present? These questions (all basic areas of inquiry in any abuse case) and many more need to be answered to assure that any decision made by the courts is made with the most complete, reliable, credible evidence possible.

Of special concern in these matters is the fact that interviews must be conducted in person. Evaluations of risk conducted by phone are not only inappropriate, they are worthless. There is nothing that can substitute for a direct, visual, in-person examination of the facts. The inquiry should not stop until all avenues of investigation have been explored. These responsibilities must not be delegated to anyone other than unbiased, independent, trained professionals. In other words, if a complaint is made by a mother that her child is displaying or exhibiting unusual behaviors, she should not be told to go back and further question the child. This is also true for third parties. If a teacher reports that a child has said something or is doing unusual things, (s)he shouldn't be told to go back and get more information. If either the teacher or mother questions the child improperly or mis-perceives what is said, unnecessary doubts may be cast upon the case and the child may be improperly discredited, or, in cases where no abuse has occurred — a false (though not malicious) allegation may be triggered .

Finally, people who conduct these investigations must be properly trained. They must have updated and continual training. Delegation of tasks and the responsibility to inquire about abuse should be carefully done, with any professional who takes on such assignment of responsibilities having the same training. For example, if a therapist is used to help determine what happened to a child because the child is too young or won't talk about it, that therapist must be properly versed in the art of forensic interviewing. Nothing is more devastating to a case than to have the validity of the information obtained called into question because someone may have inadvertently influenced what the child said.

The answers to all of these problems are not simple. Plans to address these problems should be prepared long before any case is ever handled. Resources (people) to call upon when needed should be identified and policies put in place as to when to use them long before the necessity arises. Only when a well planned and carried out investigation is completed may any competent and reliable conclusions be drawn about allegations arising in family law matters. In these matters, children depend upon child protection professionals to keep them safe. These professionals are often the only reliable sources of information a court may look to in order to make a decision about what to do with a particular case. Carefully planned responses to an allegation arising in the context of family law litigation is the key to protecting the children involved. The payoff for planning is the confidence which accompanies the conclusions drawn and dispositions made as a result of sound and firmly based evidence obtained by investigation - a confidence that will take the place of the frustrations now experienced.

A complete and competent investigation is deserved by every child identified as a suspected abuse victim. The accused equally deserves a complete and competent investigation.

We should view our responsibilities as "truth seekers," and have pride in our successes.[12]

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[12] "Successes" include those cases in which we are able to prove the allegation, therefore enhancing the potential for protective action *and* those rare cases in which we prove that no abuse has occurred.

Forensic Evaluation of

Sexually Abused Children

Presented by

Connie Carnes, MS, LPC and
Debra Nelson-Gardell, PhD

FORENSIC EVALUATION TRAINING
National Symposium on Child Sexual Abuse
Huntsville, AL
March 20, 1998

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AGENDA

8:30-10:00	Forensic Evaluation: The Research Basis
	Interviewing Non-Offending Parents
	Developmental Assessment
	Psychosocial Assessment
	Touching Education and Body Parts Inventory
10:00-10:30	Break
10:30-12:00	Abuse focused, non-leading interviewing
	Cognitive Interviewing/Narrative Elaboration
	Evaluating the Disclosure for credibility
	Prevention Education, Report Format
	Pending Research

****

Overview of the training—The Forensic Evaluation process

1. Continuum of interventions with sexually abused children
    - Forensic Interview
    - Forensic Evaluation
    - Forensically Sensitive Therapy
    - Traditional Therapy

2. Purposes of Forensic Evaluation
    - Determine if abuse occurred and by whom
    - Gather forensically sound facts for the use of CPS, Law
    - Enforcement and prosecution
    - Allow child to disclose over time in a non-threatening environment
    - Gather information on the child's psychosocial functioning in order to make treatment recommendations and to form professional opinions on the reliability of the disclosure

3. Why are children referred for Forensic Evaluation?
    - No disclosure, but the presence of behavioral or other indicators strongly suggest victimization
    - Full nature and extent of abuse not disclosed at initial investigative interview
    - Information gained in initial investigative interview needs further clarification

4. NCAC Forensic Evaluation Protocol
    - NOP interview
    - Developmental Assessment and Rapport Building
    - Psychosocial Assessment
    - Touching Education, Body Parts Inventory
    - Abuse focused/non-leading questions or Cognitive interviewing (Depending on age)
    - Body Safety, prevention education, closure

Understanding and Interviewing Non-offending Parents

1. The Non-Offending Parent's role in the investigation and in the child's reactions

2. Common Reactions of Non-offending parents
    - Disbelief or rationalization
    - Anger and/or rejection of the child
    - Rejection by the child
    - Ambivalence toward or support of the accused parent or family member
    - Concern about economic considerations
    - Denial and confusion with their own issues

3. Building a Bridge to the Non-offending parent
    - Anticipate her experience before you see her
    - Remember: She is in shock
    - Imagine yourself in her shoes
    - Don't blame her
    - Normalize her responses
    - Respond selectively and purposefully to what she says
    - Support and acknowledge her strengths
    - Acknowledge her divided loyalties
    - Ask her to tell you what it would mean to her if it were true

4. NCAC interview format

Developmental Assessment of Child Victims

- Why do a developmental assessment?
- The components of a developmental assessment
- Tools to obtain the information you need regarding the child's developmental level

Psychosocial Assessment of Child Victims

- What is psychosocial assessment and why do we need one?
- APSAC Guidelines
- The Achenbach and Friedrich scales
- The components of psychosocial assessment.
    1. The child's view of their family/support system
    2. The child's self esteem and self understanding
    3. The child's understanding of and management of feelings.
    4. About secrets and rules
- Tools for use in psychosocial assessment.

Touching Education and Body Parts Inventory as components of Forensic Evaluation

- Touching education
- The Touch Continuum
    –Developed by Sandra Hewitt
    –informal clinically based abuse screening technique
- Body parts inventory
    –Use of anatomically detailed dolls
    –APSAC guidelines
- Standardized and free style drawings

Evaluating the Disclosure for reliability

- Evaluating the reliability of a child's statements, behaviors and emotions during a Forensic Evaluation

Abuse focused, non-leading interviewing of children

1. Reasons for using abuse focused questions
    - There are many topics you need to learn about
    - Free recall memory is not well developed in young children, you need to provide the retrieval cues
    - Children from abusive families may not perceive maltreatment as out of the ordinary—unless you ask specifically
    - Children are reluctant to talk about abuse due to coercion not to tell, attachment to the abuser or general lack of trust

2. Preparing the child for a series of questions
    - Tell them you will be asking lots of questions
    - Be sensitive to the child's vulnerability to coercion
    - Give explicit permission to the child to say they do not understand you or correct you, and to say they do not know
    - Provide the "rules" for the interview setting

Cognitive Interviewing

- When to use a Cognitive Interview
- The "Rules" for the Cognitive Interview
- The Cognitive Interview Procedure
- Practice using the technique

Body Safety and Prevention activities

- Rationale for using these activities
- Tools to use for education on Body Safety and Prevention

Reporting the results

Pending Research

National Children's Advocacy Center

Protocol for Forensic Evaluation
(8 week version)

Children who have been sexually abused are often reluctant to disclose the abuse to investigators due to intimidation, fear, shame or guilt. Some children require more time and trust in the interviewer to feel comfortable with fully disclosing sensitive facts about abuse.

Clients are referred to the NCAC intervention program for forensic evaluation when: 1) the child does not disclose abuse to investigators, but exhibits behaviors or other indicators strongly suggestive of victimization, 2) the extent or nature of abuse is not disclosed by the child during the initial investigative interview by Law Enforcement/DHR, or 3) when the information gathered in the initial investigative interview needs further clarification. The purposes of the Forensic Evaluation are:

1. To determine <u>if</u> the child has been abused or not, and if so, by whom.
2. To gather forensically sound facts necessary for child protection and law enforcement officials to understand what, if anything, has happened.
3. To allow the child to disclose over time in a non-threatening environment and to assess the extent and nature of the alleged abuse.
4. To gather information regarding the child's psychosocial functioning in order to make treatment recommendations.

Prior to beginning the evaluation, information on the case from Law Enforcement, DHR, and Medical staff is collected and reviewed. Following is the procedure used in conducting forensic evaluations.

<u>Session 1:</u> The first interview is conducted with the primary caregiver who has not been alleged to have abused the child (to be called non-offending parent, or NOP, for the purposes of this protocol). Information is gathered on family history and dynamics, in order to facilitate evaluation and treatment (if needed) of the child and to develop a recommendation for involvement of the NOP in the disclosure and /or recovery process. Assessment of behavioral functioning of the child is obtained using the Child Behavioral Checklist (Achenbach) as well as clinical data. The checklist is completed by the non-offending parent and any other significant care providers, as well

as any teachers involved with the child. Assessment of any sexual behaviors exhibited or reported by the child is accomplished by using the Child Sexual Behavior Inventory (Friedrich) and other clinical information. This checklist is also completed by caregivers and teachers involved with the child. If the child is at least 8 years old, the Trauma Symptom Checklist (Briere) is administered at the completion of the evaluation.

**Note: The second and remaining clinical sessions are done with the evaluator and child present. The NOP is only involved in the sessions when input is needed, and the evaluator would never do the actual assessment work with the child in the presence of the NOP.

Session 2. The second session is devoted to developmental assessment and rapport building with the child. The evaluator explains her role as someone who helps children, and expands upon this as deemed appropriate for the individual child. Developmental assessment is focused on the following areas:

- Speech and language
- Measurement/time
- Social relatedness (overly friendly/withdrawn)
- Knowledge of DOB, address, city/state of residence
- Basic concepts of first, last, always, beside, before, inside, outside, etc.
- Numbers skills
- Kinship (family members/who is considered in family
- Perspective taking (ability to abstract ideas and concepts)
- Knowledge of color (common and uncommon)
- Feeling vocabulary (limited/moderate/extensive
- Exhibits understanding of truth versus lie

This information is gathered within the context of a session using art and play techniques, (i.e. checking the child's ability to count the number of crayons in the therapist's hand). No specific or focused efforts are made to draw out abuse specific information at this initial session.

**Note: The evaluator gauges the time for specific questioning regarding the abuse allegations based upon the child's comfort level in the therapeutic setting. If a spontaneous disclosure occurs as the child's comfort level increases, or at any point in the process, the therapist employs investigative interviewing techniques and methodologies to gather specific details regarding the disclosure. Evaluators are trained to use non-leading questioning procedures, and the Cognitive Interview technique is employed when appropriate to allow the client to produce a step by step narrative description. These techniques are built into the protocol for sessions 5-7, however, sometimes children make spontaneous

disclosures for no apparent reason in earlier sessions, and the evaluator moves into the investigative interviewing mode when this happens.

Session 3. The third session continues to focus on rapport building with the added goal of psychosocial assessment. The evaluator uses developmentally appropriate play and art therapy techniques, and/or paper and pencil exercises to begin to explore the child's self understanding, self esteem and perceptions regarding their support system or lack thereof. Note: The evaluator concentrates on assessing the psychosocial functioning of the child during these initial sessions, but psychosocial functioning continues to be observed and monitored throughout the Forensic Evaluation process.

Session 4. During the fourth session, the evaluator introduces educational materials about good, bad and secret touching, remaining keenly aware of the comfort level of the child. Other activities, such as the "Touch Continuum" are used to allow the child to comfortably talk about types of touching. A body parts inventory may be introduced at this point, if it is appropriate for the child. The inventory can be done with anatomical drawings or dolls. Regular dolls or anatomically detailed dolls are used depending on the child and situation. Anatomically detailed dolls are be used with caution, and only when absolutely needed, strictly following the guidelines for use of the dolls established by APSAC.

Sessions 5 through 7. During sessions 5, 6 and 7, the evaluator employs abuse focused, but non-leading questioning techniques to attempt to learn more about the child's experiences. Abuse focused child interviewing techniques are employed to gather information regarding such topics as family violence, substance abuse, care routines (i.e. bathing, eating), environment, people, sexual abuse and discipline. Addressing these issues is done over a series of sessions with play and art activities interjected as needed to maintain the child's comfort level. If the child is 6 or older, and some disclosure is made, the evaluator employs the Cognitive Interviewing technique to obtain detailed narrative descriptions of events. The Narrative Elaboration procedure (Saywitz) is employed to cue children to elaborate on participants, setting, actions and conversation/affective state existing during the alleged events.

Session 8. At the eighth session, the evaluator changes the focus to body safety and prevention education regardless of whether or not a disclosure has been made. Also during this final session, the evaluator does closure work with the child, including summarizing the Forensic Evaluation experience and preparing the child for the next step (therapy

or conclusion of clinical involvement). Closure is completed at this session.

During the process of evaluation, any new information pertaining to the abuse allegations is immediately relayed to the appropriate team members for follow up. The NCAC form entitled "New Disclosure Alert" is completed immediately upon obtaining new information on the case and is faxed to the appropriate member(s) of the investigative team.

Interviewing tools considered appropriate for use during the Forensic Evaluation process include, but are not limited to:

- Markers and drawing paper
- Puppets (used as communication tools and avoiding fantasy play)
- Dollhouse (Typical Day scenario (Gil) employed)
- Anatomically Detailed dolls (used only when there has already been a disclosure and there is a need to be able to show as well as tell)
- Regular dolls
- Anatomical Drawings

Upon completion of the Forensic Evaluation, the therapist collates and summarizes all collaborative information relevant to the case which may include, but is not limited to, reports from: Law enforcement agencies, DHR, medical professionals, family members, day care or school, and the National Crime Information Center for inclusion in the final report.

A written report is then prepared for the Multidisciplinary team. The Forensic Evaluation report includes abuse disclosure or non-disclosure, disclosure examination, reactions and consequences of the alleged abuse, summary of family issues, summary of collaborative reports and treatment recommendations.

National Children's Advocacy Center
Comparison of Forensic Evaluation Protocols

4 & 8 Week Versions

	4 Week Version	8 Week Version
1	NOP Interview Collect Achenbach & Friedrich Data	NOP Interview Collect Achenbach & Friedrich Data
2	Developmental Assessment. Rapport Building Psychosocial Assessment	Development Assessment/ Rapport Building
3	Touching Educaton, Body parts inventory. Abuse focused, non-leading questions and/or cognitive interview (depending on age.	Psychosocial Assessment
4	Abuse focused, non-leading questions and/or Cognitive Interviewing to fill in information gaps. Clinical closure.	Touching Education, body parts inventory
5		Abuse Focused, Non-leading questions and/or Cognitive Interview (depending on age)
6		Abuse Focused, Non-leading questions and/or Cognitive Interviewing continues
7		Fill in information gaps
8		Body Safety & Prevention Education Clinical closure.

NATIONAL CHILDREN'S ADVOCACY CENTER
Huntsville, Alabama

Developmental Assessment

CLIENT NAME: DATE:

LENGTH OF SESSION: 60 min TYPE: Individual

PRESENT AT SESSION:

MAJOR CHANGES SINCE LAST VISIT: 1st session with client

TECHNIQUE(s) USED AND PURPOSE (If applicable):

MENTAL STATUS/BEHAVIORAL OBSERVATIONS:

DEVELOPMENTAL ASSESSMENT:
a. Speech and Language:
b. Measurement/Time:
c. Social Relatedness (over friendly/withdrawn):
d. Knowledge of DOB, address, city/state of residence:
e. Basic concepts of first, last, always, beside, before, inside, outside, etc.:
f. Numbers Skills:
g. Kinship (family members/who is considered in family):
h. Perspective taking (ability to abstract ideas and concepts):
i. Knowledge of color (common and uncommon):
j. Feeling vocabulary (limited/moderate/extensive):
k. Exhibits understanding of truth vs. lie:

IMPRESSIONS:

PLAN (include developmental areas in need of further exploration):

NEXT SESSION SCHEDULED:

Signature:_____Date:

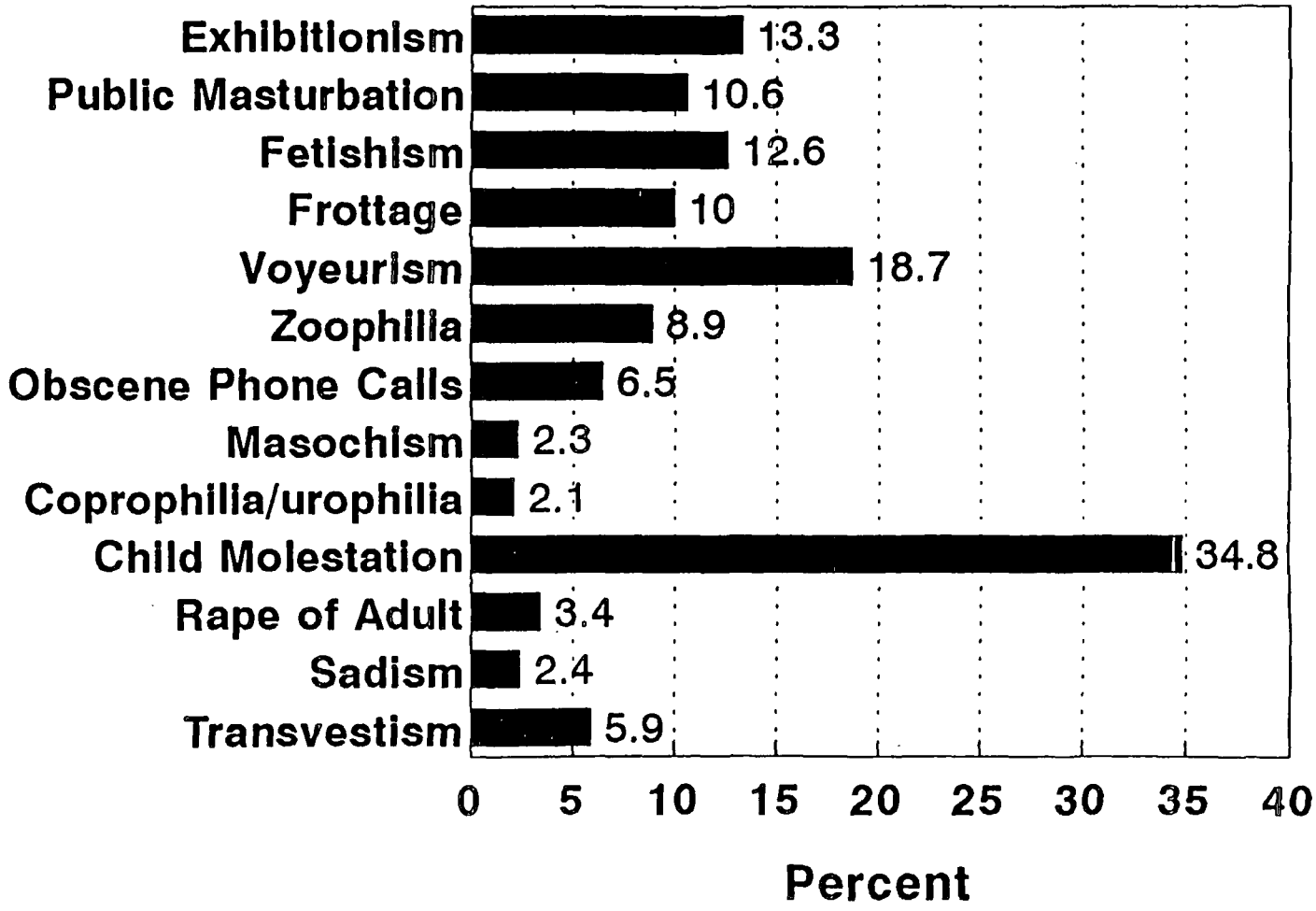
Sex Re-Offense Prevention:

Introducing the Able Assessment

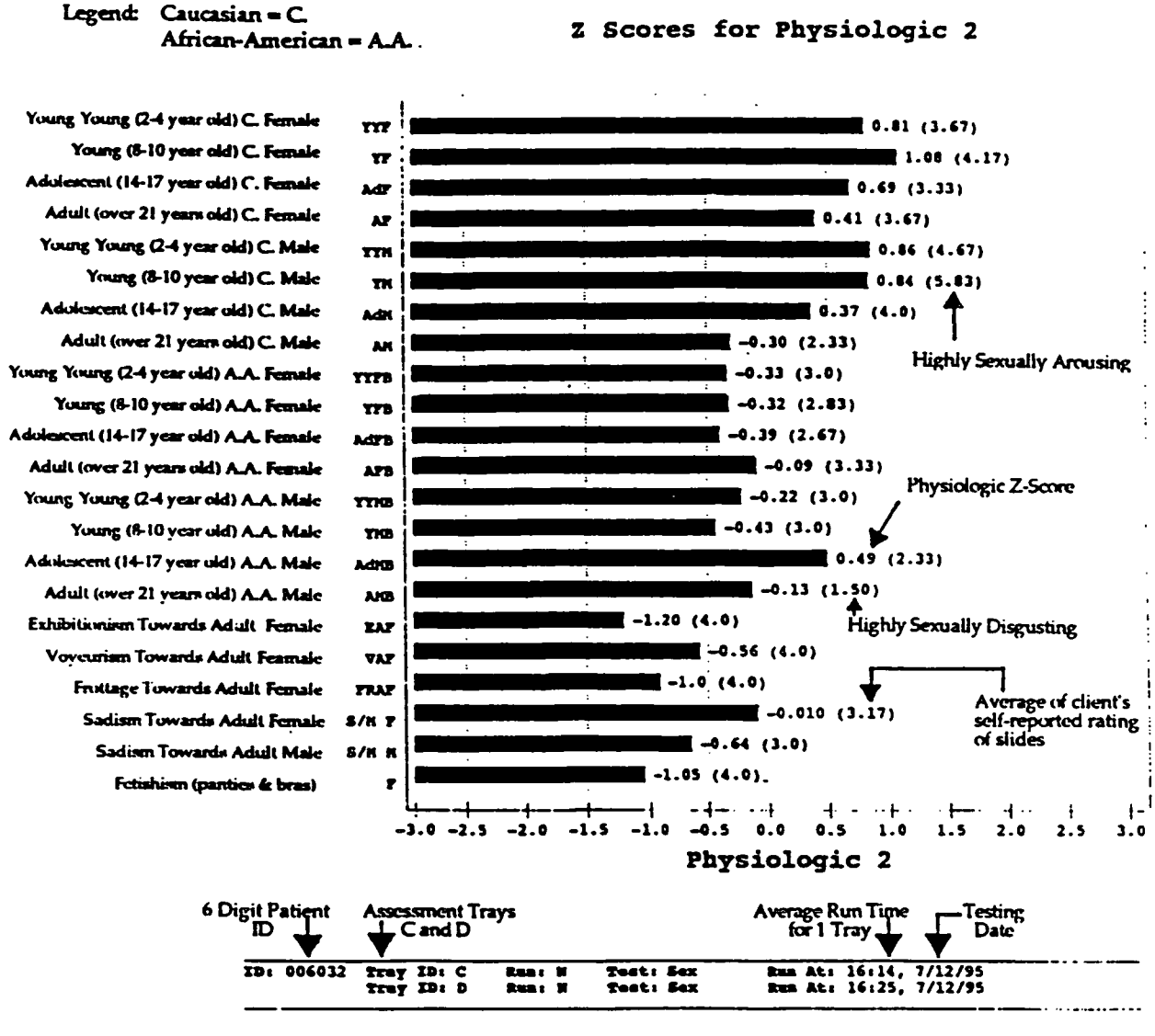
Presented by

Gene G. Abel, MD and Frankie Preston, PsyD

Sexual Behavior of 3497 Clients



Abel Assessment Graph



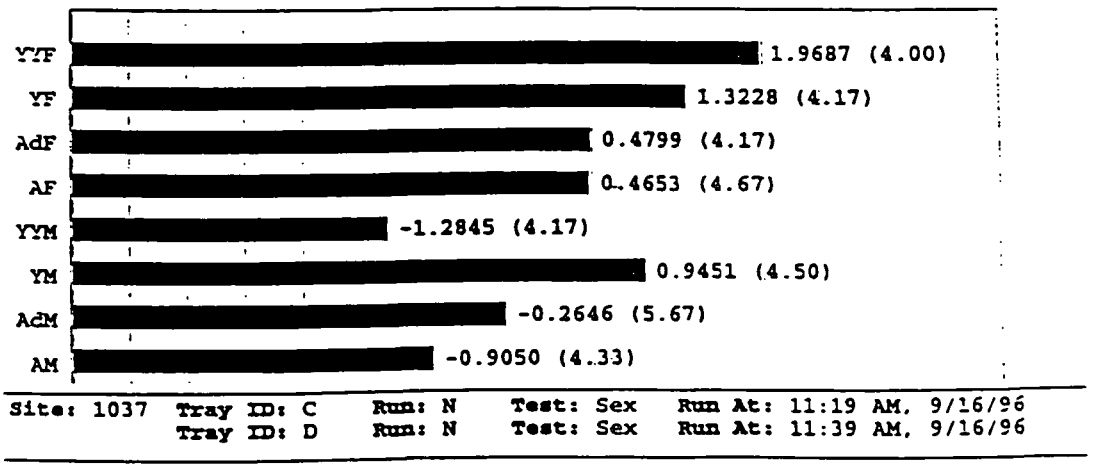
Assessment 2.25 ©1995 Gene G. Abel, M.D.

Molester of More Than Boys

A man in his mid 40s was referred by his Child Protective Case Worker following allegations he had abused his two sons under age 10. He readily admitted molesting the boys and was seeking treatment to get his "family back together". He also admitted molesting two other boys, one of which was now an adult. Visual reaction time revealed his highest sexual interest was to 2-4 year old and 8-10 year old girls. He also showed high sexual interest in 8-10 year old, adolescent and adult males as well as adolescent and adult females. Confronted by these measures he admitted his long standing sexual interest in girls and boys and his current molestation of girls in the family. The therapist successfully mobilized the Child Protection Case Worker to protect all the children.

Molester of More Than Boys

Z Scores for Objective 2



Assessment 2.39, ©1997 Abel Screening, Inc.

THE ABEL QUESTIONNAIRE FOR MEN SUMMARY

ID		Site ID No.	1037
Sex	M	Test Date	09/25/96
Race	White	Age	45

21 Deviant Sexual Behaviors

	Age Onset	Age End	N Victims	N Times	Control
1. Exhibitionism.....<N>	0	0	0	0	0
2. Public Masturbate.<Y>	18	34	2	100	6
3. Fetishism.....<N>	0	0	0	0	0
4. Frottage.....<N>	0	0	0	0	0
5. Voyeurism.....<N>	0	0	0	0	0
6. Bestiality.....<N>	0	0	0	0	0
7. Obscene Phone.....<N>	0	0	0	0	0
8. Necrophilia.....<N>	0	0	0	0	0
9. Masochism.....<N>	0	0	0	0	0
10. Coprophilia.....<N>	0	0	0	0	0
11. Pedophilia.....<Y>	7	45	11	120	3
12. Rape.....<N>	0	0	0	0	0
13. Sadism.....<N>	0	0	0	0	0
14. Transvestism.....<N>	0	0	0	0	0
15. PSM.....<N>	0	0	0	0	0
16. Prostitutes.....<N>	0	0	0	0	0
17. Sexual Affairs....<Y>	8	42	20	40	5
18. Sex w/ Strangers..<Y>	21	28	2	2	6
19. Telephone Sex.....<N>	0	0	0	0	0
20. Pornography.....<N>	0	0	0	0	0
21. Transsexualism....<N>	0	0	0	0	0

Legend for Control:

1	No control at all.
4	Can control urges half the time.
7	Absolute control.
99	99 or more times.
-99	No answer.

THE ABEL QUESTIONNAIRE FOR MEN SUMMARY

ID Site ID No. 1037

Summary of Inappropriate Sexual Behavior

The therapist should question this client in detail regarding the inappropriate sexual behaviors in which the client indicates current or previous involvement. These items are listed below. We have also indicated whether the client is currently involved in each of these behaviors and whether the client reports poor control.

Public Masturbate: Client reports complete or nearly complete control.
Pedophilia: *** Client reports LESS THAN COMPLETE CONTROL. ***
The above behavior has occurred within the past 1 year(s).
Sexual Affairs: *** Client reports LESS THAN COMPLETE CONTROL. ***
Sex w/ Strangers: Client reports complete or nearly complete control.

Cognitive Distortion Score

The Cognitive Distortion Score is calculated from items 93 through 105 in Section I of the Abel Questionnaire for Men. These items describe potential justifications frequently used by clients who are sexually involved with children. A higher score suggests a greater use of such cognitive distortions.

Cognitive Distortion Score 38% Range = 0 - 100% (0 missing answers).

Social Desirability Score

The Social Desirability Score is calculated from items 29 through 48 in Section IV of the Abel Questionnaire for Men. This scale measures a person's unwillingness to admit to any violation of common social mores, such as impatience, feelings of anger, etc. A high score may indicate the client's inability to respond truthfully to others.

Social Desirability Score 45% Range = 0 - 100% (0 missing answers).

THE ABEL QUESTIONNAIRE FOR MEN SUMMARY

ID Site ID No. 1037

Danger Registry

The Danger Registry stems from questions 74 through 89 in Section I of the Abel Questionnaire for Men. These items measure the client's attraction to, fantasies about, and future interest in young girls and boys, since the client turned 18 years old. Moderate Concerns are registered when the client reports fantasy without action; Severe Concerns are registered when the client reports actual behavior or behavioral intent. Concerns are registered when the client answers any of the questions as 'Completely True'(1) or 'Somewhat True' (2).

Client reports:
** 4 Issue(s) of MODERATE concern **,
and
** 4 Issue(s) of SEVERE concern **.

The client's responses on the questionnaire give rise to 4 MODERATE CONCERN(S).
** Client reports a sexual attraction to girls 13 years of age or younger.
** Client reports a sexual attraction to boys 13 years of age or younger.
** Client reports a sexual attraction to boys 9 years of age or younger.
** Client reports fantasies about sex with boys 9 years of age or younger.

The client's responses on the questionnaire give rise to 4 SEVERE CONCERNS.
** Client reports masturbatory fantasies of sex with girls 13 years of age or younger.
** Client reports masturbatory fantasies of sex with boys 9 years of age or younger.
** Client reports client is likely to have sex with girls 13 years of age or younger.
** Client reports client is likely to have sex with boys 9 years of age or younger.

Accusations, Arrests, and Convictions

This information stems from questions 106 though 111 in Section I of the Abel Questionnaire for Men. These items indicate the client's admission of accusations, arrests, and adjudication, and offer another independent measure of admission of pedophilia. This information should be interpreted in the context of the client's overall situation, and compared with other sources of information available to the therapist. If the client's responses are clearly at odds with information available from other sources, the therapist should follow-up with more detailed questioning.

Accusations and Admission:

To the question about sexually molesting a child, the client indicated that he was Accused, ADMITS to the transgression, but the report was overstated.

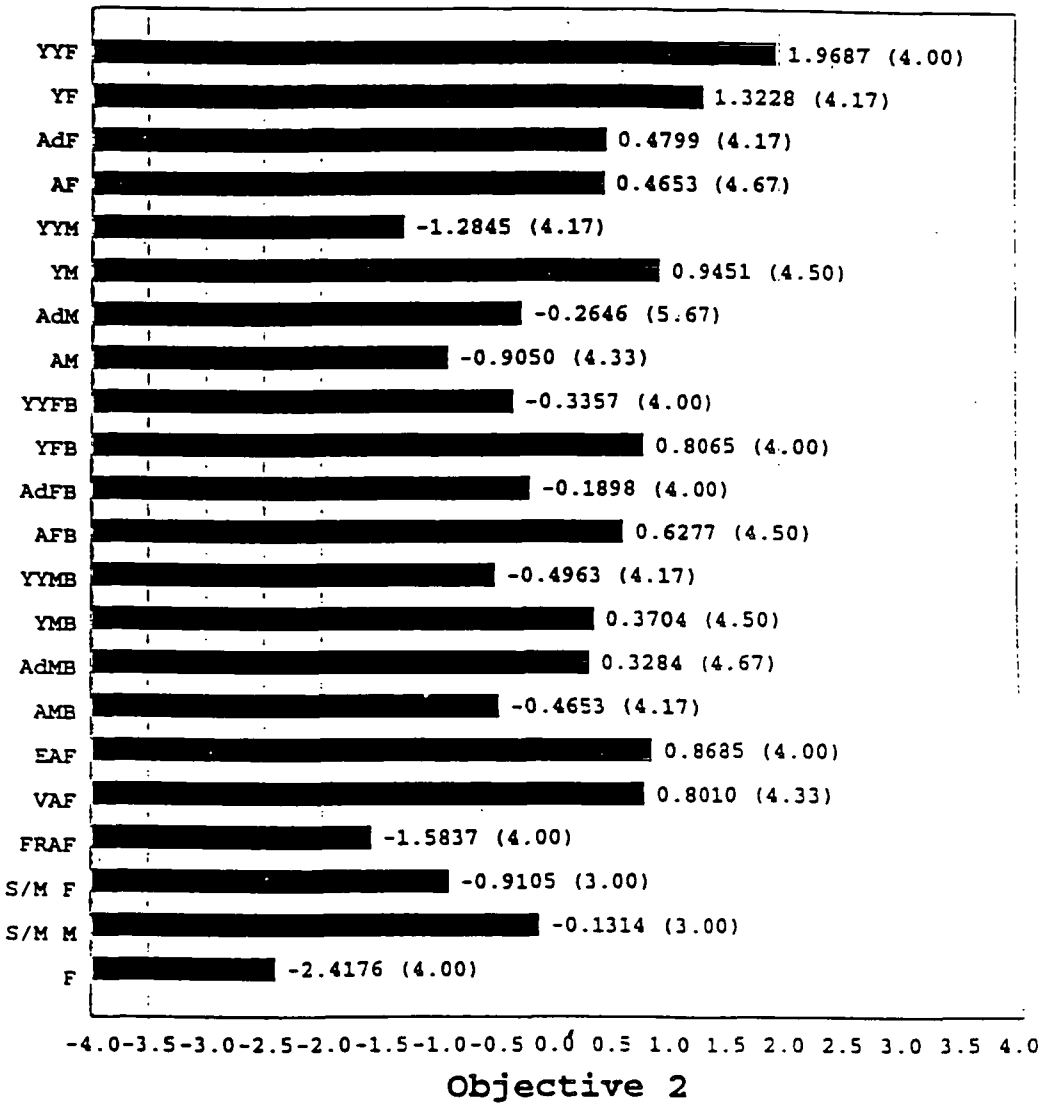
Arrests:

The client reports 1 investigation(s) or arrest(s) for sexual crimes.

Convictions:

The client reports 0 conviction(s) or deferred adjudication(s) for sexual crimes.

Z Scores for Objective 2



ID:	Site: 1037	Tray ID: C	Run: N	Test: Sex	Run At: 11:19 AM, 9/16/96
		Tray ID: D	Run: N	Test: Sex	Run At: 11:39 AM, 9/16/96

Predictors of Sexual Offenders' Recidivism

R. Hanson and M. Brussiere (1996) conducted a meta-analysis of 61 data sets involving 28,972 sex offenders with a median follow-up of 4 years. Results were transformed into correlations and adjusted for differences in recidivism baserates and averaged across studies. Overall recidivism was 13.4% for sexual offenses (18.9% for rapists and 12.7% for child molesters), 12.2% for nonsexually violent and 36.3% for any offense. 69 predictor variables of sexual reoffense were identified.

Variable	Correlation	References Supporting	Abel Assessment Source (Page-Question-Item)
Erections to Children	.32	7	Mean Child/Mean Adult VRT
MMPI Masculinity-Femininity 5	.27	3	None
Severe Psychiatric Disorder	.25	3	Therapist 0-5-C
Deviant Sexual Preference	.22	5	27-11i-2,3,4,5, 6 or 7
Prior Sex Offense	.19	29	12-111
MMPI Paranoia Scale 6	.16	4	None
Personality Disorder	.16	3	None
Negative Feelings for Mother	.16	3	None
Victim is a Stranger	.15	4	27-11h-10
Antisocial Personality	.14	6	None
Victim is a Female Child	-.14	17	27-11g-1, 2, 3 or 4
Erection to Boys	.14	3	Mean Boys minus Mean Adults VRT
Victim is a Male Child	.14	19	27-11g-5, 6, 7 or 8
Anger Problems	.13	3	None
Any Prior Offense	.13	20	12-110 plus 111
Age	-.13	21	3-1
Early Onset of Sex Offending	.12	4	27-11a
Diverse Sex Crimes	.11	5	17-1-Y + 20-4-Y + 21-5-Y + 25-9-Y + 27-11-Y + 28-12-Y + 29-13-Y + 30-14-Y
Single	.11	8	5-14-1 or 3
Victim is a Related Child	-.11	21	27-11g-2, 4, 6 or 8
MMPI Psychopathic Scale 4	.10	4	None
Child Victims of Both Sexes	.09	9	27-11g-1, 2, 3 or 4 and 5, 6, 7 or 8
Married Currently	-.09	10	5-14- 5 or 6
Exhibitionism	.09	14	17-1-Y
Admissions to Corrections	.09	4	12-110 or 111
Deviant Sexual Attitudes	.09	4	11-94-1 or 2 + 95-4 or 5 + 98-1 or 2 + 100-1 or 2 + 102- 4 or 5 + 103-4 or 5
Low Intelligence	.09	9	Therapist 0-5-B or C
Adult Male Victim	.09	5	28-12h-3 or 4
MMPI Psychasthenia Scale 7	.09	4	None
MMPI Schizophrenia Scale 8	.09	4	None

Additional variables with a correlation less than .09 included general family problems, employment instability, MMPI Hypomania Scale 9, history of juvenile delinquency, a rapist, legally a mentally disordered sex offender, MMPI Hysteria Scale 3, prior violent offenses, cognitive impairment-brain damage, depression, MMPI Lie Scale L, low social class, erections to rape, young child victim, anxiety, current sentence length, social skills, empathy for victim, length of treatment, low education, MMPI Defensiveness Scale K, MMPI Hypochondriasis Scale 1, degree of sexual contact, any substance abuse, denial of sex offense, negative attitudes towards father, sexually abused as a child, MMPI Depression Scale 2, MMPI Infrequency Scale F, force used with victim, minority race, alcohol abuse, prior non-violent offenses, and MMPI Social Introversion Scale 0.

G G Abel Atlanta 8B,4-4-97

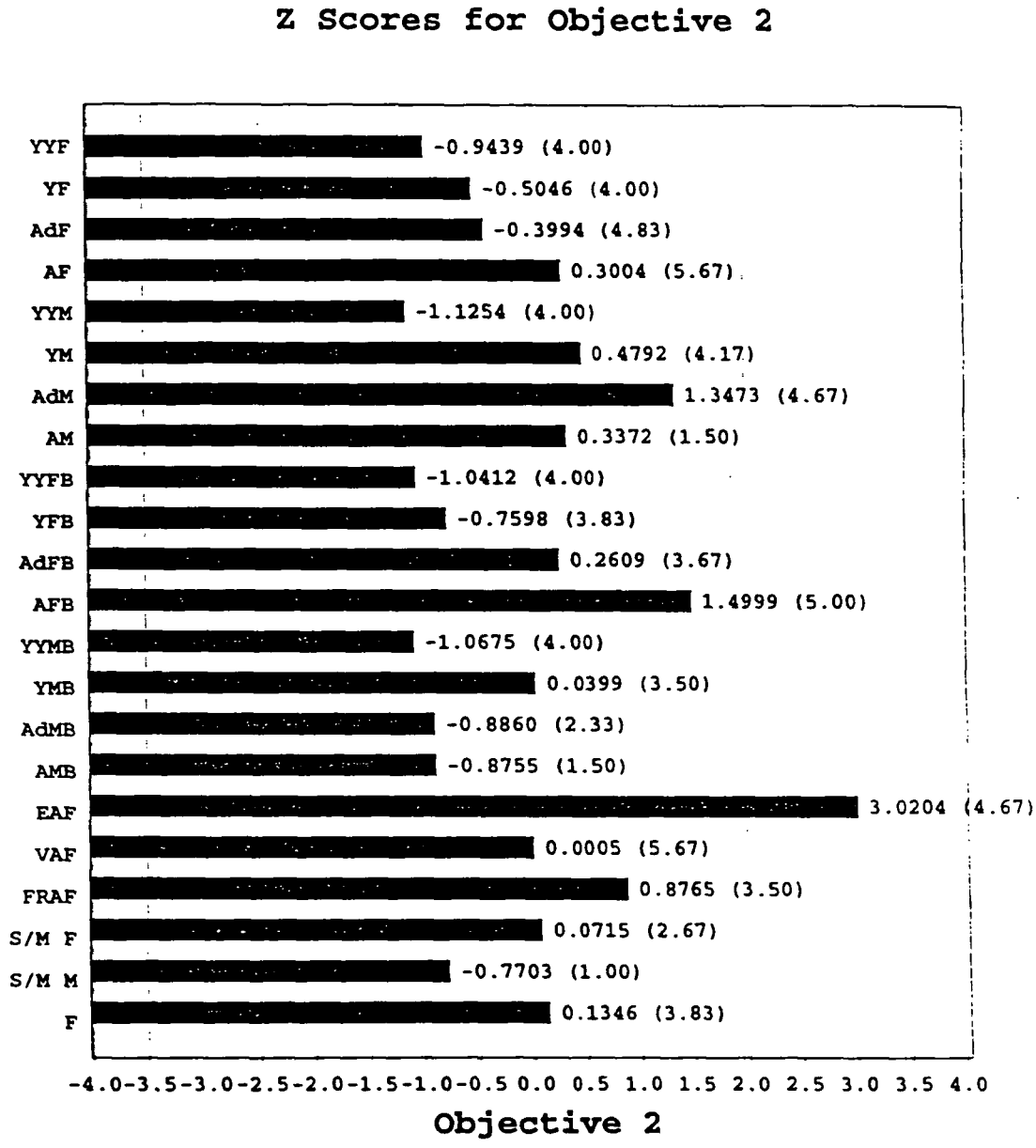
Full article entitled: Predictors of Sexual Offender Recidivism: A Meta-Analysis, available on the World Wide Web at www.sgc.gc.ca/epub/corr/e199604/e199604.htm

Relapse Prediction Score 2.7, 98th Percentile
Severe Pedophile, Molesting More Than Boys
High Relapse Risk, Pre-Treatment

Component	Value	Component	Value
1 Visual reaction time to children	1.61	11 Diverse sex crimes	2.19
2 Deviant sexual preference	3	12 Single	-0.56
3 Prior sex offense	-0.35	13 Victim is related child	-2.43
4 Victim is a stranger	5.33	14 Child victim both sexes	-0.24
5 Victim is female child	0.58	15 Married currently	-1.08
6 Visual reaction time to boys	0.98	16 Exhibitionism	-0.41
7 Victim is male child	3.25	17 Admissions to corrections	-0.41
8 Prior offense	-0.3	18 Deviant sexual attitudes	1.73
9 Age	-0.42	19 Low intelligence	-0.32
10 Early onset of sex offending	1.12	20 Adult male victim	-0.22

CASE STUDY NUMBER ONE (EGO DYSTONIC HOMOSEXUAL PEDOPHILE):

Abner is a 64 yodwm military retiree, one marriage, one adopted female child (no hx of sx abuse). Referral offense: adoles. white male. Acts: masturbation & attempted anal intercourse. First ASI done p̄ 1 yr Tx in NASOGTP. Two prior male victims. Cog. Dist"s: "seduced"/ abhors homosexual activity. Hetero Sx Hx: painful ejac. exper. c wife, Neg. MI, A&D, Rx, &Tx. Hx pos. 2 sx. Ab. (male). RPP= 75%



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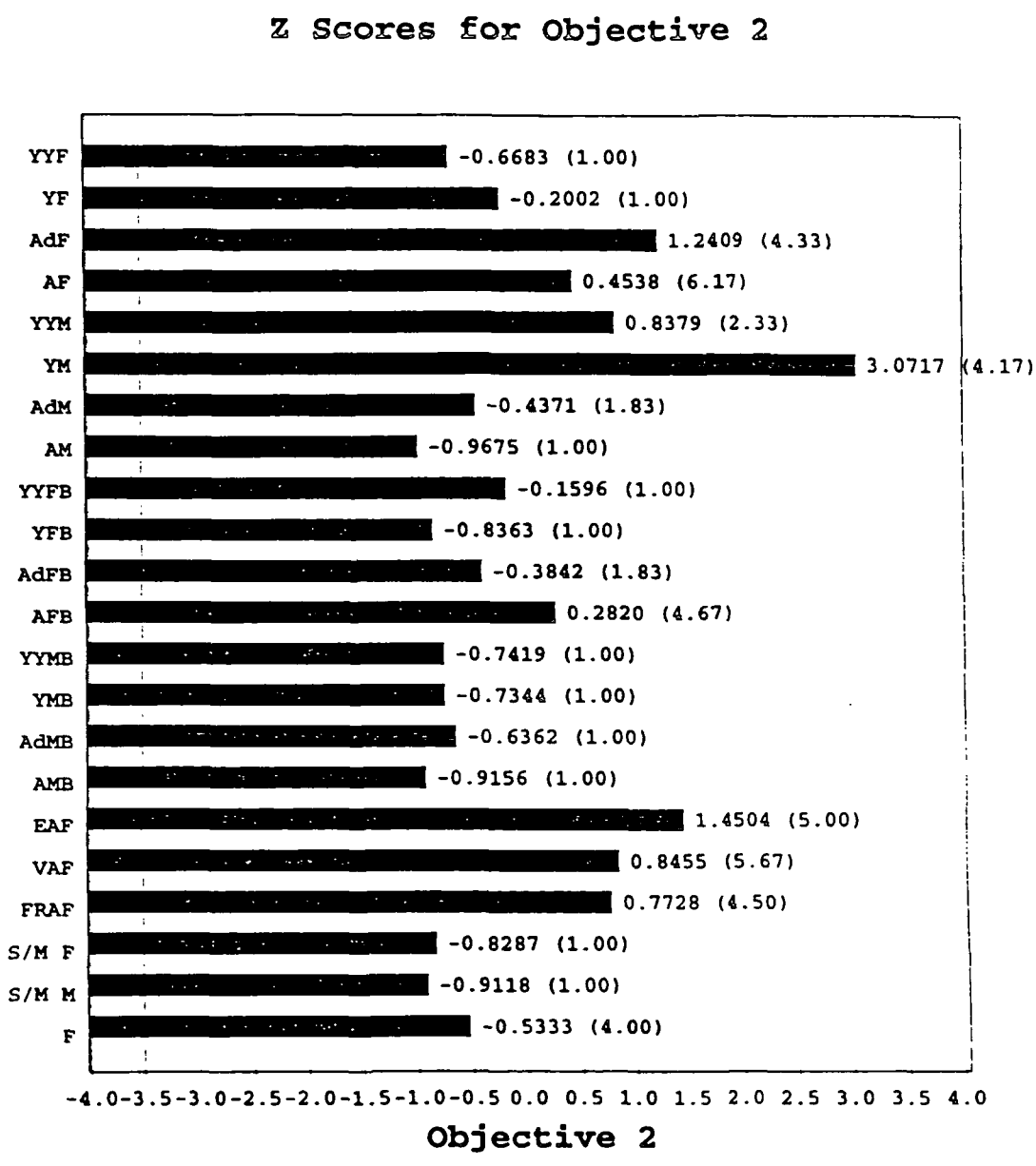
		Tray ID: D	Run: N	Test: Sex	Run At: 2:10 AM, 11/15/97

CASE STUDY NUMBER TWO: THE "SPANKER"- a RPP Post Tx/Rx GUIDE:

Dabner is a 53 yod (2)wm, military retiree c̄ no bio children[both wives had prior sons (1st a victim, 2nd not)]. Referral: 14 yowm "spanked". First ASI done p̄ 1 yr Tx in NASOGTP. One prior (step-son) victim. Cog. Dist's: power & control (being "special"). Hetero Sx Hx: unremarkable/troublesome. Neg. A&D, MI, Hx of Sx ab, Tx, or Rx. Since Tx, takes SSRI (prozac) "model group participant". Remains a social "loner" c̄ salient depressive features.

RPP=97%



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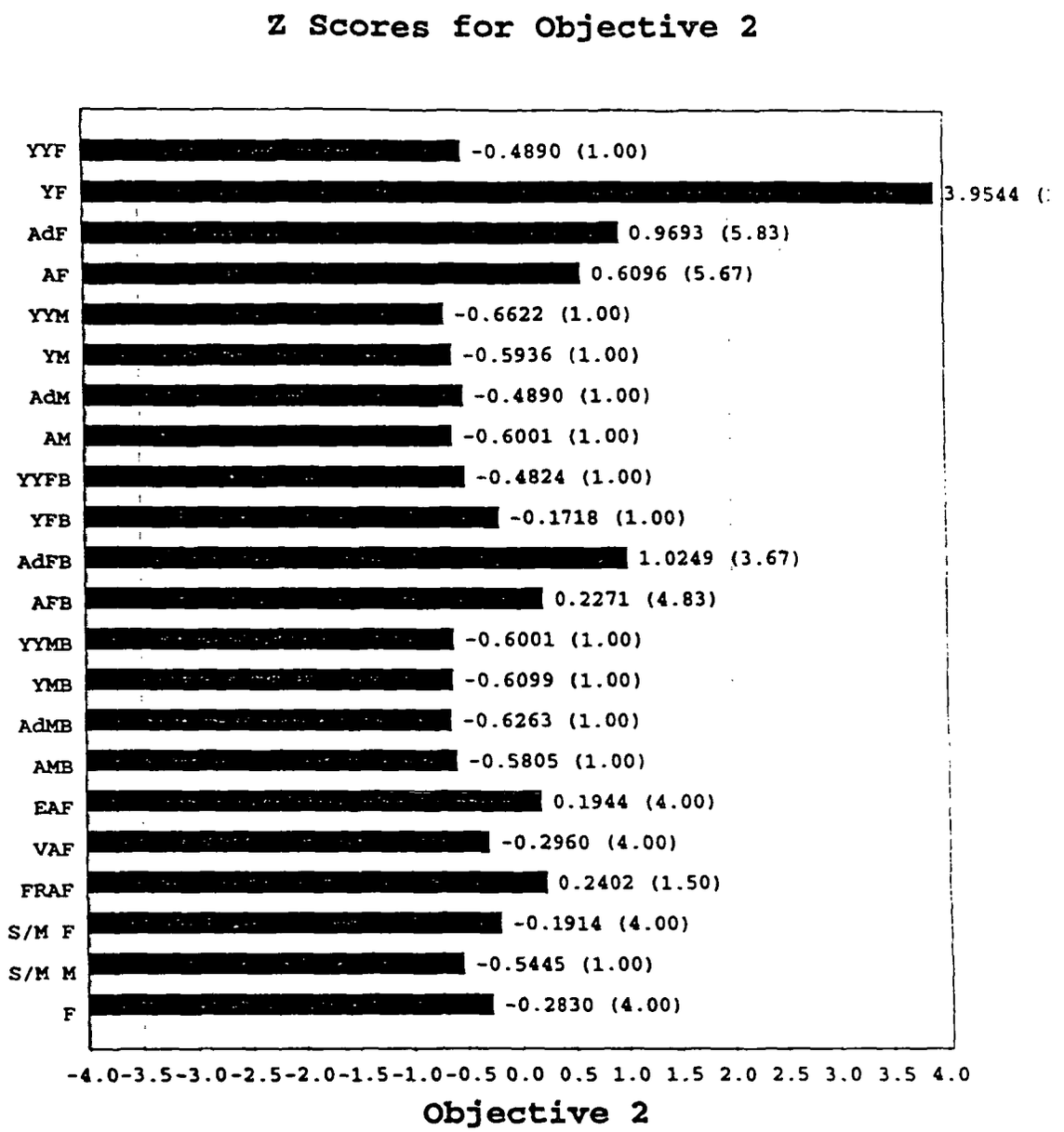
CASE STUDY NUMBER THREE: RESPECTING RPP's, "IN THE TRENCHES":

Ralph is a 29 yod(1)wm with one 3yom child. Referral: intercourse c̄ a cauc. ad. Female. Hx: pos. for A&D, prior enticement of ad. F's per phone, temper control problems, & legal (driving) violations. Cog. Dist's: "above the law", "live well & die young". Heart attack @ 28; smoker, marginal AA'er & civil litigation with ex r̄e son (primary agenda). ASI p̄ 6 mo NASOGTP Tx.

RPP=94% (arrested shortly p̄ 2 probation violations/rape of fiancee'- incarcerated)



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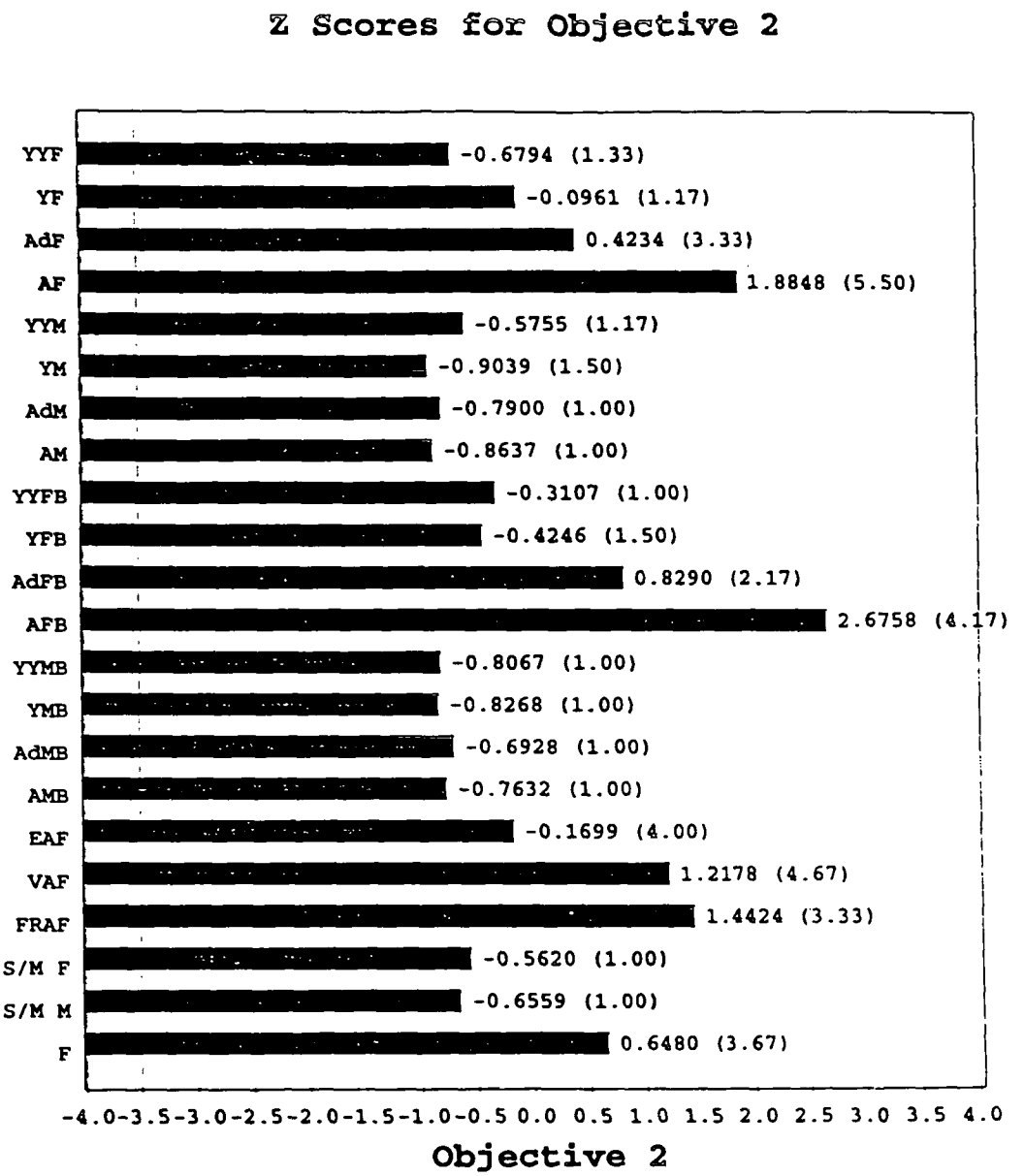
		Tray ID: D	Run: N	Test: Sex	Run At: 8:37 PM, 8/15/97

CASE STUDY NUMBER FOUR: TREATMENT IMPLICATIONS OF RPP's:

Floyd is a 54 yom(1)m, public service retiree, no bio children, no Hx of prior Tx, A&D, or Sx Ab. No prior victims. Referral: 8yowf digit/vaginal contact c̄ neighbor (surrogate grand-daughter figure). Cog Dist's: "prozac made me do it" (prescribed {pre-offense}, since d/c'd). Prolific Hx of adult porn. Took ASI p̄ 1 yr. NASOGTP Tx., "model client". Wife most involved/supportive of Sx offend Tx. RPP=6%



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		Tray ID: D	Run: N	Test: Sex	Run At: 11:26 PM, 10/31/97

Engaging Families as Partners to Reduce the Risk of Neglect

Presented by

Dianne DePanfilis, PhD

Engaging Families as Partners to Reduce the Risk of Neglect

Diane DePanfilis, Ph.D.
University of Maryland
School of Social Work

14th National Symposium on Child Sexual Abuse
Huntsville, March 20, 1998.

What contributes to neglect?

- Risk and protective factors interact across four levels: (1) the individual level; (2) the family microsystem; (3) the exosystem; and (4) the social macro system (Belsky, 1980).

Topics of Discussion

- Definitions of neglect
- Risks for neglect
- Principles of effective intervention
- Outcomes of intervention
- Review of intervention models

Risks and Protective Factors - Family Members

- Children, caregivers, other adult household members:
  - *Behavior*
  - *Emotion*
  - *Physical*
  - *Cognitive*
  - *Social*

How to identify neglect?

- Use specific operational definitions
- Understand risks and protective factors

Risk and Protective Factors -Family

- Demographics
- Role expectations/satisfaction
- Communication
- Problem solving
- Mutual support
- Violence

Risks and Protective Factors - Environment

- Social support functions:
  - *emotional support*
  - *child related support*
  - *financial support*
  - *instrumental support*
  - *formal support*
- Adequacy of resources

Principles for Working with Families to Reduce Risk

- Ecological developmental framework
- Importance of outreach & community
- Family assessment & individualization
- Helping alliance with family
- Empowerment & strengths based
- Cultural competence
- Developmentally appropriate

Environment (continued)

- Helpfulness of network:
  - *extended family*
  - *friends*
  - *formal & informal systems*
- Housing Conditions
- Neighborhood Conditions
- Culture

Intervention Outcomes

- Family Maintenance and Safety
- Family Member Functioning
- Family Functioning
- Problem Solving
- Social Support
- Care of Children

Operational Definitions of Neglect[1]

Inadequate/delayed health care: failure of a child to receive needed care for physical injury, acute illnesses, physical disabilities, or chronic condition or impairment that if left untreated could result in negative consequences for the child (Adapted from: Magura and Moses, 1986; U.S. Department of Health and Human Services, 1996; Zuravin and DePanfilis, 1996).

Inadequate nutrition: failure to provide a child with regular and ample meals that meet basic nutritional requirements or when a caregiver fails to provide the necessary rehabilitative diet to a child with particular types of physical health problems (Adapted from: Zuravin and DePanfilis, 1996).

Poor personal hygiene: failure to attend to cleanliness of the child's hair, skin, teeth, and clothes (Adapted from Magura and Moses, 1986; Zuravin and DePanfilis, 1996).

Inadequate clothing: chronic inappropriate clothing for the weather or conditions (Adapted from: Magura and Moses, 1986).

Unsafe household conditions: presence of obvious hazardous physical conditions in the home that could result in negative consequences for the child(ren) (Adapted from Magura and Moses, 1986; Zuravin and DePanfilis, 1996).

Unsanitary household conditions: presence of obvious hazardous unsanitary conditions in the home (Adapted from Magura and Moses, 1986; Zuravin and DePanfilis, 1996).

Unstable living conditions: moves of residence due to eviction or lack of planning at least three times within a six month period or homelessness due to the lack of available, affordable housing or the caregiver's inability to manage finances (Adapted from: Zuravin and DePanfilis, 1996).

Shuttling: the child is repeatedly left at one household or another due to apparent unwillingness to maintain custody, or chronically and repeatedly leaving a child with others for days/weeks at a time (Adapted from: U.S. Department of Health and Human Services, 1996; Zuravin and DePanfilis, 1996).

Inadequate supervision: child left unsupervised or inadequately supervised for extended periods of time or allowed to remain away from home overnight without the caregiver knowing the child's whereabouts (Adapted from: U.S. Department of Health and Human Services, 1996).

Inappropriate substitute caregiver: failure to arrange for safe and appropriate substitute child care when the caregiver leaves child with an inappropriate caregiver (Adapted from: Magura and Moses, 1986; Zuravin and DePanfilis, 1996).

Abandonment: desertion of a child without arranging for reasonable care and supervision in situations when children are not claimed within 2 days and when children are left by caregivers who give no (or false) information about their whereabouts (Adapted from: U.S. Department of Health and Human Services, 1996).

Expulsion: blatant refusals of custody without adequate arrangements for care by others or refusal to accept custody of a returned runaway (Adapted from: U.S. Department of Health and Human Services, 1996).

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[1]Developed by Diane DePanfilis, University of Maryland School of Social Work, 1997.

Witnessing violence: a child witnesses violence in the home, e.g., partner abuse or violence between other persons who visit the home on a regular basis (Adapted from: U.S. Department of Health and Human Services, 1996).

Drug exposed newborn: a newborn infant has been exposed to drugs because the mother has used one or more illegal substances during her pregnancy (National Council of Juvenile and Family Court Judges, 1992).

Permitting alcohol or drug use: encouraging or permitting of drug or alcohol use by a child (Adapted from: U.S. Department of Health and Human Services, 1996).

Permitting other maladaptive behavior: encouraging or permitting of other maladaptive behavior (e.g., severe assaultiveness, chronic delinquency) under circumstances where the caregiver had reason to be aware of the existence and seriousness of the problem but did not attempt to intervene (Adapted from: U.S. Department of Health and Human Services, 1996).

Inadequate nurturance or affection: marked inattention to the child's needs for affection, emotional support, attention, or competence; being detached or uninvolved, interacting only when absolutely necessary, failing to express affection, caring, and love for the child. This includes cases of nonorganic failure to thrive as well as other instances of passive emotional rejection of a child or apparent lack of concern for a child's emotional well-being or development. (Adapted from: American Professional Society on the Abuse of Children, 1995; U.S. Department of Health and Human Services, 1996).

Isolating: the child is consistently denied opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home; markedly overprotective restrictions which foster immaturity or emotional over dependency; chronically applying expectations clearly inappropriate in relation to the child's age or level of development; inattention to the child's developmental/emotional needs (Adapted from: American Professional Society on the Abuse of Children, 1995; U.S. Department of Health and Human Services, 1996).

Delay in obtaining needed mental health care: a child is not provided needed treatment for an emotional or behavioral impairment (Adapted from: U.S. Department of Health and Human Services, 1996; Zuravin and DePanfilis, 1996).

Chronic truancy: habitual truancy (minimum of 20 days) without a legitimate reason (Adapted from: U.S. Department of Health and Human Services, 1996; Zuravin and DePanfilis, 1996).

Failure to enroll/other truancy: a child (age 6) is not enrolled in school or a pattern of keeping a school-age child home for nonlegitimate reasons (e.g., to work, to care for siblings, etc.) an average of at least 3 days a month (Adapted from: U.S. Department of Health and Human Services, 1996).

Unmet special education needs: a child fails to receive recommended remedial educational services, or treatment for a child's diagnosed learning disorder or other special educational needs or problems of the child (Adapted from: American Professional Society on the Abuse of Children, 1995; U.S. Department of Health and Human Services, 1996).

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Family Connections Intervention Outcomes1

Outcome	Measures
FAMILY MAINTENANCE AND SAFETY: The family demonstrates the ability to meet the basic needs of the family for food, clothing, housing, and health care.	**Child Well Being Scales** physical health care nutrition/diet clothing personal hygiene household furnishings overcrowding household sanitation security of residence availability of utilities physical safety in home **Family Needs Scale** **Family Resource Scale**
FAMILY MEMBER FUNCTIONING **Caregiver:** The caregiver demonstrates abilities to achieve self sufficiency, cope with daily stresses, manage emotions, and control impulses.	**employment & income** **Family Risk Scales** caregiver's physical health caregiver's mental health caregiver's substance abuse
Children: The children demonstrate developmental appropriateness in all areas of functioning.	**Family Risk Scales** child's physical health and disabilities child's mental health child's school adjustment child's delinquent behavior child's home related behavior
FAMILY FUNCTIONING: The family demonstrates strength in multiple areas such as family-identity, information-sharing, coping and resources and uses non-violent methods to resolve family conflict.	**Family Risk Scales** adult relationships in household **Family Functioning Style Scale**

1 DePanfilis, D. (1997). Family Connections Intervention Manual. Baltimore: University of Maryland School of Social Work.

Outcome	Measures
PROBLEM SOLVING: Family members demonstrate abilities and motivation to accurately identify and solve problems.	**Child Well Being Scales** money management caregiver recognition of needs caregiver motivation to solve problems
SOCIAL SUPPORT: Family has access to and effectively uses extended family, friends, and systems to meet social support functions: i.e., emotional, child related, financial, instrumental, and formal.	**Support Functions Scale** **Family Support Scale** **Personal Network Matrix** **Child Well Being Scales** support for principal caregiver availability/accessibility of services caregiver cooperation with services
CARE OF CHILDREN: Caregivers demonstrate appropriate attitudes and skill to meet the unique needs of their children.	**Child Well Being Scales** supervision of young children supervision of teenage children arrangements for substitute child care caregiver capacity for child care continuity of care caregiver affection for children caregiver approval of children caregiver expectations of children caregiver consistency of discipline caregiver teaching of children

References for Intern Driven Assessment measures:

Child Well Being Scales

Magura, S., & Moses, B. S. (1986). Outcome Measures for Child Welfare Services. Washington, DC: Child Welfare League of America.

Family Risk Scales

Magura, S., Moses, B. S., & Jones, M. S. (1986). Assessing risk and measuring change in families. Washington, DC: Child Welfare League of America.

Family Needs Scale, Family Resource Scale, Family Functioning Style Scale, Support Functions Scale, Family Support Scale, Personal Network Matrix

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Table 1. Alternative interventions when children are neglected.

Ecological (Concrete)	Ecological (Social Support)	Developmental	Cognitive/ Behavioral	Individual	Family System
- housing assistance - emergency financial, food, or other assistance - clothing, household items - advocacy for availability or accessibility to community resources - hands-on assistance to increase safety and sanitation of home (home management aides) -transportation -free or low-cost medical care - low cost but quality child care	- individual social support (parent aide, volunteer) - connections to church activities - mentor involvement - social support groups - development of neighborhood child care co-op - neighborhood center activities - social networking - recreation programs - cultural festivals and other activities	- therapuetic day care - individual assistance with developmental role achievement, e.g., parenting, - public health visiting with focus on developmental including attachment needs of family members - peer groups (often at schools) geared to developmental tasks, -mentors to provide nurturing, cultural enrichment, recreation, role modeling	- social skills training - communication skill building -teach home management, parent-child interaction, meal preparation skills and other life skills - teach new thought processes; e.g., regarding childhood history - parenting education - employment counseling and/or training - financial management counseling -problem solving training	-AOD in-patient and out-patient counseling, - detoxification - 12 Step programs - mental health in-patient and out-patient counseling - crisis intervention - stress management counseling -play therapy	- home based family centered counseling regarding family functioning, communication skills, home management, roles and responsibilities - center based family therapy - mobilizing family strengths - nuturing family camps - family skulpting

Preventing Child Sexual Abuse:

What's New and Effective

Presented by

Sandy K. Wurtele, PhD

PREVENTING CHILD SEXUAL ABUSE:
WHAT'S NEW AND EFFECTIVE

I. Child Sexual Abuse Prevention Efforts
   A. History of Development
      1. Chronology
      2. Factors Shaping CSA Prevention Efforts
         a. Why do prevention strategies focus on children?
         b. Who else might share in the responsibility for prevention?
         c. What are the barriers to sharing?
   B. Child-focused CSA Prevention Programs
      1. Content
         a. Define and describe sexual abuse
         b. Describe Offenders
         c. Stress body ownership and self-pride
         d. Teach resistance and decision-making skills
         e. Promote disclosure, teach about secrets
         f. Relieve guilt

      2. Process
         a. Is Developmentally appropriate
         b. Includes rehearsal, role-play, practice
         c. Is sensitive to audience characteristics
         d. Includes multiple presentations, periodic reviews
         e. Includes evaluation

II. PIE Model
   A. Preparation
   B. Implementation
   C. Evaluation

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PIE MODEL: PREPARATION, IMPLEMENTATION, EVALUATION

STAGE 1: PREPARATION

__ Identify need
__ Identify target group(s) of children
__ Select program(s) and presenter(s)
__ Identify and meet with representatives from child's system
- School
- Home
- Youth Group
- State Social Services
- Health Care Professionals (physical and mental)
- Law Enforcement
- Prevention Task Force
- Higher Education
- Media

__ Provide instruction to adults in system (e.g., school personnel, parents)
- Their role in preventing CSA
- Detecting CSA
- Handling disclosures, Reporting CSA
- Ensuring safe setting

STAGE 2: IMPLEMENT PROGRAM(S)

STAGE 3: EVALUATE THE PROGRAM

__ Employ a variety of data sources
- Children
- Parents
- Implementers

__ Use sound evaluation methods
__ Examine the cost of implementing the program

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The Use of the Medium of Picture Drawing in Sexual Abuse Assessments

Presented by

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The Use of the Medium of Picture Drawing in Sexual Abuse Assessments

Kathleen Coulborn Faller

(adapted from the APSAC Study Guide: *Interviewing children suspected of having been sexually abused*)

One medium that can be used to assess children and elicit information about possible sexual abuse from them is picture drawing. Conte and colleagues (1991) found that 87 per cent of respondents from their study of 212 sexual abuse experts in 40 states used free drawings when evaluating sexual abuse allegations. A smaller proportion of Kendall-Tackett's (1992) Boston area mental health and legal experts used drawings in sexual abuse assessments, less than half.

Although the APSAC Guidelines mention drawings as one means of eliciting information about possible sexual abuse, they do not elaborate. In contrast, the AACAP Guidelines have a separate section on the use of children's drawings, with suggestions for drawing tasks and some guidelines regarding interpreting drawings.

Some research has been undertaken, which attempts to differentiate characteristics of drawings of sexually abused children from non-abused children. Several studies have focused on the sexual body parts in free drawings. Yates and colleagues (Yates, Beutler, & Crago, 1985) using free drawings with 18 sexually abused girls and 17 disturbed non-abused girls, ranging in age from 3.5 to 17, found that the sexually abused children were likely to either exaggerate and focus on the sexual parts of the body or to avoid them. In one study, Hibbard and colleagues (Hibbard, Roghmann, & Hoekelman, 1987) found that 57 3 to 7 year old children assessed for sexual abuse were six to eight times (the variation based upon whether they were suspected or confirmed cases) more likely to draw genitalia than 55 non-abused children. However, the rates of genital drawings were quite low for both groups. In a later study by Hibbard and Hartman (1990) with 65 victims and 64 non-victims, only victims drew genitalia in their pictures, but the number was so small that differences were not statistically significant. Friedrich (1990) provides comparative data from parental responses to the Child Sexual Behavior Inventory. Parents of children referred for sexual abuse are more likely to report their children include genitals in their drawings than children not referred for sexual abuse. However, Friedrich notes that some non-referred children also were reported to draw genitalia. These findings suggest that in the few instances when children draw genitals, this is cause for concern and further inquiry. However, it would be inappropriate to make a diagnosis of sexual abuse based upon the presence (or absence) of sexual parts in a child's drawing.

Another approach to the use of drawings is that developed by Burgess and colleagues (e.g. Burgess & Hartman, 1993; Burgess, McCausland, & Wolbert, 1981). They instruct evaluators to have children draw seven separate pictures: 1. your favorite weather; 2. your whole self as a younger child; 3. your whole self today; 4. the family doing something together (the Kinetic family drawing); 5. what happened to you (i.e. the sexual abuse); 6. a house and a tree; and 7. your own drawing (free drawing).

Burgess and Hartman (1993) describe each of these drawings and drawing tasks as having a specific function in the assessment process. They state that such drawings should be used as an "associative tool for memory" and caution that those interpreting drawings should be professionals trained in interpreting artwork.

Several studies have used this series of drawings. Burgess and colleagues (1987) had 81 drawings of sexually abused children who testified in court rated by six clinicians skilled in the use of drawings with sexually abused children. They found indicators of numerous psychosocial sequelae of sexual abuse in the children's drawings, for example anxiety, insecurity, isolation, body image problems, regression, and repeated memories of the abuse.

Elizabeth Burgess (1988) also employed this schema in research with a sample of nine children sexually abused in day care and eight comparison children. She examined 53 characteristics of these two sets of drawings and noted differences in percentages of such traits in the two groups. However, no statistical analyses were presented. Nevertheless she found that the drawings of sexually abused children depicted an avoidance of drawing the sexual abuse, omission and sexualization of body parts, sad and affectless mood, and anxiety. She also found evidence of the success of therapy in the drawings of abused children.

Finally Burgess and colleagues (Howe, Burgess, & McCormack, 1987) had 124 runaway adolescents, 53 of whom reported sexual abuse, engage in this drawing exercise. Statistically significant differences were found in psychiatric diagnosis based upon the drawings, specifically psychotic, avoidant, anxious-

avoidant, and anxious-aggressive. Because this drawing exercise has been interpreted in a variety of ways, its generalizability is limited.

There have been other attempts to examine the affective content of drawings of children who may have been sexually abused. Chantler and colleagues (1993), in a study that also involved the use of the Louisville Behavior Checklist, asked participants to "draw a whole person". Participants were sexually abused, clinic, and community samples. Their pictures were then scored according to Koppitz's 30 Emotional Indicators and 6 flag items for maladjustment. Although there were significant differences in findings on both measures by group, predictive validity was quite modest. The authors suggest caution in using this drawing task to decide whether children have been sexually abused.

A somewhat different approach is taken by Kaufman and Wohl (1992) in a book on drawings of sexually abused children. They scored the House-Tree-Person and Kinetic Family Drawings on 86 items that they decided were indicative of Finkelhor's (1986) four categories of traumatagenic impact from sexual abuse: betrayal (24 items), traumatic sexualization (32 items), stigmatization (19 items), and powerlessness (11 items). Only a small number of these 86 items are described. Children from high certainty sexual abuse cases were compared to clinic and community samples, with 18 5-10 year olds in each group. There are some statistically significant differences among groups on total scores, but none on the items within the categories of betrayal and powerlessness and only one each on sexualization and stigmatization. Moreover, although no statistic is provided, the clinic sample is over a year older than the other two groups, and no post hoc tests to look at between groups differences were conducted after the ANOVAs. Thus, the approach developed by Kaufman and Wohl is interesting and may well have merit, but cannot be evaluated as it is presented.

Another potentially useful drawing task is one described by Hewitt and Arrowood (1994), called the Touch Continuum. It actually is two drawing tasks, and most of the drawing is done by the interviewer. Hewitt and Arrowood recommend this strategy for children 4-8 and note findings on 42 children, whose drawing outputs are compared to clinical conclusions about sexual abuse. The first task involves dividing a piece of paper into four boxes and drawing faces in each to represent happy, sad, mad, and scared affects. The interviewer then encourages the child to label the emotion in each face. The second task begins with the interviewer dividing a piece of paper into six boxes. Stick figures that represent the child are drawn in each box, and the interviewer labels or has the child label the box hugging, tickling, spanking, kissing, hitting, and private parts touching. Each type of touch is discussed with the child in terms of the feelings it generates, the body parts involved, and the persons who touch the child in that way. This drawing task may elicit information about physical and sexual abuse. The authors present findings comparing touch continuum data to conclusions based upon a comprehensive assessment of possible sexual abuse. There were no false positives from the Touch Continuum data, but a high rate of false negatives.

From a clinical perspective, a number of writers have offered suggestions regarding specific drawing tasks that might elicit information relevant to sexual abuse. Children may first be asked to draw anything, and their choice of subject may be revealing (Faller, 1988). They may be asked to draw themselves (Benedek & Schetky, 1987; Faller, 1988; Friedrich, 1990) and then tell something about the picture, such as what makes them happy, sad, angry, and scared (Faller, 1993). They might also be asked to draw their family or the Kinetic Family Drawing, that is, their family doing something (AACAP Guidelines, 1990; Benedek & Schetky, 1987; Faller, 1993; Friedrich, 1990). Any of these drawing exercises may yield information helpful in assessment for possible sexual abuse.

However, drawings that are likely to be more to the point, and less open to a variety of interpretations are the following: a picture of the alleged offender, the place where the sexual abuse occurred, an instrument that might have been used in the abuse, or the abusive act, itself (Benedek & Schetky, 1987; Faller, 1993; Friedrich, 1990). Although Benedek and Schetky emphasize the importance of the affect in the picture. However, having the child write or writing for the child who and what is in pictures, that portray aspects of the sexual abuse, can render them pieces of evidence that are clinically and legally convincing. They are admissible in court as a part of the business record (Faller, 1993). Wilson (1992) favors a focus on drawings that depict aspects of the abuse rather than more general pictures that the evaluator interprets.

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ANATOMICAL DOLLS: USES AND CONTROVERSIES

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1. Anatomical dolls--How widespread is their use?

According to the research of Conte and colleagues (1991), anatomical dolls are the most widely used medium (by 92% of respondents) in interviewing children suspected of being sexually abused. Similarly, Kendall-Tackett and Watson (1991) report that in a survey of 201 Boston area professionals conducting sexual abuse investigations, 80 per cent of mental health professionals and 62 per cent of law enforcement personnel indicated they employ anatomical dolls. In addition, of the various media employed by evaluators, the anatomical dolls are essentially the only ones which have been subjected to research. To a considerable extent, this research has been driven by attacks on the dolls in legal arenas. Legal challenges include that they are being improperly employed as a psychological test, that they have grotesquely exaggerated sexual organs, and that they are leading or suggestive. Yet most of the research supports their efficacy in sexual abuse evaluations (Maan, 1991).

This section will cover the issue of the suggestibility of the dolls, the research on differences in responses of sexually abused and nonabused children to the dolls, the research comparing the effectiveness of anatomical dolls to other techniques, and techniques for using the dolls.

2. Are the dolls suggestive?

The research on the suggestiveness of the dolls consists of studies of the reactions of children with no history of sexual abuse to the dolls and a study by Bays of the size of the genitalia and breasts of anatomical dolls.

Most of the research on the reactions of non-abused children to the dolls essentially indicates that the dolls do not elicit sexual activity in the doll play of children with no prior sexual knowledge. However, children may be curious about the sexual parts of the dolls and insert fingers in the orifices.

Sivan and her colleagues (1988) exposed 144 middle class, three to eight year olds from the Iowa City area to anatomical dolls. None of the children engaged in sexualized behavior with the dolls; only two per cent of participants exhibited aggressive play with the dolls; and predictably girls were more interested in the dolls than boys. A more recent study (Dawson et al., 1992) with a smaller number of children (10 boys and 10 girls) reports comparable findings, with no intercourse behavior

demonstrated by the children, but higher percentages engaging in aggressive behavior.

The sample of 223 children involved in a similar study by Everson and Boat (Everson & Boat, 1990; Boat & Everson, 1994) was more varied demographically and younger, children ranging from two to five years old. In addition, in this study children were given the instruction, "Show me what the dolls can do together," after the dolls were undressed. Six percent of Everson and Boat's subjects engaged in oral or genital intercourse using the dolls. None of the two year olds demonstrated such behavior; however, older, black, and poor children had higher rates. The rates for older, black, poor males were 27% (4/15) with the interviewer present and 22% (2/9) when the child was alone. This group was the only one to demonstrate sexualized behavior with the dolls in the presence of the interviewer. Everson and Boat interviewed the mothers of children demonstrating sexualized behavior and found most of them could offer relatively benign explanations for their children's sexual knowledge, usually having viewed pornography or adolescents involved in sexual activity.

In addition, Everson and Boat (1990) reviewed seven previous studies of children's sexualized behavior with anatomical dolls and noted that the overall rate from these studies is two per cent. They conclude based upon their own research and that of others that the dolls do not cause sexually naive children to act out sexually, but they do appear to provide sexually knowledgeable children a stimulus to engage in sexualized doll play.

In contrast, Bruck and colleagues (1994) present findings from an analogue study with three year old boys and girls who received medical exams, which they interpret as indicating anatomical dolls are suggestive. Bruck and colleagues found that some children (they do not say how many) inserted fingers in the vaginal and anal openings of the anatomical dolls. Although this behavior is considered normal by clinicians, it is judged by these researchers likely to be viewed by clinicians as suspicious of sexual abuse. This study will be discussed in detail later.

As stated earlier, an additional criticism made of the anatomical dolls is that their enlarged genitals are both traumatic to interviewees and suggestive. Frustrated by these challenges, Bays (1990) set out to study genitalia with 17 adult male dolls and genitalia and breasts of 17 adult female dolls. As well she reports on a preliminary study of 9 pair of male and female child dolls. Her findings are that the breasts and genitalia of adult dolls are either proportional or smaller than normal, except that with some penises it depends upon whether they are considered stretched or unstretched flaccid penises. With

the child dolls, the vulvar openings were proportional to girls 4 to 10 and the penises proportional for boys 4 to 18. Bays admonishes doll manufacturers that they should make their juvenile penises the equivalent of those for boys 3 through 12.

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3. Do sexually abused children react differently to the dolls from non-abused children?

Four studies compare the responses of children referred for sexual abuse to those not so referred to anatomical dolls. Altogether 172 children were involved in these four studies, Cohn's having the largest number of children, 70. Thus, only a modest number of subjects have been involved in this sort of research. All studies had equal numbers of children referred for sexual abuse and non-referred children, and ages ranged from two to eight years. Except for the research of August and Foreman, who only examined girls, the studies had both male and female subjects. With the exception of the research of Cohn, studies found statistically significant and higher proportions of intercourse demonstration by children referred for sexual abuse evaluation. Cohn reports three per cent of subjects in both groups demonstrated intercourse with the dolls; however, the total exposure time of her children to the dolls was 11 minutes. In all research, a substantial

proportion of the children referred for sexual abuse did not demonstrate sexualized behavior with the dolls, the smallest proportion (10%) being found in the work of Jampole and Webber, but they only had 10 children in each group. White and colleagues (White, Strom, Santilli, & Halpin, 1986) and August and Foreman (1989) report no sexual intercourse demonstrations among their non-referred subjects.

Thus, it appears that sexually abused children are more likely to engage in sexualized behavior with anatomical dolls than non-abused children. However, many abused children will not demonstrate sexual activity, and a small number of non-abused children will.

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4. Are the anatomical dolls superior to other techniques?

Clinicians have felt that anatomical dolls greatly enhance their ability to elicit information about sexual abuse; however, the research findings, so far, are not as supportive as clinicians might anticipate. There are five studies reporting on the use of anatomical dolls as compared to other techniques. Two involve children alleged to have been sexually abused (Britton & O'Keefe, 1991; Leventhal et al., 1989); one involves research on children seen in an outpatient clinic, including children alleged to have been abused (Steward, 1989); and two are analogue studies (Aman & Goodman, 1987; Bruck, Ceci. Francoueur, & Renick, 1994). With the exception of the study by Bruck and colleagues (1994), these studies indicate that generally anatomical dolls improve children's responses to abuse related queries when compared to questioning without props (Aman & Goodman, 1990; Leventhal et al., 1989, Steward, 1989), but that they are not superior to non-anatomical dolls (Aman & Goodman, 1990; Britton & O'Keefe, 1991) or other media (Steward, 1989).

It is difficult to reconcile the findings of Bruck and colleagues (1994) with other research, both because their methodology differs somewhat, and their results diverge from those of other doll studies. They found very high rates of inaccuracy among three year olds interviewed within minutes of a medical exam, regardless of method of questioning. Forty children received a well child exam, during which half received a light touch on the genitals and buttocks. First the children were asked a direct question about genital and anal touch with anatomical dolls ("Did Dr. F touch you here?" as the interviewer pointed to a private body part). Then they were asked a leading or misleading (misleading if no such touch had occurred) question, "Show on the doll how Dr. F touched your buttocks" (the child's name for the relevant body part was used). Finally they were commanded to show on their own bodies how Dr. F touched their private parts (this technique was only used with children who had actually experienced the touch). The children provided high rates of false negative responses (about 50%) to these direct questions and commands, and the girls high rates of false positives (about 50%) in all three conditions. The response was scored incorrect if the child touched, for example, the anus instead of the vagina in response to a command to show on the doll or themselves how the doctor touched the vagina. In addition, apparently to support their hypothesis that the anatomical dolls are not useful, they recoded behaviors with dolls, departing from their original definition of a correct response. Thus, initially any demonstration of touching, rubbing, or insertion to the correct private part was considered an acceptable response to the command, "Show me on the doll how Dr. F. touched your vagina/buttocks." However, since Dr. F. only lightly touched the relevant body part, anything other than that was recoded a false positive. As a result, the correct replies for the three year old girls who received the private parts exam decreased from 71 percent to 38 percent.

These findings do not indicate that anatomical dolls create inaccuracies, but that either the study design (perhaps using a light touch of private parts, when presumably many other parts of the body were handled) is problematic, or the young age of the study population have led to these somewhat anomalous results. Such high proportions of incorrect responses are not found in other studies even those involving three year olds. Replication at another site is needed in order to give weight to the findings (Everson, 1994). This study will be discussed again in the section of the Study Guide on children's memory and suggestibility.

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5. Strategies for using the dolls
Basic reference

Everson, M. & Boat, B. (1994). Putting the anatomical doll controversy in perspective: An examination of the major uses and criticisms of the dolls in child sexual abuse evaluations. Child Abuse and Neglect. 18(2)113-130.

Everson and Boat (1994) review guidelines for use of anatomical dolls and address the major criticisms of the dolls in light of the functions guidelines advise.

Review and critique

Many writers warn that anatomical dolls should not be used by persons who are untrained in their use. However, the doll research has not addressed the issue of optimal methods for using them. Therefore, guidelines for their use are based upon clinical experience, in some cases, a consensus of a group of professionals, and common sense.

Everson and Boat (1994) found 20 sets of guidelines for using anatomical dolls. From these they derived seven different functions for the dolls. The functions and the number of adherents are as follows: 1. a comforter (2); 2. an ice breaker (5); 3. an anatomical model (16); 4. a demonstration aid (18); 5. a memory stimulus (11); 6. a diagnostic screen (11); and 7. a diagnostic test (1 possible).

Their survey demonstrates that views among professionals about how to use the dolls are diverse. However, there is fairly wide support for their use as an anatomical model, that is as a vehicle for discussing body parts and identifying the child's names for the private parts, and as a demonstration aid, a medium for assisting the child in disclosure of sexual abuse. As noted above, there is limited research that indicates that the dolls (and other props) can facilitate disclosure of private part touching.

In addition, there is agreement that the dolls are not a psychological test, any more than, for example, the dollhouse is. Thus, the reaction of children to the dolls cannot be used to categorically differentiate sexually abused from non-abused children. The fact that children fail to demonstrate sexual activity with the dolls does not mean they have not been sexually abused, and conversely the fact that they do show sexual activity does not mean that they have been sexually abused.

However, a substantial number of writers advocate the use of the dolls as a diagnostic screen. That is, a child's demonstration of sexualized behavior with the dolls raises a concern about sexual abuse, but, by itself, is usually not

conclusive. Support for the use of the dolls as a diagnostic screen is found in the research comparing the reactions to the dolls by children alleged to be sexually abused and those not alleged to be. Nevertheless, that children's reactions should only serve as a screen is supported by the findings of Everson and Boat's research, that nonabused, but sexually knowledgeable, children will be stimulated by the dolls to engage them in sexualized behavior.

A considerable number of the guidelines see the function of the dolls as a memory stimulus as important. That is, the sight of the private parts on the dolls jogs the child's memory and may result in a statement or demonstration that provides information about sexual activity. The research cited earlier comparing the effectiveness of anatomical dolls (or other aids) to mere questioning supports their use as a memory stimulus.

In part because guidelines may differ regarding what they describe as the dolls' primary functions, they differ in how they recommend the dolls be used. For example, writers differ in their advice about when the dolls should be presented. Some (White et al., undated; Boat and Everson, 1988) suggest they should be presented before any questions are asked that might indicate possible sexual abuse. This is useful if they are to be used as an anatomical model. Boat and Everson (1988) also suggest observing the child in free play with the dolls after they have been presented and before questions are asked. This strategy would allow for the doll use as a diagnostic screen and a memory stimulus.

Others suggest the dolls might be presented later after the child has begun to disclose or has made a verbal statement (APSAC, 1992; Faller, 1993). In such cases, the dolls could serve as a demonstration aid, that is, as a means of facilitating descriptive information from a child whose language skills are limited or who is reluctant to talk; as a medium for clarifying verbal statements; or as a way of corroborating disclosures. However, requiring a verbal disclosure first would defeat the use of the dolls as a demonstration aid for children who are fearful or reluctant to disclose or as a memory stimulus.

Guidelines also vary in how many dolls the evaluator should present to the child. When describing using the dolls as an anatomical model, writers recommend two, three, or four. As an ice breaker, it might be useful to present four or more so that the child becomes desensitized to the dolls, and sees that the evaluator is comfortable talking about private parts, before any questions are asked about possible abuse However, if the dolls are to be used as a demonstration aid or a memory stimulus, it might be best to assist the child in choosing dolls of the same number, race, age, and gender

as the people in the circumstance in which the child may have been sexually abused.

The guidelines that advise use of the dolls as an anatomical model instruct the evaluator to assist the child in undressing them and to have the child identify the body parts and their functions, including the sexual ones. This is good practice because it assures accurate communication about the private parts. In addition, it allows the interviewer to assess some aspects of competency (the child has names for the body parts and knows their functions), and it can serve as a diagnostic screen (the child, in describing the functions of the private parts, reveals advanced sexual knowledge). However, failure to present the dolls in this manner, or only asking the child to identify the private parts, because the interviewer is using the dolls as a demonstration aid or a memory stimulus, does not invalidate the assessment.

White et al. (undated) only advocate the use of dolls as an anatomical model and provide 14 questions about body parts, with instructions that the evaluator should ask these about sexual and non-sexual parts. Their advice does not allow for other doll functions. Nor does it allow the evaluator to vary the use of the dolls according to the circumstances of the case.

Faller (1993) has suggested three possible scenarios for doll use, which allow them to serve a variety of functions, and states these scenarios should not be considered inclusive. The scenarios are as follows. The child may spontaneously initiate interaction with the dolls because they are present in the playroom, and the interviewer facilitates their use. The evaluator introduces the dolls after the child has begun discussion of sexual abuse to facilitate, clarify, or corroborate disclosures. And the interviewer presents the dolls without any cues from the child in order to initiate a discussion of body parts if other attempts to understand whether or not the child has been sexually abused have been unsuccessful.

Morgan (1995) recommends caution in using anatomical dolls because they have been subject to legal challenges and suggests introducing them after the child has indicated sexual abuse has occurred. She says they may be presented either clothed or unclothed, but clothing may need to be put on for the child to use them to demonstrate the abuse. She recommends a period of unstructured exploration of the dolls after they have been introduced and then a body parts inventory. The interviewer returns to a discussion of the child's prior disclosure after the inventory and asks the child to choose appropriate dolls and demonstrate what happened. Follow-up questions are employed.

To summarize, there are many opinions about how to use the dolls, but none has been empirically demonstrated to be superior or correct. Evaluators are probably safe in taking their cues from the child and varying their doll technique according to the function the dolls are serving and the circumstances of the case. However, the dolls should not be used in a leading manner, for example, asking the child to show with the dolls how or where the alleged perpetrator touched the child, when the child has not indicated there was any such activity (APSAC, 1992; Bruck et al., 1994).

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Safe Kids/Safe Streets:

A Progress Report

Presented by

Nancy Van Fleet

Family and Child Abuse Prevention Center's, Toledo, OH

LUCAS COUNTY SAFE KIDS SAFE STREETS PROJECT

SUMMARY

The Lucas County Safe Kids Safe Streets Project has developed programs to restructure and straighten systems to be more comprehensive and proactive in helping children and adolescents and their families who have been or are at risk of being abused and neglected, to improve policy and practice within the systems to straighten coordinated management of abuse and neglect cases, and to develop community-wide, comprehensive programs to reduce and prevent child abuse and neglect through a large collaborative of agencies serving children and families.

The following summarizes the program elements, the goals designed to address those elements, and the programs working to meet those goals. A committee of professionals coordinates the development of the programs. The committees and their respective tasks are also listed.

I. SYSTEM REFORM AND ACCOUNTABILITY

II. CONTINUUM OF SERVICES TO PROTECT CHILDREN AND SUPPORT FAMILIES

Goal 1: Child abuse victims and their families will receive assessment and comprehensive support service delivery and advocacy at a child-friendly non-stigmatizing location where all other agencies necessary to investigate, prosecute and adjudicate a child sexual abuse case can coordinate their activities.

CHILDREN'S ADVOCACY CENTER PROTOCOL SUB-COMMITTEE

Task: To develop a protocol which clearly defines the roles and responsibilities of the agencies and professionals involved in the investigation and prosecution of child sexual abuse and other severe cases of child abuse, and is the framework for the community agencies to enact their commitment to provide a coordinated, child sensitive multidisciplinary approach to child abuse. This will include the role of the following agencies: Lucas County Children Services, Lucas County Prosecutor's Office, Family and Child Abuse Prevention Center - Lucas County Children's Advocacy Center, all Lucas County law enforcement offices including the Toledo Police Department and the Lucas County Sheriff's Department, all Lucas County hospitals, Lucas County Juvenile Court, and mental health providers.

MULTI-DISCIPLINARY TRAINING SUB-COMMITTEE

Task : To identify training needs in the professional community, to develop a multidisciplinary curriculum related to child abuse intervention, and to identify and obtain resources which will enable us provide the highest quality training for professionals intervening in child abuse. The goal is to provide the opportunity for professionals to develop skills and increase knowledge.

Goal 2: Families who have participated in treatment and intervention will complete their therapy and be restored to a higher functioning level due to improved follow-up.

TREATMENT AND FOLLOW-UP SUBCOMMITTEE
Task: To develop a plan to ensure professional follow-up and support after intervention and treatment are completed or discontinued and court adjudication if applicable. To develop a plan for tracking to include common data collection and evaluation methods.

Goal 3: Families will be identified and assessed for support needs at the earliest point and at-risk families will be referred for intensive long-term follow-up, enabling them to have the most chance of positive parenting, stress reduction and high family functioning, thereby reducing the risk and ultimately the incidence of child abuse and neglect.

HEALTHY FAMILIES LUCAS COUNTY SUB-COMMITTEE
Task: The task of this sub- committee was to address the issues which dealt with providing community-wide, culturally sensitive individualized risk assessment of all families of a new born (first births) and long term follow-up of at risk families through intense home visitation using the research-based Healthy-Families America Model. The majority of issues identified involved the implementation of a home visiting service in Lucas County called Healthy Families Lucas County, how to design the home visiting service to best serve families, and planning the implementation of this program. The second major aspect addressed involved developing a long term funding strategy for this program which would allow it to continue to expand.

III. DATA COLLECTION AND EVALUATION

Goal 4 Lucas County will improve its ability to document needs and improve services through use of uniform data collection and sharing of data.

Goal 5 Agencies in Lucas County involved in child abuse prevention and intervention will use appropriate outcome and process objectives in all intervention \ prevention programs to document program effectiveness and impact in reducing the incidence of child abuse and neglect, there by presenting a compelling case for new and continued program funding.

UNIFORM DATA COLLECTION AND EVALUATION SUB-COMMITTEE
Task: The task of the Uniform Data Collection & Evaluation (UDC&E) sub-committee is twofold. First, different agencies of Lucas County will be surveyed to determine what statistics they are keeping and prepare to implement a uniform cross-agency method of data collection. Second, the UDC&E sub-committee will evaluate the project using the goals and objectives contained in the grant proposal. In general, we are to evaluate whether or not we reached our overall goals of reducing the incidence of child abuse and improving the prevention and intervention services that enable families to use their strengths to restore positive family functioning.

IV. PREVENTION EDUCATION AND PUBLIC INFORMATION

Goal 6: The broad community in Lucas County will have less tolerance for child abuse, will recognize child abuse and neglect and report it appropriately, and will recognize positive parenting techniques as reducing the risk for child abuse and neglect.

COMMUNITY EDUCATION AND MEDIA CAMPAIGN COMMITTEE

Task: To develop a master and comprehensive plan to increase the general public's knowledge of child abuse and neglect issues, parenting issues, and how to report child abuse and neglect. This comprehensive plan will involve the use of the both print and electronic media.

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Intervention with Aggressive Children and Their Families

Presented by

David J. Kolko, PhD

INTERVENTION WITH AGGRESSIVE CHILDREN AND THEIR FAMILIES

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Handouts

BEHAVIOR MANAGEMENT

Levels

- Clinical Symptoms, Behavioral Controls, Participation
- Reinforcers: Freedoms; Activity/Social

Individualized and General Targets

- Prosocial; Deviant Behavior
- Tied to Program Progress--> Community Progress

Clear Criteria for Program Exit

SKILLS TRAINING: SOCIAL SKILLS

Characteristics of Friendships

- Benefits to Them

Discrimination of Appropriate/Inappropriate Uses

What Kids Say/Do Using Social Skills with Friends/Family

- Being Polite
- Conversations/Openers
- Making Requests
- Standing up for Self

Assertive vs. Passive vs. Aggressive

SKILLS TRAINING: ATTRIBUTION "RETRAINING"

Key Personal Beliefs

- Rigidity ("Hostile Bias")
- Tied to Self/Peer Esteem -- Power, Dominance

Gentle Challenge

- Evaluate: Logical, Helpful
- Goals: Instrumental, Relationship, Safety/Security

PARENT AND FAMILY TREATMENT

Parent Treatment/Counseling

- Motivation; Goals
- Psychiatric Disorders; High Expectations

Parent-Child or Family Therapy

- Involvement; Family Activities
- Monitoring; House Rules;
- Problem-solving; Negotiation
- Communication

SCHOOL CONSULTATION/TRAINING

Homework and academic activities/tasks

- Individual and General Targets
- Home-School Liaison -- Consequences in Each Setting

Classroom Observation

- Teacher Competency
- Setting Appropriateness
- Curriculum/Tasks (work load/type)
- Discipline Policy/Flexibility

COMMUNITY-LIAISON/PEER

Peers/Neighbors and Their Influences

Outreach to Local Agencies/Centers

Child/Parent

Advocacy in Community/School

TREATMENT CONSIDERATIONS

Modeling of antisocial behavior; group balance

Fairness, Injustice, and Attributional Bias

Emotional reactivity (reactive aggression)

Impact of hyperactivity/impulsivity, limited social skill

Psychoeducation

Socialization to treatment/model and clinician

Family problem-solving

COMMUNITY (MOBILE) SERVICES

Provider "Team"

Clinician	Treatment; Plans
Therapeutic Staff Support	Skills; Liaison
Special educator	School; Training
Behavioral Consultant	Coordination; Monitor.

GENERAL CONSIDERATIONS

Coordination/brokering-- clients, providers

Treatment Priorities

Assessment and Monitoring

Generalist vs. Specialist Training

Clinic-Community

MULTISYSTEMIC THERAPY (MST)

Child <--> Context Fit	Strengths
Responsibility	Action-oriented
Target Multiple Settings	Developmental Appropriateness
Daily/Weekly Effort	Efficacy Evaluation
Maintenance	

Source: Stroul & Friedman, 1986; Henggeler et al., 1994

CLINICAL ISSUES

Community-based programs/settings

Target contextual issues -- treatment priorities

Child, parent, and family focus

Liaison with school, CMHC, and juvenile court

Crisis management training & use of supports

Flexible contingency management in home

Minimize obstacles to access and application

Generalization/maintenance

Helping Teens Heal

Presented by

Sharon A. McGee, MS, LPC

Helping Teens Heal

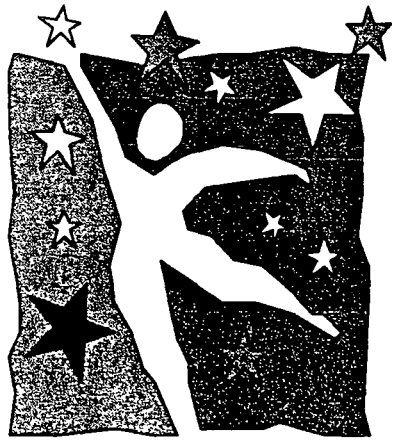
OBJECTIVES:

A) Familiarize participants with developmental aspects and therapy considerations for adolescents.

B) Acquaint participants with some of the problems and pit falls in working with teens.

C) Provide participants with many therapeutic activities for use with teens.

D) Identify resources and suggested reading to use with teens and to educate the therapists.



Adolescents, more specifically teenagers, can be some of the most challenging clients therapists ever encounter. They keep you guessing and demand that you always stay one step ahead of them in the therapy process. They approach the world in their own unique way. Consequently, they often view therapy and therapists in a very unique way. Some of their feelings can be quite intense and explicit. One teenager summed up her view of therapy in a way that is consistent with how most teenagers view therapy. "Go to counseling, are you crazy?" It is not easy to be allowed into their world and unfortunately our efforts may not always succeed. However, it is possible to break through that resistance and fear teenagers bring into the therapy process. They need qualified, patient therapists who are willing to step into their world, learn their language and help them heal. Everyone is different so some ideas will work for you some will not. The key is to be open to new things. Traditional therapy will often not work with them, but there are things that will. Then, we are able to have the honor of being a part of the magic of their healing.

"They need qualified, patient therapists who are willing to step into their world, learn their language and help them heal."

"We as therapists should be honored to be a part of the magic of their healing."

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Notes

Adolescent Developmental Considerations

- ***Personal Fable:*** Feeling shared by many adolescents that they are not subject to the same rules as other people. (Elkind, 1974, Quadrel, Fischoff & David, 1993). "Nothing bad will happen to me."

- ***Egocentric:*** They are the center of the universe. No one feels as bad as they do and no one understands them. Everyone is as concerned and interested in their life as they are. "What happened to me is because of me." Fragile self-esteem.

- ***Identity versus Identity Confusion:*** "Who am I?" The fifth stage in Erikson's psychosocial crisis. They are trying to find out who they are and what is their identity as well as their role in society. If this identity is not established they will be confused about who they are and the role they have.

- ***Imaginary Audience:*** Their thinking becomes self-centered and self-conscious. They feel they are always on stage and everyone around them is as aware of how they look and behave as they themselves are.

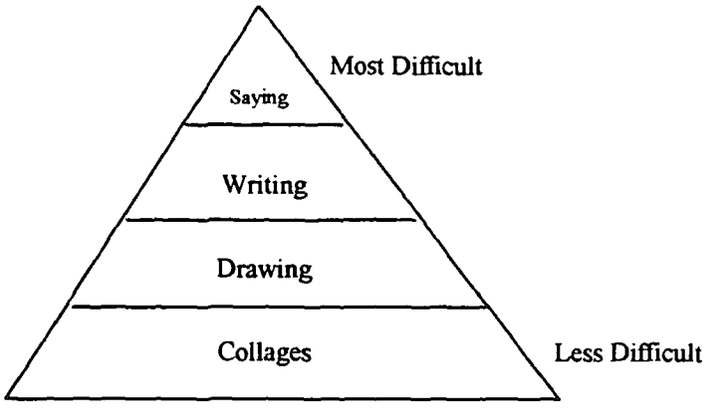
- ***Physical Changes:*** Body, thought, hormones all change. Difficult to deal with and adjust to as well as understand.

(Psychology Stephen David and Joseph Palladino, 1995)

Notes

Therapy Considerations

Provide Distance



Start with the least difficult and overwhelming types of therapeutic activities and slowly move to more intense types of activities.

Learn Their Style

Auditory: Rely heavily on what they hear. Prefer listening to reading; music is outlet.
Visual: Like to read. May take notes, journal write, draw.
Kinesthetic: They sit and look preoccupied but do take in information. May take longer for them to process, so go slower. Their work may not make sense to us but it does to them.

Trauma Assessments

Jan Hindman's tool. Works well, provides distance but also confronts the trauma.

Power Struggle

Let the teen have input into therapy process. Give them choices and some freedom.

Consider Unusual Therapy Locations

Use of other locations besides the office can be helpful, parks, McDonalds, driving or just a walk can often open them up.

The Danger of Stripping Away Defenses

Do not encourage a teen to let go of coping skills, defenses or protective measures unless they are safe and we as therapists provide or help them discovery new skills.

Boundaries

Make it very clear what our role is as their therapists. Remind them of our role every once in a while. Immediately address any boundary violations and be sure we (the therapist) are not over stepping or confusing our role for our clients. We are not their parents, best friend or sibling, we are their therapist.

Suggested Reading For Teens and Their Therapist

Incest and Sexuality
by Wendy Maltz

The Courage to Be Yourself
by Sue Patton Thoele

Chicken Soup for the Teenage Soul
by Jack Canfield and Mark Victor Hansen

Beginning to Heal
by Ellen Bass and Laura Davis

How Long Does It Hurt
by Mather and Debye

Shinning Through... Puling It Together After Sexual Abuse
by Loiselle and Wright

Hope in Healing
by Tess Edwards and Mary Derouard

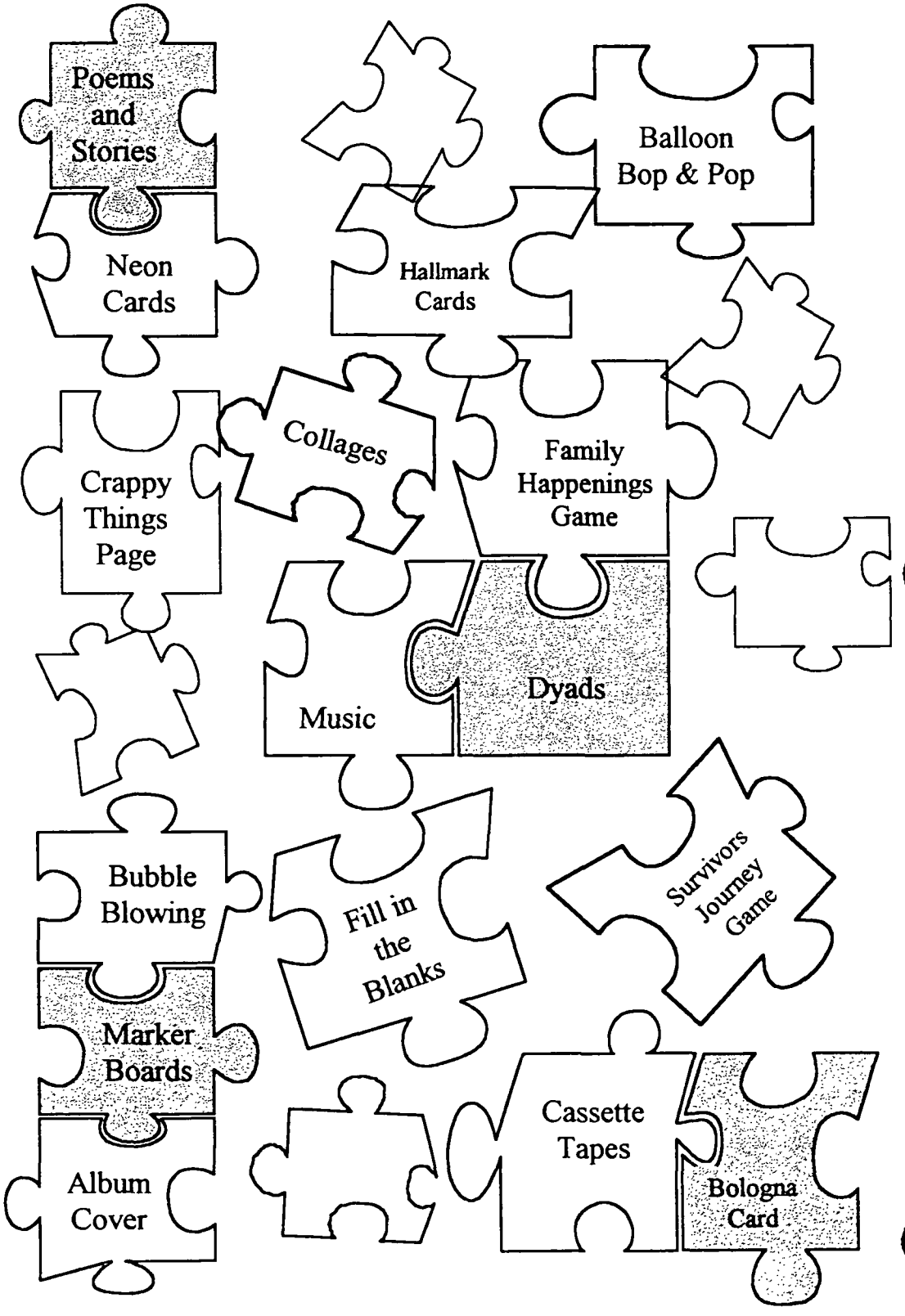
For Parents

When the Bough Breaks
by Aphrodite Matsakis

After the Nightmare
by Ovaris

When Your Child Has Been Molested
by Hagans and Case

Therapy Activities
Putting The Pieces Together



Words From Teens . . .

Many of my teenage clients asked to share some thoughts with you about what does and does not work for them in therapy.

"Don't tell me what to do. I hate that. That's what he did. Give me ideas, ask me what I think, but if you come at me all "in charge" I will shut you down fast." - Angel

"Let me talk about all things about what happened that bothers me, not just the sexual abuse itself. All of it effects me." - Melba

"When you sit behind your desk and have on your business suit writing down everything we say it feels like an interview not like you want to help me." - Amber

"I can tell quickly if working with me is just your job or if you do it because you care. If it's just a job, then you can't help me and I won't come." - Nicole

"Make it fun when you can. Talking about this stuff is hard. Lighten it up to help me get a better perspective." - Sharon

Some Ideas on Making Therapy Rooms and Therapy Teenager Friendly

All of the following are just general ideas that often help a teen feel more at home in your office and relate to you.

- Do not sit behind a desk with the desk between you and the teen.
- Do not sit directly beside them. Give them some space.
- Have intriguing artwork on the walls, desk or table. Animal pet pictures work well to get them to address own pets.
- Have child area separate from adult area. Teddy Bears and "homey" things work to help them feel comfortable. Let the teen choose where to sit.
- Have stress balls or some type of couch ball, magnet pictures, water globe around where they will sit. A distraction for their hands often leaves them available to talk.
- If you have a CD player or cassette player you use in the office have at least one current artists tape sitting out so it is noticeable.
- Let them get comfortable. Even let them ask you questions.
- Do not worry about cleaning up clutter. As long as it is within reason a teen feels comfortable in it usually.
- Try wearing more casual clothes when seeing teen clients. They relate to that more than a business suit.

Suggested Reading For Therapists

Treating Abused Adolescents
by Eliana Gil

Incest. . . Treatment Manual
by Adele Mayer

An Adult Child's Guide to What's "Normal"
by Friel & Friel

Just Before Dawn
by Jan Hindman

The Morning Breaks
by Jan Hindman

Treating Sexually Abused Children and Their Families
by Beverly James

Healing the Incest Wound
by Christine Courtois

Bridging the Silence: Nonverbal Modalities in the Treatment of Adult Survivors of Childhood Sexual Abuse
by Susan Simonds

A Few Thoughts on . . . Do's and Don'ts

These are ideas collected from teen clients when I asked them to tell me what they would say to professionals who work with teens.

Do	Don't
Loosen up and use some slang now and then, but only now and then.	Don't try and talk like them.
Make suggestions and give them choices.	Don't demand they do certain therapeutic activities.
Pace the work so they do not feel overwhelmed.	Don't push them making them tell all immediately.
Learn more about the developmental stage they are in and their thought processes and cognitive abilities.	Don't assume you know all there is to know about how they think and what it is like for them. Having gone through it doesn't qualify as understanding it.
Incorporate other life problems and situations in the sessions. If they are dealing with other issues be willing to address it.	Don't always talk only about the sexual abuse.
Let them have a say in the therapy process. Have Have them tell you what they need.	Don't take control from them. They will rebel.
Let them see you loosen up some. You'll be amazed at the difference it makes.	Don't always be the "professional."
Use some physical contact slowly but very little until you know it's okay. Even then be careful.	Don't touch them without asking.
Help the non offending parent learn how to help their teen. Build their strengths.	Don't undermine their non offending parent or the non offending parent or the authority in their home.
Give little segments to read. Be aware if their learning style (auditory, visual, kinesthetic) and incorporate it.	Don't give them lots of things to read and go over between sessions.
Work on therapy activities in session. Send supplemental things home.	Don't expect them to bring "therapy homework" back with them.
Keep plugging a long and don't give up on them.	Don't loose hope if it seems they are not listening.
Be clear on your role. Re-remind them of it. Be a part of their healing.	Don't cross the line from therapist to "friends." Don't let them do it to you.
Explain why you take notes in session if you do. Try to do it only some of the time.	Don't always take notes in the session.

Fatal Child Abuse:

Autopsy Protocol and Death Scene Investigation

Presented by

Mary S. Case, MD

PROTOCOL

for

CHILD-DEATH AUTOPSIES

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CHILD DEATH AUTOPSY PROTOCOL

The following protocol is a guideline for a comprehensive pediatric autopsy when the manner of death is uncertain or suspicious. Clinical judgment is required, on a case-by-case basis, to determine which procedures are performed.

I. INVESTIGATION

A. Review of Records

Prior to beginning the autopsy, ideally all records that are available should be reviewed and all further records that are necessary should be ordered. These records would include all investigative reports, DFS records, police report, paramedic reports, emergency room records and the previous hospital and/or physician's records, including results of laboratory examinations and X-rays. .Medical insurance records might be useful in providing information on previous illness, accident or medical treatment.

The medical record is likely to be incomplete due to the emergency situation facing a physician when a severely ill or injured child is brought to the hospital. It is important to discuss with the attending physician, as soon as possible after the death of a child, his or her recollection of not only the injuries but the general clinical status, history and family situation. The physician should also be queried with regard to resuscitation performed.

B. Family History

Prior to the autopsy, the pathologist should obtain as much of the child's personal history and family history as possible. This should include developmental, medical and social history. This history may give important clues to findings at autopsy and their interpretation. More often than not, this information will be obtained by medical personnel, DFS investigators or law enforcement.

C. Agency Investigation

It is important to have an open line of communication between those agencies responsible for investigation, cause and manner of death determination and possible prosecution. Intense collaboration with the local child fatality review panel is ideal.

11/4/94

D. Scene Investigation

A scene investigation by the pathologist/investigator is often essential in evaluating mechanisms of injury. Furthermore, the home environment including cleanliness, safety hazards, neighborhood, pets, quantity and quality of food, medications, etc., may provide important information in making the cause/manner of death determination.

II. AUTOPSY: GENERAL EXAMINATION

A. Confirm identification, if known

An identification tag should be attached to the body. Identification can be confirmed by a relative or other person who knew the child. If the identification of the child is unknown, footprints should be obtained at the completion of the autopsy. If the body is decomposed or skeletalized, dental, radiologic or anthropologic identification will be necessary.

B. Identification of photographs

Photographs are an essential part of the autopsy record and should be used to document all of the injuries to the child. Each photograph should have a ruler and identification tag present. There should be one photograph of the face for later identification purposes in court. The photographs should systematically cover each region of the body. Individual lesions or groups of lesions must be photographed at close range. A normal focal length lens is not sufficient for proper autopsy photography. A macro lens is essential. Available room light will not provide proper color balance. Either flash or photo-flood light must be used, each with the film that will provide proper color balance. Several Kodak publications provide guidance for setting up a photographic facility.

C. Examination of clothing and all items accompanying the body

It is essential that the body be brought to the autopsy suite with the clothing and other associated items undisturbed. The police must be discouraged from removing the clothing at the scene. The clothing and other personal items should be examined and described. This examination should be done in the presence of an evidence technician from the crime laboratory of the appropriate police jurisdiction. Tears, blood stains and the general cleanliness of the clothing should be described.

D. Search for Trace Evidence

A search should be made for hairs, fibers or other trace evidence that may be on the body or clothing. As appropriate, these should be removed prior to removal of the clothing, identified and given to the crime laboratory evidence technicians. The clothing should subsequently be removed and the body again searched for trace evidence. If there is suspicion of sexual abuse, oral, rectal and vaginal swabs should be taken for antigenic typing of semen and/or microbiological studies, as appropriate. The technique used should be established in consultation with crime laboratory personnel. Swabs of bite marks should be taken. These specimens must be obtained prior to washing the body.

E. Radiologic Skeletal Survey

A complete skeletal survey should be done at the start of the autopsy, and the films must be available for review during the autopsy. Films should also be reviewed by a radiologist experienced in child trauma whenever possible.

III. EXTERNAL EXAMINATION

In addition to photographs of the body, body charts and diagrams should be prepared to document essential findings at the autopsy.

A. General Appearance

The general appearance of the child should be documented. This should include height and weight, head circumference in children less than two, body stature, the presence or absence of rigor mortis and the locations of post mortem lividity if it is present. A general description of the body is appropriate in any autopsy.

The time of death occasionally cannot be accurately determined. Although drop in body temperature, rise in vitreous potassium and other post mortem events may give an approximation of the time of death, there are so many biological variables present in such a determination that is prudent to be circumspect in one's opinion.

B. Cleanliness

Is the child's skin clean? Is there dirt present in skin folds? Is this an acute or chronic status? Poor hygiene may be manifested by severe chronic diaper rash, lichenification of the skin and chronic seborrhea.

C. Nutrition

Nutritional assessment of the child can be made by comparing its height and weight to standard growth curve charts. Include gross description of presence of body fat.

D. Dehydration

Is dehydration present? In young infants, the fontanelle may be depressed. Sunken eyes, poor skin turgor and dry mucosal membranes are gross indicators of dehydration. Vitreous humor electrolyte analysis may show an elevated urea nitrogen and sodium level. Dehydration usually reflects an acute condition.

E. Failure to Thrive

This may be due to metabolic disorders, congenital anomalies or chronic disease. Chronic abuse, nutritional deprivation and emotional neglect can also cause failure to thrive.

F. Congenital Anomalies

Is there evidence of any congenital anomalies? Are there manifestations of a generic disorder or of Fetal Alcohol Syndrome?

G. Any Evidence of Abuse/Neglect

If the child is normal size for age, shows no evidence of dehydration or poor hygiene, and has no evidence of cutaneous or sexual injury, then this should be mentioned as an essential negative finding.

H. Evidence of Sexual Abuse

If there is no physical evidence of sexual abuse, then this should be recorded as an essential negative finding. If there is evidence of sexual abuse, this should be described under evidence of injury to the perineal region, rectum and genitalia.

I. Evidence of Bite Marks

If injuries suspicious of bite marks are present, a forensic odontologist or crime laboratory technician should be consulted prior to proceeding with the autopsy. Failure to observe this rule may cause irretrievable loss of evidence. The skin should not be washed prior to examination of the bite marks since this will prevent attempts at recovery of dried saliva for evaluation. Bite marks should not be excised since any attempt will produce tissue distortion.

IV. EVIDENCE OF EXTERNAL INJURY

Child abuse injuries may be numerous, of different ages, produced by a variety of blunt trauma and other forms of injuries and involve many parts of the body. As a result, describing child abuse injuries can be tedious and confusing to the reader of the protocol if the description is not given in some organized tabulated form. This can be done by separately describing external injuries and internal injuries, by breaking down the description of injuries into various anatomic regions of the body and by separately describing recent injuries, healing injuries and healed injuries.

A. Recent Injuries

These are often best described by anatomic region. The type of injury (contusion, abrasion or laceration) should be identified and dimensions given.

In suspected beating cases, lengthwise incisions through the skin and subcutaneous tissues of the involved anatomic regions should be made to determine the depth to which hemorrhage extends. This provides an indication of the severity of the blunt force used and may also reveal significant soft tissue injury not apparent from examination of the skin surface.

If the injury is patterned, a description of the pattern should supplement the photograph of the injury. Sections through representative lesions should be taken for microscopic examination.

B. Healing Injuries

These should be described in a manner similar to the description of the recent injuries. Sections of representative injuries should be taken for microscopic examination.

C. Healed Injuries

The pattern of scars is frequently characteristic of the type of implements used to produce the injuries. Scars should be recorded in a manner similar to description of other injuries.

V. EVIDENCE OF INTERNAL INJURY

These injuries are often best described by anatomic region. It is important to attempt to date the injuries both grossly and by microscopic examination. Where possible, internal injuries should be correlated with external injuries.

VI. EVIDENCE OF SKELETAL INJURY

This description should be based on X-ray examination and direct examination. Again, it is important to attempt to determine the age of the various lesions.

VII. EVIDENCE OF RESUSCITATION

Evidence of resuscitation must be described. Direct injection of epinephrine into the heart may produce pericardial hemorrhage. Lesions such as rib fractures, intra-abdominal hemorrhage, liver lacerations and other internal injuries should be presumed as not due to resuscitation unless proved otherwise. Even vigorous resuscitation in a young child will rarely, if ever, produce these injuries.

VIII. EVIDENCE OF THERAPY

Prolonged hospitalization may obscure evidence of injury, and even brief hospitalization and therapy may alter the appearance of injuries. All findings related to therapy should be described.

IX. INTERNAL EXAMINATION: GENERAL

This examination should mention positive and negative findings regarding the neck, organs of the chest and organs of the abdomen in regard to antecedent disease or abnormality.

X. SYSTEMS REVIEW

Each organ system should be described separately as with a usual medical autopsy. Special procedures include dissection of the posterior neck region in suspected shaken baby autopsies. It may also be necessary to remove the eyes to examine for evidence of retinal hemorrhage.

XI. MICROSCOPIC EXAMINATION

This should include sections of representative injury sites as well as routine sections of internal organs. The injury process evolves much more rapidly in young children than in adults, and this must be considered when dating the age of injuries. The usual time required for resolution of an injury may be affected by the child's state of nutrition, intercurrent infection and coma.

XII. SPECIAL STUDIES

A. Post Mortem Chemistry

Vitreous humor should be saved for appropriate electrolyte and chemistry studies. Serum and cerebral spinal fluid (CSF) should also be saved, as necessary.

B. Toxicology

Samples of blood, bile, urine and gastric contents should be saved for toxicologic analysis. Where unusual drugs or poisons are suspected, other tissues should be saved as appropriate.

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