Sexual Abuse of Children: Recommendations and Analysis

This journal issue provides an overview of what is known about the problem of sexual abuse of children and society’s response to it. Each of the articles in this issue contains some recommendations by the specific authors. The following is a list of recommendations by staff of the Center for the Future of Children. They are discussed more fully in the accompanying Analysis.

**Recommendations**

1. The term child sexual abuse covers a wide range of activities. It is important that specific definitions are provided both in statutes governing intervention and in research about prevalence or treatment effectiveness.

2. More comprehensive and reliable information about the incidence and prevalence of child sexual abuse is needed. The federal government should play a leading role in improving epidemiological information about the prevalence of child abuse. States need to ensure that there are adequate data systems to track the incidence of these cases both in their criminal and child protection systems.

3. More training is needed for mandated reporters about when a report of suspected abuse is required and when it is not. Laws mandating reporting of suspected child abuse have led to the identification of more cases of abuse. However, there are a large number (estimates for national averages are 61% to 65% of all reports made) that cannot be substantiated. The percentage can be higher in some locales. Some level of unsubstantiated cases is expected when reporters are encouraged to report reasonable suspicions. But states and locales must continuously monitor the number of unsubstantiated cases to determine whether it
indicates a need for better training in the community or different procedures within the child protective services agency.

4. States should adopt a three-tiered classification system for reports of child abuse: reports that are substantiated; reports for which the evidence is too uncertain to proceed; and reports that are determined to be untrue. Reports determined to be untrue should not be maintained in central registries, and states should ensure that they are automatically expunged.

5. Both the criminal justice and child protection systems investigate and adjudicate child sexual abuse cases. Better data are needed about each stage of decision making in responding to cases of sexual abuse and whether these systems are effective in protecting children.

6. There has been considerable concern about children’s suggestibility as witnesses. Research has shown that children can be reliable witnesses but that steps should be taken to minimize suggestibility. These steps include reducing the numbers of interviews and interviewers, and using interviewers who have been specially trained in eliciting information from children in nonsuggestive ways. Related to this, guidelines for the use of anatomically detailed dolls need to be developed and disseminated to all who interview children. These dolls should not be used by interviewers who have not been trained in the dangers and benefits of their use. States should explore the possibility of setting standards to certify specially trained child interviewers. All investigative interviews of children should be videotaped.

7. States and local law enforcement and child protection agencies should make every effort to reduce the stress to the child of the investigation and adjudication processes. These efforts include use of multidisciplinary teams for coordinated investigations and efforts by the courts to prepare and protect the child as a witness.

8. There is considerable controversy about whether and to what extent mental health professionals should be involved in the investigation and adjudication of child sexual abuse cases. Mental health professionals and judges need to be fully versed in the controversy about proper expert testimony and the status of case law. In addition, the mental health profession should set standards for its members which address issues such as avoiding conflicts in the roles of therapist and investigator, qualifications for providing expert testimony, and content of expert testimony.
9. There are many areas for improvement in the medical community’s response to child sexual abuse. Doctors need more training in identifying and reporting sexual abuse. Pediatricians need to be trained to include anal and genital inspections in routine well-child checkups and to identify when there is a reason to suspect sexual abuse. Medical evidentiary examinations should be conducted by specialists. Common terminology and procedures need to be developed for these evidentiary examinations, and research is needed on the medical aspects of child sexual abuse.

10. Children who have been victims of sexual abuse often suffer from a number of mental health problems. More and better quality research is needed to determine which children are at risk for serious problems and which treatments are most effective in dealing with these problems.

11. Better information is needed about the rate of recidivism among different types of child sexual offenders. Controlled treatment outcome studies with long-term follow-up are needed to assess whether treatment can be effective and which treatments are effective with different types of offenders. Special attention should be given to data collection and research regarding juvenile offenders and treatment for them.

12. Child sexual abuse prevention efforts have focused on school-based curricula directed at teaching children how to protect themselves from sexual abuse. Research shows that these efforts can lead to short-term knowledge gains, but research has not evaluated whether these programs are effective in reducing either the incidence or the severity of abuse. Prevention efforts need to be broadened, expanded, and evaluated.

Analysis

The problem of sexual abuse of children has moved to the front of American consciousness in recent years. Media stories have riveted society’s attention to investigations and proceedings involving a wide array of people, institutions, and circumstances. Many individuals, those in the public eye and those not, have written about and discussed their own experiences with child sexual abuse. Opinions and emotions about the subject run high. This journal issue reviews what we know about the problem of sexual abuse of children—its prevalence and consequences, our society’s attempts to intervene when it occurs, and efforts to treat and prevent it.

In recent years, as public attention to child sexual abuse has grown, so has knowledge about it. The legal, child welfare, medical, and mental health professions have made significant progress in promoting better
understanding and improving response. But despite this progress, knowledge is still limited, and both controversies and uncertainties are abundant. Much needs to be done to improve public policy regarding this significant problem for children.

This Analysis is organized into three sections. The first section reviews what is known about the scope and nature of child sexual abuse, including prevalence and incidence, characteristics of victims and offenders, and mental health consequences for victims. The second section focuses on the reporting, investigation, and adjudication of sexual abuse claims, with particular focus on working with children as witnesses and the roles of the medical and mental health professions. The third section addresses issues of treatment and prevention. This Analysis cannot comprehensively cover all of the topics and recommendations that are contained in the individual articles of this journal issue. Instead, it highlights what we believe are some important recommendations for discussion and implementation.

Before embarking on this discussion, we note that there are many aspects of the problem of sexual abuse of children that make understanding and responding to it especially difficult. First, the term covers a wide range of behavior. Offenders can be family members or strangers. The acts of abuse vary in nature, frequency, intensity, and duration. Thus, policies in this area must address a wide range of situations. Second, child sexual abuse typically occurs in private, under a cloak of secrecy, and most often produces no physical signs, making detection difficult. Thus, unless secrecy is somehow broken, there is very little that can be done to protect many of the victims of sexual abuse or stop the offenders. Third, the victims are children of different ages and at different stages of cognitive, physical, and emotional development, making everything about this problem more complex. This fact affects how well children can talk about what did or did not happen. It affects the extent to which they suffer physical consequences. It affects the nature and extent of mental health consequences—both long and short term—and makes understanding these extremely difficult. And it complicates efforts to devise prevention and treatment strategies. The fact that children are involved also infuses this topic with heightened emotion and urgency. Finally, sexual abuse of children is a particularly difficult problem for our society to address because it involves sex. Americans have never been comfortable or unified in devising public policy about matters involving sex.

These complicating factors will always make this problem a very difficult one to address, more difficult than many of the other important issues for children that this journal has focused on to date. Acknowledging this complexity, however, does not mean that the issue cannot be addressed. This Analysis highlights some areas for attention.

First, we offer a brief description of the scope and nature of child sexual abuse.
Scope and Nature of Child Sexual Abuse

Sexual abuse of children is an important problem. As Conte discusses in his article, society has not always acknowledged it as such. Throughout history, many forces have shaped the depth of both awareness of and response to child sexual abuse. As will be discussed in this section, it is now known that, at any one time, hundreds of thousands of children have been victims of child sexual abuse. Child sexual abuse victims often suffer from serious mental health and other problems. It is difficult, however, to generalize about impacts because the nature and circumstances of sexual abuse are so varied.

The Problem

Any discussion of the scope of child sexual abuse must begin with a definition. Too often this is not done. State statutes provide the basis for intervention are sometimes too vague to provide guidance to those who must apply them or to allow comparison among states. Efforts to collect information about the scope of the problem have also been hindered because researchers have not been precise or consistent in defining sexual abuse. As discussed next, more specificity and uniformity is needed both in statutory and research definitions.

Definition

Child sexual abuse is generally defined as sexual activities involving a child and an adult or significantly older child. Although some societies have traditions of culturally sanctioned sexual conduct with children (see the article by Conte in this journal issue), this country does not, and there is considerable consensus about proscribed sexual activities with children. Many state statutes contain detailed descriptions of what constitutes child sexual abuse. For example, California Penal Code Section 11165.1 defines child sexual abuse as follows: any penetration of the vagina or anal opening of a child by the penis of another person; any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person; any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose (except as performed for a valid medical purpose); the intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification (the statute specifies that this does not include normal caretaker responsibilities or interactions with, or demonstrations of affection for the child, or acts performed for a valid medical purpose); and the intentional masturbation of the perpetrator’s genitals in the presence of a child.

The California statute also defines sexual abuse as including sexual exploitation of children. This statute covers use of children in activities such as pornography and prostitution. Crimes of indecent exposure also apply when an adult exposes his or her private parts to a child. The scope of this statute is clarified by the decades of individual cases in which courts have applied it.

It is important to acknowledge that a wide range of activities, varying greatly in type, frequency, duration, and intensity, can meet the above definitions—for example, a single incident of inappropriate touching of an adolescent girl by a friend of the family; repeated sexual intercourse between a father and his daughter over a number of years; a stranger rubbing up against a young boy while standing in line at a shopping mall. Each of these activities meets the statutory definition of sexual abuse and is legally actionable; but, because these activities vary so in degree, they are often responded to very differently by the victims, the agencies investigating the activities, and the courts hearing cases based on them.

Every state should ensure that its statute is as specific and explicit as possible to provide clear notice about what is proscribed behavior and guidance to those who are responsible for intervening in these cases.
In addition, even a statute as specific as California’s has provisions that sometimes require case-by-case interpretations. Because some sections of the statute require a finding that the motive for the activity was sexual arousal or gratification, courts must sometimes evaluate defenses that sexual abuse did not occur because the act was simply part of normal caretaking or an act of affection. Also, in many instances, determining what happened, let alone what was intended, is a difficult process.

These problems of interpreting and applying sexual abuse statutes are even more difficult when state statutes are not as specific as California’s but instead simply use terms like sexual contact or sexual abuse without defining them further. Every state should ensure that its statute is as specific and explicit as possible to provide clear notice about what is proscribed behavior and guidance to those who are responsible for intervening in these cases.

Unfortunately, child sexual abuse has not always been defined clearly in research either. As will be discussed in the next section, in many of the adult surveys about child sexual abuse, researchers did not tally separate statistics for contact and non-contact sexual abuse or define specifically what was meant by either. Also, because there is significant variation in definition from study to study, comparison of their findings is difficult.

Incidence and Prevalence

As Finkelhor discusses in his article, incidence figures measure the number of cases of sexual abuse that come to the attention of professionals each year. Prevalence figures measure the number of people who have suffered sexual abuse at some point in their childhood. Neither type of data has been easy to come by.

Official records of those agencies charged by society to respond to child sexual abuse provide some, but very incomplete, information about incidence. As several articles explain (see the articles by Finkelhor, Pence and Wilson, and Myers), cases of child sexual abuse are most often handled either by the criminal system or by the child protection system. Generally, cases in which the alleged offender is a family member allowed the abuse to occur, are investigated by child protective services and are handled as civil child abuse cases in juvenile or family court, sometimes with parallel criminal proceedings. Cases in which the alleged offender is not a family or household member are typically referred to as child sexual assault or molestation cases and are most often handled exclusively as criminal matters.

Unfortunately, neither the criminal nor child protection system maintains comprehensive data about cases of sexual abuse of children. (See the article by Finkelhor and the Child Indicators section by Lewit.) The most recent estimate of incidence looks only at the child protection system and finds that, in 1993, there were 330,000 reports of child sexual abuse, of which 150,000 were substantiated. Approximately 11% of the 2,984,000 reports of child abuse and neglect received by child protective services agencies in 1993 were for sexual abuse. Finkelhor also notes in his article that, since 1980, the number of child sexual abuse reports has increased at a significantly higher rate than child abuse reports generally.

It is important to remember, however, that these numbers may include duplicated reports, that is, one or more reports about the same incident and/or about the same child. Furthermore, these numbers include only reports made to child protective services. The incidence number would be higher if those sexual abuse cases that are handled by the criminal justice system were included, but currently there is no national data collection system that provides data on sexual crimes against children.

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Because sexual abuse often goes undisclosed, a more comprehensive picture of the scope of the problem is obtained by asking adults whether they were sexually abused as children. The article by Finkelhor reviews 19 such adult retrospective studies. These studies vary in their definition of abuse, methodological approach, and quality. They often leave room for considerable interpretation by the respondent. Some include noncontact exploitation or exhibitionism, others do not. The findings from these studies are also highly varied. The percentage of adults disclosing histories of sexual abuse in these studies ranges from 2% to 62% for females and 3% to 16% for males. Finkelhor and many others believe that the better studies suggest that at least 20% of American women and 5% to 10% of American men experienced some form of sexual abuse as children.

In considering these adult retrospective surveys, however, it is important to remember their limitations. For example, they could underestimate the prevalence of sexual abuse because of the respondents’ reluctance to report or inability to remember an event from childhood. Or they could overestimate prevalence either because the respondent did not remember accurately or interpreted an event as sexual abuse when it would not be viewed as such by others or under a legal definition.

At one level, precise estimates of prevalence are not vitally important. There is evidence that large numbers of children experience child sexual abuse, and this fact alone should be sufficient to fuel new efforts at improving our response to this problem. On the other hand, a clearer understanding about incidence and prevalence is critical to make decisions about allocation of resources, to convey accurately to the public the scope of the problem, and to allow society to track its progress in addressing the problem.

Improved and ongoing efforts to obtain more reliable data about the incidence and prevalence of child sexual abuse are needed. In these efforts, uniform and specific definitions should be used. We agree with the National Research Council’s recent recommendation to expand efforts to collect epidemiological information about the prevalence of child abuse. The National Research Council panel recommends that questions on child abuse and neglect should be added to national surveys such as the National Health Interview Survey, the National Survey of Children, and the National Longitudinal Survey of Youth. In addition, both national and state sources should continue to work to improve data collection about both criminal and civil child abuse cases, and to work toward merging data from these sources. Even short of such national and state efforts, however, it is important for local law enforcement and child protection agencies to analyze their case loads to gain a better understanding of both the incidence of these cases and how they are being handled in their systems.

In the meantime, caution must be exercised when using the figures that are available. Members of the media, researchers, and commentators need to be clear about the estimates they use, what they are derived from, and what they mean. Otherwise, there is room for creating misunderstanding among policymakers and the public. This misunderstanding can go either way: overestimating prevalence and encouraging overreaction, or underestimating prevalence and encouraging complacency. Neither stance is warranted by current information.

The Children

As discussed above, child sexual abuse covers a very wide range of activities. Variations in the nature, type, intensity, frequency, and duration of the offense not only affect how cases are handled but also the mental health impact they have on the child victims. In addition, a number of factors, such as the presence of a supportive parent, may mitigate negative impacts. Other factors, such as paren-
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tal substance abuse or physical abuse, may aggravate negative impacts. Although research on mental health effects has grown dramatically in the past decade, knowledge about the consequences of sexual abuse is far from complete, and better understanding is needed about those combinations of factors which put children at greater risk for serious problems.

Before discussing mental health impacts on child victims, it is helpful to know more about these children.

**Ages and Circumstances**

Finkelhor draws a number of estimates from adult retrospective surveys about the characteristics of abuse. He finds that most sexual abuse is committed by men (90%) and by persons known to the child (70% to 90%), such as family members, friends of the family, or acquaintances. Retrospective studies show that family offenders constitute 30% to 50% of the offenders against girls and 10% to 20% of the offenders against boys. The peak age of vulnerability is 7 to 13 years of age for both boys and girls. Around 20% to 25% of all incidents of sexual abuse recalled in retrospective surveys involve penetration or oral-genital contact. Finkelhor, notes, however, that, among those cases reported either to child protection or law enforcement, the percentage involving penetration or oral-genital contact increases to 50%.

Official data systems provide practically no insight into the circumstances of sexual abuse. Some states have automated information about such characteristics as the age of the children and the disposition of sexual abuse reports. But obtaining more detailed information about the nature of the activity alleged, the alleged offender, or other characteristics is only possible by reviewing individual case files. Criminal cases are even more difficult to analyze because official statistics typically do not separate sexual assault cases against children from those against adults.

Finkelhor reports that there are no clear risk markers for children regarding sexual abuse. Gender and age are perhaps the most established (generally, girls ages 7 to 13 are considered most at risk), but even they are not without caveats. Abuse of boys and very young children simply may be significantly underreported. For example, adult retrospective studies suggest that boys are abused at one-half to one-third the rate of girls but then constitute only about 20% of the cases reported to child protection.

Similarly, Finkelhor reports that there is a discrepancy between clinical and retrospective studies on the issue of social status and race. Among reported cases of sexual abuse, families of lower socioeconomic status are overrepresented (but less so than for other types of abuse). But in retrospective surveys, economically disadvantaged people report little or no more sexual abuse than others. Minorities are often overrepresented in the case loads of child protective service agencies but are not shown to be at higher risk in adult retrospective studies. (See the article by Finkelhor in this journal issue.)

**Mental Health Impacts**

As discussed above, prevalence data suggest that large numbers of children are sexually abused. An important question then becomes what is the nature and extent of harm they experience as a result. In sexual abuse cases, documenting this harm is more complex than in physical abuse cases because, in many instances, there are no apparent physical injuries accompanying sexual abuse. Given the great degree of consensus in this country about proscribed sexual conduct with children, the system would probably respond to sexual abuse even if there were no specific documented harm to children. However, in the past decade, there has been a growing body of research documenting serious mental health problems in many of the children who were sexually abused.

Briere and Elliott review in their article the considerable literature discussing
These problems. Much of this information is derived from research on adults who were abused as children, although there are some data from recent studies involving children. Furthermore, many of the studies have relied on clinical or forensic samples and may not be generalizable to all sexually abused children. Briere and Elliott conclude that, even with these limitations, research to date provides strong evidence of the negative psychological effects of child sexual abuse, and that contentions that child sexual abuse is a neutral or even benign event has little current acceptance.

The problems found in victims of child sexual abuse are varied. Briere and Elliott note that one common diagnosis is post-traumatic stress disorder (PTSD). A diagnosis of PTSD requires the occurrence of a traumatic event, as well as (1) frequent reexperiencing of the event through nightmares or intrusive thoughts; (2) a numbing of general responsiveness to, or avoidance of, current events, and (3) persistent symptoms of increased arousal, such as jumpiness, sleep disturbance, or poor concentration. One review found that, although most child sexual abuse victims do not meet the full diagnostic criteria for PTSD, more than 80% are reported to have some posttraumatic symptoms. 12

Briere and Elliott identify cognitive distortions as another category of problems experienced by both children and adults who were abused as children. These include chronic perceptions of helplessness and danger, guilt, low self-esteem, and self-blame. Depression, anxiety, and anger are types of emotional distress commonly found among both children and adults who have experienced childhood sexual abuse. Some have estimated that depression is the most common symptom reported by adults who were molested as children. 13

Impaired sense of self is a fourth category of negative psychological consequences reviewed by Briere and Elliott. Adults molested early in life can have more problems understanding or relating to others independent of their own experiences or needs, and they may not be able to perceive or experience their own internal states independent of the reactions or demands of others.

A variety of avoidance behaviors are also associated with sexual abuse. These include dissociative phenomena (for example, “spacing out” or amnesia for painful abuse-related memories); substance abuse and addiction; suicide; indiscriminate sexual behavior; self-mutilation; and bingeing and purging (although this is a relatively new area of research, and there is disagreement about association between eating disorders and childhood sexual abuse). Finally, research and clinical observation have suggested that child sexual abuse is associated with both initial and long-term alterations in social functioning and difficulties in interpersonal relationships. For a full discussion, see the article by Briere and Elliott.

Briere and Elliott caution, however, that there is no universal or uniform impact of sexual abuse. It cannot be assumed that the relative presence or absence of a given symptom or symptom complex is indicative of a sexual abuse history.
was intra- or extrafamily or by factors such as intensity, duration, and severity or by factors related to the response to the abuse allegation.

The Offenders

Understanding the nature of child sexual abuse is further complicated by the wide range of characteristics of offenders. As Becker discusses in her article, the population of known offenders includes one-time and habitual sexual offenders; intrafamily and extrafamily offenders (strangers and acquaintances); and adults and juveniles. Offenders also vary in terms of age, occupation, income level, marital status, and ethnic group.

At one time it was believed that sex offenders chose either adults or children as victims, not both, and that they offended against either members of their families or against acquaintances or strangers, but not both. It now appears that the situation is more complex. For example, a study of 561 nonincarcerated sex offenders found that, of offenders who engaged in contact abuse (that is, excluding such crimes as exhibitionism, exploitation, or voyeurism), one-third offended against both children and adults. Twenty-three percent of the sample engaged in both intrafamily and extrafamily abuse.¹⁵

There is currently no empirically validated etiology for child sexual abuse. However, progress has been made in developing typologies for distinguishing among offenders, and this work may lead to a better understanding of the multiple pathways by which these behaviors develop. For example, one typology for extrafamily offenders describes a range from “interpersonal offenders” who have developed a sustained sexual and nonsexual relationship with an individual child, to “sadistic offenders” who rarely have nonsexual contact with children and have a history of violent acts which are arousing to the offender.¹⁶

Many child sexual abusers are themselves adolescents.¹⁷ Although there is no information about the percentage of either criminal or child abuse and neglect cases that involve juvenile offenders, there is evidence that large numbers of juveniles are being referred for treatment for sexual offenses.¹⁸ Much more attention needs to be paid to this population. Families, responding agencies, and the courts need information and guidance about the nature of juvenile offending and appropriate responses to it.¹⁹ (See further discussion in the article by Becker in this journal issue.)

One of the most important concerns about offender characteristics is the incidence of recidivism. The often popular suggestions for more incarceration and less probation for sex offenders reflect a strong assumption that recidivism is very high for this population. The data on this issue, however, are very limited.

Recidivism typically refers to whether an offender, after having been found guilty for a sexual offense, will commit another offense. Sometimes the focus is specifically on whether the offender will

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**The extent to which a child manifests psychological problems after being sexually abused, either in the short or long term, is a function of an undetermined number of variables about the circumstances of the abuse, as well as individual and environmental factors that existed prior to, or occurred subsequent to, the incidents of sexual abuse.**
The recidivism rate for sex offenders in general, and for child sex offenders specifically, is not the only relevant consideration when determining whether greater resources should be spent for incarceration and probation monitoring for this offense than for other serious offenses. Those who do argue for this practice, believe not only that recidivism is high for this group, but also that preventing child sexual abuse should be given the highest priority. Because recidivism is often the main reason cited for stricter sentencing, more accurate estimates of recidivism would inform these debates. Information is especially needed about how recidivism changes among different types of offenders.

**Reporting, Investigation, and Adjudication**

As discussed above, government response to sexual abuse of children occurs through either the criminal justice system, the child protection system, or both. The purposes of intervention by the two systems are different in many ways. The primary focus of the criminal justice system is on punishing perpetrators of sexual abuse. The primary focus of the civil child protection system is on protecting the child while, whenever possible, keeping the family together. The systems share the goal of prevention, that is responding to the situation in a way that keeps the offense from happening again to the same child or to other children.

Given that so much attention has been focused on the processes of reporting, investigation, and adjudication, it is important to know the results of these efforts and whether children have been protected. Unfortunately, very little information is available.

The powers available to the two systems are different. The criminal court determines whether a convicted offender will be incarcerated; the child protection system determines whether the intrafamily offender will be allowed to live with and have custody over the child he has victimized and/or the child’s siblings. Both systems can condition a placement or sentencing decision on the offender and/or family receiving treatment. For example, in criminal court, probation can be conditioned on treatment; in juvenile court, family reunification can be conditioned on treatment.

The fact that both the criminal and child protection systems respond to child sexual abuse complicates issues of reporting, investigation, and adjudication. To increase efficiency and minimize inconvenience and trauma to the child, the systems must work closely together. This is often not an easy task. Differences in training and approach need to be resolved, and procedures for sharing confidential information need to be developed.

This section discusses some of the issues that influence both the criminal and the child protection systems: mandatory reporting; the child witness; and the involvement of the mental health and medical professions in the investigation and adjudication of child sexual abuse cases. Recommendations are made in each area.

**Pathways for Civil and Criminal Cases**

Before discussing reporting, investigation, and adjudication, it is important to note that some observers believe that these processes have received too much priority in the public response to child sexual abuse. As Melton notes in his article, recent reports of the U.S. Advisory Board on Child Abuse and Neglect have cautioned that, in placing the emphasis on proving child sexual abuse allegations, the child protection system has lost its focus on the child and the need for treatment and prevention.

Given that so much attention has been focused on the processes of reporting, investigation, and adjudication, it is important to know the results of these efforts and whether children have been protected. Unfortunately, very little information is available. For example, in abuse and neglect cases, both federal and state laws mandate that the child protective service agency make reasonable efforts to prevent removal of the child from the home or, if temporary removal is necessary,
make reasonable efforts to reunify the family. Keeping a family together or reunifying a family whose members have been separated usually requires that a variety of services be provided to the family. Yet, very little is known about how this requirement plays out in intrafamily cases of child sexual abuse handled by the child protection system. For many involved in handling these cases, there is a significant question about what family preservation can or should mean in the context of sexual abuse. There are almost no data to describe what currently happens. For example, there is little or no information about the percentage of cases in which a child is removed from his family or the alleged offender agrees to leave the household; about the length of time for which the alleged offender and victim are kept apart; or about the percentage of intrafamily cases in which reunification occurs, either with or without the alleged offender in the home. There is also very little information about what services are typically provided in these cases. It is important to note that, in many child sexual abuse cases, the family also suffers from a number of other problems (for example, substance abuse and physical abuse) for which services are needed.

A few studies have reviewed a sample of individual cases in particular locales. These studies have documented gaps in the provision of services to families and a tendency in these cases for children to be removed from their families and kept out of their homes for significant periods of time.

Similarly, with respect to those cases handled by the criminal justice system, we have limited national or state data. Myers describes the possible alternatives in the criminal justice process, including diversion, plea bargaining, trial, probation, and incarceration. Prosecutors consider many factors when deciding whether to file formal criminal charges. One study found that, among intrafamily child abuse cases reported to child protective services, the percentage of cases in which parallel criminal prosecutions were initiated was higher for sexual abuse than for other types of abuse. In a 1987 survey of 159 cases in three counties in New Jersey, Virginia, and California, 80% of convicted child molesters were sentenced to probation, with 89% of those cases including court-mandated treatment as a condition of probation. (See a discussion of stages in the criminal process in the article by Myers.)

Mandatory reporting laws have greatly assisted our society in identifying and responding to child sexual abuse. However, there may be an excessive number of reports made based on weak suspicions that cannot be substantiated by investigators.

An important concern overall is the need for coordination between the two systems when criminal cases involve intrafamily abuse. This is important not only in the investigative stage, but also in the disposition stage. For example, when an offender is released after incarceration, are child protection authorities alerted and are efforts made to determine whether he should be free to go home if the child victim is in the home?

More data about what is actually happening in these systems would be helpful in improving government response to this problem. Even without these data, however, there are opportunities for both child protective services and law enforcement, working with the mental health and medical professions, to show leadership in improving both understanding and response. These opportunities are discussed next.

**Reporting**

More effort needs to be made to ensure a reporting system that is as complete and accurate as possible. As Pence and Wilson describe, every state has a mandatory reporting law under which specified categories of persons are required to report instances in which there is a reasonable suspicion that a child has been or will be abused. Typically, these reports are mandated to be made to the child protective service agency, and that agency is mandated to cross-report to law enforcement. Reporters are granted immunity for mak-
Each state, and indeed each locale, should look closely at the extent to which mandated reporters or other citizens are reporting incidents that are unsubstantiated.

be made. We disagree, however, with his recommendation to amend these laws to give immunity from prosecution for good faith failure to report. Either approach carries risks. If there is no immunity for good faith failure to report, mandated reporters may act defensively and report even the most tenuous cases. With a good faith defense available, however, reporters may decide not to report reasonable suspicions when they simply do not want to get involved. There is no evidence to quantify which risk is greater. We believe, however, that the decisions about whether there is a reasonable ground for intervention will, on the whole, be better made by child protective or law enforcement officials with training and experience in making such determinations, even if this practice results in some amount of over-reporting by mandated reporters.

On the other hand, attention must be given to the large number of reports made that cannot be substantiated. As the articles by Finkelhor, Pence and Wilson, and Besharov discuss, there has been considerable controversy about the extent to which the number of unsubstantiated reports has been and continues to be a problem. Two recent national reports, however, found average substantiation rates nationally of 39% and 35%. (See the discussion in the Child Indicators section of this journal issue.) In some locales, the substantiation rate is only 8%. Unsubstantiated cases are not necessarily bad. Law and policy encourage reports of suspicions, not confirmed cases, and some of these will not be substantiated—either because the protective service agency finds them to be untrue, because there is too little evidence to warrant opening a case, or because there is abuse but it is not judged to be sufficiently grievous. When any type of unsubstantiated report becomes very frequent, it is cause for concern. Are resources being used efficiently? Is too much effort being spent investigating frivolous or excessively weak cases? Or is excessive triaging occurring because of inadequate resources for investigation or follow-through? We believe that each state, and indeed each locale, should look closely at the extent to which mandated reporters or other citizens are reporting incidents that are unsubstantiated, either because the evidence is too uncertain or because the allegations are determined to be untrue. If that percentage is high or increasing, an analysis should be undertaken to understand why and to make sure that mandated reporters and the community at large have the best understanding possible about what constitutes a reasonable suspicion of abuse. A high percentage of cases determined to be untrue is especially wasteful and is intrusive for innocent families.

We also agree with Pence and Wilson that, in record keeping, all states should establish a three-tiered classification system to record the disposition of child abuse reports: reports that are substantiated; reports for which evidence is too uncertain to proceed; and reports determined to be untrue. (The specific names used for each tier are not important, although it would be useful if states employed a uniform set of terms. For example, currently there is great confusion about how different states use terms such as indicated, unsubstantiated, and unfounded.)

Furthermore, states should be diligent in ensuring that records of allegations determined to be untrue are automatically expunged. Some states already have such
provisions, and every effort should be made to ensure that they are followed. These reports should not be part of any registry that is used by law enforcement or other agencies for purposes of background checks or employment decisions. Although states and local child protection agencies should track the numbers and circumstances of reports determined to be untrue for purposes of monitoring and improving administrative practices, there is no need to maintain the identifying names or details of these reports. Innocent persons must be protected from any stigma or negative consequence of such reports.

**Investigation and Adjudication**

Often immediately after a report is made, child protective services and/or law enforcement agencies investigate the allegation. How allegations are investigated and eventually tried in court has been and continues to be the subject of extensive discussion in the professional literature about child sexual abuse.

**The Child as Witness**

Much of the attention given in the literature to the investigative and adjudicative processes derives from concerns about the child—how to obtain accurate information from the child and how to protect the child from the stresses that characterize these processes.

- **Suggestibility.** As Myers notes in his article in this journal issue, psychologists have long documented suggestibility in recollections by adults. There has been particular concern, however, that children, because of their developmental limitations, are more suggestible than adults. The concern has been greatest for preschool-age children (typically three- to five-year-olds). There is a growing literature on suggestibility of children in general and of very young children in particular. Since 1980, more than 20 studies concerning children’s suggestibility have focused in part on preschool-age children.

Ceci and Bruck recently summarized the results of these studies. They observe that preschoolers are more vulnerable than older children to a variety of factors that contribute to unreliable reports and that, although they can be accurate reporters, some do make mistakes, particularly when they undergo suggestive interviews. Ceci and Bruck find that research does not “provide a definitive conclusion about the reliability of all child witnesses’ reports,” and state that “past pronouncements by some rather extreme advocates on both sides of the bench are simply unfounded.” They find that truth lies somewhere between the extremes, that “children are neither as hypersuggestible and coachable as some pro-defense advocates have alleged, nor as resistant to suggestions about their own bodies as some prosecution advocates have claimed. They can be led, under certain conditions, to incorporate false suggestions into their accounts of even intimate bodily touching, but they can also be amazingly resistant to false suggestions and able to provide highly detailed and accurate reports of events that transpired weeks or months ago.”

Children can experience a number of stresses when they are interviewed. A parent or other person important to them may be encouraging a specific line of testimony. This can be a particular problem when sexual abuse allegations are part of child custody disputes. A child may also feel pressure from repeated interviews by investigators or impressions about whether the interviewer is pleased or dissatisfied with the child’s report. As Ceci and Bruck note, there is increasing knowledge about measures that can lessen stress for children and the risk of suggestibility. These include minimizing the number of interviews and interviewers of children and using interviewers who are skilled in eliciting information through nonleading questions, do not have an attachment to a particular hypothesis about

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**Given the evolving research about children’s suggestibility, caution is in order. Exaggerated claims that children, including preschool children, can never accurately report or always accurately report are not supported by the literature.**
what happened, and are patient and non-judgmental when talking with a child. (See also the discussion by Myers in his article in this journal issue.)

Given the evolving research about children’s suggestibility, caution is in order. Exaggerated claims that children, including preschool children, can never accurately report or always accurately report are not supported by the literature. In addition, because there is growing knowledge about factors contributing to suggestibility, as well as practical ways to lower it, it is important that those who do interview children are properly trained and that professional groups develop model protocols or guidelines for interviewing children. Some efforts in this regard are under way. For example, in a recent three-year study of multidisciplinary interview centers in Sacramento and Orange counties in California, child interview specialists received a specialized 40-hour course on interviewing children. The research and evaluation panel for this project concluded that trained child interview specialists were critical to the success of the centers and recommended that such specialists receive extensive start-up and ongoing training in child development, forensically defensible interviewing, and the informational needs of investigative agencies. The panel further recommended that California certify professionals who complete requirements established by the state for child interview specialists. We believe that this is a promising approach and that all states should explore the merits of certifying specially trained child interviewers.

Two specific investigative tools relate directly to the issue of suggestibility and deserve mention. They are the use of anatomical dolls in interviewing children and the practice of videotaping interviews with children.

- **Using Anatomical Dolls.** The use of anatomical dolls is widespread. Recent surveys find that 90% of field professionals involved with interviewing children about suspected child abuse use anatomical dolls at least occasionally in their investigative interviews with children. Interviewers find them helpful in understanding children’s names for body parts and in allowing children to show what happened without struggling with language. Critics claim that the dolls themselves stimulate sexual play, even in the absence of any experience of sexual abuse. Furthermore, critics claim that no judgments can be made from a child’s play with dolls because there are no normative data about the play of nonabused children. Ceci and Bruck’s review suggests that the research literature on this issue is not yet determinative of either the benefits or the risks associated with the use of these dolls.

There are some areas of consensus, however. It is now widely acknowledged that doll play is not a diagnostic test for detecting child sexual abuse; how a child uses or plays with a doll is not determinative of whether sexual abuse occurred. There also appears to be consensus that, if dolls are used, they should be used only by people trained to use them properly. Here, too, guidelines are being developed by professional organizations such as the American Professional Society on the Abuse of Children to provide direction for the thousands of individuals who interview children. When complete, much work will need to be done to ensure dissemination and use of these guidelines. For example, in 1987, Boat and Everson surveyed 295 child protection workers, law enforcement officers, physicians, and mental health practitioners concerning the use of dolls and found that few doll users had access to a manual, and many reported they had not received formal training in the use of dolls in sexual abuse cases. If states set standards for certified child interviewers as mentioned above, the mandated training should include a component on doll use.

- **Videotaping Interviews.** Given the level of current knowledge about suggestibility, the trier of fact is often asked to determine from all of the evidence before the

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**Doll play is not a diagnostic test for detecting child sexual abuse; how a child uses or plays with a doll is not determinative of whether sexual abuse occurred.**
court whether a particular child’s testimony was tainted by the nature of questions asked, the use of dolls, or some other factor. A positive development has been the growing practice of videotaping investigative interviews with children. Videotaping accomplishes several things. First, it may minimize the number of interviews a child must go through because the variety of professionals involved in investigating these cases can view the tape and perhaps get the information that they need without reinterviewing the child. Second, the tape can capture body language, tone, and facial expressions, all of which can help portray what both the interviewer and the child are communicating. In many cases, issues of the credibility and suggestibility of the child are raised, and the videotape can show a judge and jury a more complete picture of how the interview was conducted.43

Some have been hesitant to videotape complete interviews with children for fear that the children will show ambivalence and inconsistencies in their accounts which defense lawyers will exploit at trial. In practice, however, many prosecuting attorneys have found that being able to see the complete interview with the child often provides powerful and moving testimony which convinces jurors that, despite difficulties in telling consistently and easily what happened, the child is telling the truth and was not coerced or led in his testimony. In the California study of multidisciplinary interview centers, videotaping was found to have few negative consequences. Most professionals working with the centers were enthusiastic about videotaping, and the research and evaluation advisory panel recommended that investigative interviews continue to be taped.36

Minimizing Stress on the Child. Stress on the child during the course of the investigation and adjudication of child sexual abuse cases can be tremendous. This is particularly so in intrafamily cases. A significant influence on the amount of stress for the child is the family dynamics surrounding allegations of abuse. One of the most difficult situations arises when sexual abuse allegations are made by one parent against another in the context of divorce and child custody proceedings.44 But even outside the context of divorce, these allegations often split a family apart.

A mother may be forced to choose whether to believe her child or her husband. Siblings often blame the disclosing child for the resulting problems in the family. At a time when a child most needs the support of a parent, judges find that many children are not believed but are instead blamed and rejected by one or both parents. Families, particularly mothers, need early support to work through the many stresses they experience and the difficult choices they face.

A number of steps can be taken to minimize stress for the child during the investigation and adjudication stages. Over the past decade, great strides have been made in jurisdictions across the country to minimize both the number of interviewers and the number of interviews for the child and to coordinate the investigative work of all involved. As Pence and Wilson note, most states have laws authorizing or mandating multidisciplinary teams. Integrated, multidisciplinary investigations or, at a minimum, coordinated investigations, should be a priority in every community. There is also a new awareness of the need to provide preparation and support for the child abuse victim as he goes through the trial process. Myers discusses in his article a number of steps courts can take to make the courtroom a less foreign and frightening environment. These steps include familiarizing the child ahead of time with the courtroom, establishing court schools for children who are scheduled to testify, and allowing a trusted adult to remain in the courtroom while the child testifies. Such efforts should be developed by all courts hearing these cases.45

Judges also play an important role in protecting and assisting the child during the adversarial process. As with any wit-
ness, judges have considerable discretion in controlling the questioning of the child, either by cautiously permitting somewhat leading questions for the child or by controlling when necessary the tactics and scope of defense cross-examination.46 Judges also have leeway in some circumstances to allow the child to

testify outside the direct presence of the alleged offender.47 Judges need to be familiar with the available options and the criteria for using them.45

**The Role of Mental Health Professionals**

One of the areas of greatest controversy concerns the proper role of mental health professionals in the investigation and adjudication of child sexual abuse claims. Such professionals can include psychiatrists, psychologists, social workers, family therapists, academicians specializing in child development, counselors, and a wide array of therapists. Melton asserts in his article that mental health professionals should not be involved in these processes, especially in the adjudicative process. He contends that such involvement conflicts with the goals of the mental health profession. Also, because knowledge about the mental health characteristics of victims of child sexual abuse is limited, Melton believes that testimony about these characteristics is more prejudicial than informative. He also argues that placing priority on investigation and adjudication detracts from the time, attention, and resources devoted to helping the child.

We believe that Melton raises many valid points about conflicts in roles and the confusion that can be caused in children and families when mental health professionals interview them not for treatment purposes, but primarily for investigative purposes. However, we do not think that mental health professionals should be banned from the investigative process; they can be among the most skillful interviewers of children. When a mental health professional is involved in investigation, he should be careful to make clear to the parent(s) that he is acting as an investigator, not as a therapist. In this role, his primary concern is determining whether there is evidence of abuse, not treating the child. This may well lead to lines of questioning that would not be followed in therapy. One important role of the investigative team is to link the child as soon as possible to treatment services when they are indicated.48


The greater controversy now, however, concerns the proper role for mental health experts at trial. As discussed by Myers in a recent article, mental health professionals have sought to testify as experts under several different scenarios, and the courts have been divided in their response.49 First, mental health professionals have been asked to describe behaviors and psychological effects commonly observed in sexually abused children. In this testimony, they do not state an opinion about whether the particular child was abused, but their testimony is offered as part of the effort to prove that allegation. As Myers reports, courts have not agreed about whether such evidence should be admitted. Some have not allowed it;50 some have allowed it;51 and some have allowed it under certain circumstances.52 Melton argues in his article in this journal issue that such testimony should be prohibited as misleading and not based on a sufficient scientific foundation.

Mental health professionals have also been asked to provide expert opinion that the particular child was sexually abused. The courts have been somewhat divided about whether such testimony should be allowed,53 although some believe that most courts now exclude it.54

In a third role, mental health professionals have been asked to testify as experts to rehabilitate a child’s impeached credibility. This often occurs when a child delayed reporting the sexual abuse or, in the course of the investigation or trial, recanted or showed inconsistencies in his testimony. As Myers reports, the great majority of courts allow mental health experts to testify that many sexually abused chil-
Finally, expert mental health testimony is sometimes offered by the defendant. Mental health professionals may seek to testify that the defendant does not fit the profile of an offender. However, as noted above, there is no scientifically validated profile of a “typical” offender, and such testimony will not be allowed. A more legitimate type of expert testimony for the defense criticizes the methods that were used to interview the child.

The issues of when science is sufficient to become the basis of expert testimony and who has the proper qualifications to offer such testimony are not unique to the area of sexual abuse. There is not likely to be a clear-cut resolution of these issues by the courts for years to come. Given this fact, it is very important that judges who handle sexual abuse cases receive training about both the complex case law and the science underlying it. Also, the mental health profession itself should analyze and inform its members about the debate in the courts and develop guidelines about acceptable types of expert testimony and expert witness qualifications.

■ Repressed Memory Debate. A second, extremely controversial area involving mental health professionals concerns the validity of the accounts by increasing numbers of adults who, through a process of therapy, claim to remember instances of child sexual abuse. Just as the number of these cases and the media coverage given them has been increasing in recent months, so has the vocal movement counter to them, alleging that these are false memories, not repressed memories, encouraged by untrained and/or unscrupulous mental health professionals. One of the key problems seen is the growth in the number of “abuse specialists,” many of whom actually have little or no knowledge of either mental illness or the workings of memory.

The subject of repressed and recovered memory is highly divisive within the mental health profession and among the public generally. A body of literature on this topic is beginning to emerge. It is both appropriate and essential that the key professions involved show leadership in improving the science and public understanding about this issue, and in setting standards and guidelines for those providing therapy relating to sexual abuse.

The growing attention to repressed memory carries two dangers important to highlight in this journal issue. First, every effort must be made not to confuse the issue of adults remembering events of childhood with the issue of children remembering events of childhood.
medical profession can further refine and develop its role in these cases.

First, doctors need to be trained to include anal and genital inspections in routine well-child checkups and to identify when there is a reason to suspect sexual abuse. There is also a need to help physicians resolve their doubts and questions about when and how to report suspected child sexual abuse. Kerns and colleagues recommend that every child who has been alleged to have been sexually abused be examined by a doctor to determine whether there has been any physical injury. For many of these children, a primary care physician should be able to perform this screening exam and to reassure the child that there has been no physical damage. However, when there are signs of abnormal anogenital findings, an exam by a specialist should be requested.

There are many areas for improving the medical profession’s ability to conduct such specialized medical evidentiary evaluations. Common terminology and procedure guidelines need to be developed. More research is needed on many critical issues, such as what is normal pediatric anogenital anatomy; what is the relationship between sexually transmitted diseases in children and sexual abuse; and how does healing occur for anogenital injuries in children. In addition, those medical professionals involved in evidentiary examinations need considerable training in techniques for interviewing children and preserving evidence.

Research is needed to identify which children are most at risk for subsequent problems and how best to tailor treatments to their individual needs.

Treatment

One of the goals of society in responding to sexual abuse is to provide treatment to minimize the negative effects of victimization on children and to rehabilitate the offender to prevent another sexual abuse offense. Significant treatment communities have developed around both. In this journal issue, two articles discuss treatment: Beutler and colleagues focus on treatment effectiveness for children, and Becker reviews treatment for offenders. Both report a growing but still very limited body of research about effectiveness.

For Children

Children who have been sexually abused gain access to treatment either through order of the court, provision of child protective services, or voluntary efforts on their behalf by parents or custodians. It is not known what percentage of child victims receive treatment. As Beutler describes, however, we do know that the treatment provided is delivered in a myriad of settings, by a myriad of providers, with varying goals, assessment strategies, and techniques.

Research on effectiveness of treatment is very limited. In their review, Beutler and colleagues find that there are presently no published outcome studies that have assigned sexually abused child patients to treatments in ways that minimize the likelihood of bias and that include adequate control or comparison groups or adequate follow-up. They do believe, however, that the current quasi-experimental research suggests both a need for and a benefit from mental health support during the acute adjustment period for those children most at risk for long-term negative effects.

Beutler and colleagues emphasize that the event of sexual abuse does not, in and of itself, always create a need for treatment. Spontaneous recovery occurs for a significant number of child victims. Research is needed to identify which children are most at risk for subsequent problems and how best to tailor treatments to their individual needs.

Mental health professionals can provide leadership in improving knowledge about when and what type of treatment should be offered. As the National Research Council recently recommended, high-quality evaluation studies of existing program and service interventions are needed to develop criteria and instruments that can help identify promising develop-
ments in the delivery of treatment services. Along similar lines, Beutler and colleagues recommend greater use of models of short-term psychotherapy that have been tested and found effective for such symptoms as depression, anxiety, substance abuse, and eating disorders. They recommend controlled clinical trial experiments to evaluate the effectiveness of these models for children whose symptoms are associated with child sexual abuse.

In the interim, how can those working at a community level decide when to seek treatment for a child and what type to seek? We believe that judges and child protective workers must become familiar with the treatment providers in their community. In some communities, there will be few or none, and efforts will need to be made to create treatment resources. In other communities, there will be many treatment programs, and information should be gathered about provider credentials and training; public and private alternatives for financing treatment; the type of assessment used for determining treatment; the type and goals of treatment; and any evaluations of treatment effectiveness that have been done. With this information, judges and child protective service workers will be better able to make decisions about when and where to refer children. Although not every child will need treatment, every child should be assessed for mental health difficulties and, if these are present, should receive treatment.

For Offenders

There has been great growth in the number of treatment programs for sexual offenders. At least 1,500 programs nationally offer professional assessment and treatment. Their staff members come from a variety of disciplines, levels of experience, and education. (Currently only the state of Washington requires special certification for counselors treating sex offenders, although others are considering it.) In addition to these programs, there are hundreds of self-help groups around the country, many focusing on intrafamily abuse.

The primary goal of all offender treatment is to prevent or reduce recidivism. Research to date has not proven effectiveness in reaching this goal. As one commentator urged, “At this stage in the development of our understanding of treatment and its effectiveness, we believe the best approach is to ask not the categorical question, ‘can sex offenders be treated?’ but rather a more modest question ‘can we discern grounds for optimism?’” Becker reviews several studies which, although they are typically limited because they did not employ closely matched control groups, suggest that treatment can reduce recidivism for some offenders. As she notes, controlled treatment outcome studies with long-term follow-up are needed to assess which treatments are most effective with different categories of offenders. One of the greatest areas of need is to develop and test treatment models for juvenile offenders. Attention to this population is fairly recent, and few outcome studies have been undertaken. (See the discussion in the article by Becker.)

Prevention

Daro reviews prevention efforts for child sexual abuse. Unlike prevention efforts for other types of abuse and neglect, prevention efforts for sexual abuse have focused almost exclusively on trying to teach all children through group-based instruction about how to protect themselves from, or respond to, sexual abuse.

Unlike prevention efforts for other types of abuse and neglect, prevention efforts for sexual abuse have focused almost exclusively on trying to teach all children through group-based instruction about how to protect themselves from, or respond to, sexual abuse.
counties found that more than 85% of the districts had offered programs in at least one school within the past year. Daro reviews the content of these programs and what is known about their effectiveness from 17 studies employing random assignment to treatment and control groups and 21 additional quasi-experimental studies. Overall, these studies show that even after a few presentations, children do learn some of the concepts being promoted. (For example, children may show an increase in knowledge about safety rules, understanding about their right to control who touches them, and awareness about who to turn to if they have been abused.) Knowledge gains, however, are fewer in preschool children. Only a few studies did follow-up testing later than two months after the intervention, so whether knowledge gains last is unclear. A few studies noted that, after the program, a number of children disclosed incidents of inappropriate touching or ongoing sexual abuse.

Most evaluations have not assessed whether a gain in knowledge will actually translate into behavior and protect children from abuse. In fact, a recent survey suggests that, even when children had received a good program and viewed it favorably, there were no measurable signs that they were able to limit sexual threats and assaults. There may be negative impacts of these efforts, such as engendering fear and anxiety in children. Daro discusses the mixed research on this issue. The two randomized trials which examined this concept did not find a notable impact on children’s fear and anxiety; but two evaluations with quasi-experimental designs did show such an impact. As schools across the country consider purchasing these programs, they must be aware of their limitations, the most significant of which is that there is no demonstrated effectiveness in helping children to actually prevent or resist sexual abuse.

It is also important to broaden primary prevention efforts. Daro suggests that these efforts should include new emphasis on public information announcements, programs to improve parenting and communication skills, and support services for children who are experiencing periods of special stress or isolation. Berrick and Gilbert propose a model that emphasizes adult responsibility for young children and teaches general communication skills along with lessons about body awareness and secret touching which are integrated into the ongoing process of education by classroom teachers.

Increasing the attention to supervision of children seems especially important. Many children are left alone for significant numbers of hours each day, increasing their vulnerability to many risks, including child sexual abuse. Improvements might include more availability of after-school child care and activities and establishing community hot lines for children to call when they have questions or need help.

Finally, the focus of prevention efforts cannot be only on the nuclear family. Often grandparents, aunts and uncles, cousins, or friends of the family will have some inkling or even knowledge that sexual abuse may be occurring. Extended family members and friends need education and information about how to handle these situations.

**Conclusion**

Our society is in a period of heightened attention to the problem of child sexual abuse. Significant progress has been made in documenting the scope of the problem; improving the response of law enforcement, child protective services, and the justice system; and in developing treatment and prevention approaches. Yet critical questions remain unanswered and are often hotly debated. As was discussed above, there are many opportunities for the law enforcement, child protection, mental health, medical, and legal professions to deepen society’s understanding of and improve its response to child sexual abuse.
It is of concern, however, that we are also in a period of heightened criticism of those involved in handling sexual abuse cases. Conte discusses in his article what many perceive to be a “backlash” against the progress made in this area. Criticism that is supported and balanced is essential to progress and improvement, but criticism that is unsupported and exaggerated is counterproductive and even destructive. Because child sexual abuse is such an emotional topic, it is especially important that all involved strive constantly to anchor their actions, analysis, and opinions in the best information available, avoiding the temptation to overclaim or underestimate what is known about a particular aspect of the problem.

In the coming decade, it is important that we continue and accelerate the progress made in the past decade in dealing with child sexual abuse. To do so will require commitment across many sectors of society. With such commitment, we are confident that the prevalence of this problem can be reduced and its impact on the lives of children can be lessened.

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1. There are some important areas where statutory definitions of child sexual abuse differ. Perhaps the most significant area is in specification of the age of the child to whom these statutes apply. In California, a child is a person under the age of 18 years. Cal. Penal Code Section 11165. In Alabama, sexual abuse in the first degree occurs when the child victim is under 12 years of age, and sexual abuse in the second degree occurs when the victim is under 16 but older than 12. Ala. Code Sections 13A-6-66 and 13A-6-67 (1993).
2. California’s child abuse statute relies on the criminal statute to define child sexual abuse. Section 300 of the Welfare & Institutions Code gives the juvenile court jurisdiction over children who have been sexually abused or are at substantial risk of being sexually abused, “as defined in Section 11165.1 of the Penal Code, by his or her parent or guardian or a member of his or her household, or the parent or guardian has failed to adequately protect the minor from sexual abuse when the parent or guardian knew or reasonably should have known that the minor was in danger of child sexual abuse.” Cal. Welfare & Institutions Code Section 300 (West 1993).
7. For example, one of the best studies of prevalence was a 1985 survey conducted by the Los Angeles Times Poll in which a national sample of 2,626 men and women 18 years of age or older were interviewed over the phone. Even in this survey, however, the phrasing of questions left considerable room for interpretation. As Finkelhor, Hotaling, and Lewis note, these questions were more comprehensive than those used in many other surveys. But they still left considerable room for interpretation, allowing the respondent to interpret phrases such as “anything like that” and inviting reports of “any experience you would now consider sexual abuse.” For example, respondents were asked: “When you were a child (elsewhere indicated to be age 18 or under), can you remember having any experience you would now consider sexual abuse—like someone trying or succeeding in having any kind of sexual intercourse with you, or anything like that?” See Finkelhor, D., Hotaling, G., Lewis, I.A., and Smith, C. Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. Child Abuse & Neglect (1990) 14:19-28.

10. One example of an in-depth look at case loads and decision making by a local child protective services agency is the Administrative Practices Improvement Project in Santa Clara County, California. In this project, a very detailed review of the county case load is being undertaken using computerized case records, case file reviews, interviews, and surveys. For more information, call Sylvia Pizzini, APIP Project Director, (408) 441-5614.


21. Many states have passed statutes to ease confidentiality barriers in the context of multidisciplinary response to child sexual abuse. See, for example, California Welfare and Institutions Code Sections 18951, 18961, and 18961.5. A helpful resource on confidentiality issues is Soler, M., Shotton, A., and Bell, J. *Glass walls: Confidentiality provisions and inter-agency collaborations*. San Francisco: Youth Law Center, March 1993.


24. A 1985 study in St. Louis, Missouri, followed 124 validated cases of child sexual abuse from report through investigation, treatment, and termination for a minimum of one year. It found that the nature and duration of the services offered to families were unlikely to have lasting positive impact. In only 15% of the cases were services offered related to substance abuse, a major factor in child sexual abuse. Only 38% of child sexual abuse victims received mental health counseling. Seldom were all members of the family offered services. Lynn, M., Jacob, N., and Pierce, L. Child sexual abuse: A follow-up study of reports to a protective service hotline. *Children and Youth Services Review* (1988) 10,2:151-65.

25. A Michigan study evaluated 58 confirmed cases of child sexual abuse between 1977 and 1984 and then conducted follow-ups three years later. In 62% of the cases, children had...
been placed outside the home for some length of time. Of those placed, 43.1% were still in out-of-home care at the 3-year mark. The mean length of placement for all children placed was 3.3 years. For those still in care at the follow-up, the average time in placement was 4.3 years. Faller, K. What happens to sexually abused children identified by child protective services? Children and Youth Services Review (1991) 13:101-11.


30. In Santa Clara County, California, the Administrative Practices Improvement Project found that, in 1993, of 24,454 reports received, 22,437 (91.8%) were closed at intake, 1,142 (4.7%) resulted in voluntary services to the families, and 875 (3.6%) resulted in Juvenile Court action to establish dependency. See note no. 10.

31. For management or research purposes, even more detailed classification may be desirable. For example, a fourth tier for cases that were substantiated but were closed might be a helpful category to monitor. For an in-depth discussion of the different purposes and uses of central registries, see Bross, D. Confidentiality, due process, and the business of central registries: Legal and policy considerations. Unpublished paper prepared for the National Center for State Courts, March 1988. Available from Don Bross, Kempe Center, 1205 Oneida St., Denver, CO 80220.


35. See note no. 33, Ceci and Bruck, pp. 16-17.


37. See note no. 33, Ceci and Bruck, p. 13.


41. The American Professional Society on the Abuse of Children in Chicago, Illinois, currently has a task force working to develop guidelines for the use of anatomical dolls during investigation or evaluation of suspected child sexual abuse.


43. A videotape can be used by prosecution or defense or both at trial. It does not, however, take the place of the child testifying in court; whether videotaped testimony should be allowed in lieu of live testimony is a separate issue. See Maryland v. Craig, 497 U.S. 836 (1990) for discussion of the constitutional right of confrontation in the article by Myers in this journal issue, p. 88.
44. A 1986 study of 12 courts throughout the United States found that slightly less than 2% of the contested child custody or visitation disputes involved an allegation of sexual abuse. Thoennes, N., and Tjaden, P. The extent, nature, and validity of sexual abuse allegations in custody/visitation disputes. Child Abuse & Neglect (1990) 14:151-63. See also Nicholson, P.B., and Bulkley, J., eds. Sexual abuse allegations in custody and visitation cases. Washington, DC: American Bar Association, 1988, which estimated that sexual abuse allegations occur in 2% to 10% of the cases involving custody or visitation disputes.


46. See, for example, the discussion of leading questions in Myers, J.E.B. Evidence in child abuse and neglect cases. Vol. 1. New York: Wiley, 1992, §§5.7 et seq.

47. In Maryland v. Craig, 497 U.S. 836 (1990), the Supreme Court held that, although the Sixth Amendment of the Constitution reflects a preference for face-to-face confrontation with the defendant at trial, this can be modified if the court determines that the child witness will suffer serious emotional distress such that the child cannot reasonably communicate.

48. In a recent study of multidisciplinary interview centers in California, it was found that the multidisciplinary approach can increase the proportion of children who are referred to and receive necessary medical and mental health services. See note no. 36, California Attorney General’s Office.


50. See, for example, Commonwealth v. Dunkle, 602 A2d 830, 832-835 (Pa. 1992) (expert testimony concerning typical behavior patterns exhibited by sexually abused children was not probative and should not have been admitted; it was not adequately established that the Sexually Abused Child Syndrome had gained general acceptance as a diagnostic tool by the scientific community); and Nelson v. State, 782 P2d 290, 291, 297-299 (Alaska App. 1989) (social worker’s testimony that alleged victims’ reports were consistent with valid reports of sexual abuse were no different than an expert opinion that victims were telling the truth; that was for the jury to decide).

51. See, for example, Broderick v. King’s Way Assembly of God, 808 P2d 1211, 1216-1217 (Alaska 1991) (qualified expert can offer opinion that child’s behavior was “clinically consistent with the finding that she had been sexually molested”); and Commonwealth v. Joseph Dockman, 542 NE2d 591, 594, 597-598 (Mass. 1989) (a child psychiatrist’s testimony as expert witness describing “the commonly recognized clinical phenomena related to child sexual abuse” was admissible because it was beyond the common knowledge of jurors and aided them, and was properly limited by judge’s instructions to the jury).

52. See State v. Rimmasch, 775 P2d 388, 393-404 (Utah 1989) (admission of expert testimony by mental health professionals violates Utah Rule of Evidence 702, because “sexually abused child profile” on which experts based their opinions was not found to be scientifically reliable enough; leaves open the possibility that in future this reliability requirement could be met).

53. For cases in which courts admitted expert opinion about whether a particular child was sexually abused, see Broderick v. King’s Way Assembly of God, 808 P2d 1211, 1216-1217 (Alaska 1991) (testimony by expert that child was sexually abused was admissible because, although related to ultimate issue of fact, it satisfied the requirements of Evidence Rule 702 of being based on specialized knowledge and assisting the triers of fact); Glendenning v. State, 536 So2d 212, 213, 220-221, cert. denied, 492 U.S. 907 (1989) (qualified expert could offer own opinion as to whether alleged victim was sexually abused because it helped the jury and because its probative value outweighed any unfair prejudice; jury was left free to determine amount of weight to give opinion); and Seering v. Cal. Dept of Social Services, 239 Cal Rptr 422, 423, 427 (Cal App 1 Dist. 1987) (expert testimony by child’s psychiatrist that child had been sexually abused was admissible when given as personal opinion, but not when based on a scientific method that had not passed the Frye test). For discussion of cases in which expert opinion of particular child was judged inadmissible, see Commonwealth v. Dunkle, 602 A2d 830, 834, 836 (Pa. 1992) (expert testimony about general characteristics of sexually abused children combined with observations by others of child’s “unusual” behavior “attempts—in contravention of the rules of evidence—to suggest that
the victim was, in fact, exhibiting symptoms of sexual abuse” and was therefore inadmissible); *State v. Moran*, 728 P2d 248 (Ariz. 1986) (expert testimony that victim’s behavior matched that of sexually abused children generally was inadmissible); and *Johnson v. State*, 732 SW2d 817, 818-821 (Ark. 1987) (opinion of physician that child had been sexually abused was inadmissible because it was based solely on child’s own statements to physician; testimony did not aid jurors; they could draw their own conclusions from child witness’s statements). For discussion of cases in which, under some circumstances, expert opinion about a particular child might be admitted, see *Goodson v. State*, 566 So2d 1142, 1144-1148 (Miss. 1990) (expert testimony by physician that child’s reaction to examination was “extremely unusual” was admissible under Evidence Rules 702 and 703; error occurred when physician gave own opinion that child “had been sexually traumatized”; nothing in record showed that physician was qualified as expert in field of child sexual abuse; her opinion was not based on any “established and accepted scientific predicate”); and *In re Amber B.*, 236 Cal Rptr 623, 625 (Cal App 1 Dist 1987) (expert testimony based on use of anatomically detailed dolls to determine whether alleged child victim was sexually abused was inadmissible unless proven to be accepted as reliable by scientific community).


55. See, for example, *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 113 S. Ct. 2786 (1993).

56. For discussion of expert testimony and professional organizations as ethical gatekeepers, see note no. 33, Ceci and Bruck.


61. There is some evidence of a tendency of physicians to underreport child abuse and neglect cases. See discussion in the article by Kerns, Terman, and Larson in this journal issue.


63. At least seven longitudinal studies had demonstrated spontaneous abatement of symptoms. One study found that two-thirds of abused preschoolers recovered to normal range on selected psychological tests within 12 to 18 months. See note no. 14, Kendall-Tackett, Williams, and Finkelhor, pp. 171-72.

64. See note no. 9, National Research Council, pp. 33 and 34

65. See note no. 18, Knopp, Freeman-Longo, and Stevenson.


69. Related to treatment, a number of states have been experimenting with long-term probation with intensive monitoring for sex offenders. For example, Arizona law authorizes trial courts to order life-long probation for sex offenders. The effectiveness of such approaches, whether or not coupled with treatment, needs to be monitored and evaluated. See discussion in the article by Becker in this journal issue.


71. One study did find that, immediately following the prevention program, children were less likely to leave the school building with a stranger. Fryer, G., Kraizer, S., and Miyoshi, T. Measuring actual reduction of risk to child abuse: A new approach. *Child Abuse & Neglect* (1987) 11:173-79.

72. Finkelhor, D., Asdigian, N., and Dziuba-Leatherman, J. Victimization prevention training in action: A national survey of children’s experiences coping with actual threats and assaults. Durham: University of New Hampshire, Family Research Laboratory, March 1994. This same survey found that the percentage of children experiencing an injury in a sexual victimization was greater for the children who had received a comprehensive prevention training program than for those who had not, presumably because they tried to resist their attackers. The authors note, however, that this finding was based on a small number of cases, and the statistical confidence was not strong. But it is potentially a very important observation.


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