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Reactions of children to interviews using anatomically correct dolls

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REACTIONS OF CHILDREN TO INTERVIEWS USING ANATOMICALLY CORRECT DOLLS

by

Joyce Ann DeVoss

A Dissertation Submitted to the Faculty of the

DEPARTMENT OF COUNSELING AND GUIDANCE

In Partial Fulfillment of the Requirements
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SIGNED: Joyce A. DeVaas

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ABSTRACT

This study tested an underlying assumption of professionals who interview young children with anatomically correct dolls: children who have been sexually abused react differently to interviews with the dolls than children who have not been sexually abused. The behavior of a group of children who were referred to a mental health clinic in the southwestern United States because of suspected sexual abuse was compared to the behavior of a group of children referred to the same clinic for other reasons while the children were interviewed by clinicians using anatomically correct dolls.

The study examined four categories of behavior which consisted of indicators of child sexual abuse from the literature. The four categories were: 1) sexual behavior; 2) anger/aggression; 3) anxiety/regression; and 4) avoidant behavior.

Clinicians at the mental health clinic identified potential subjects for the study from the outpatient population. Parents were given written and verbal descriptions of the study and asked to contact the researcher if they were interested in allowing their

child to participate. The voluntary nature of participation in the study was stressed. Eleven children who were referred because of suspected sexual abuse and eleven children referred for other reasons were successfully recruited. Groups were matched as closely as possible as to sex, age, racial/ethnic group and developmental level.

Two dependent measures were employed: the Behavioral Checklist and the Likelihood of Victimization Scale. Both instruments were designed for the research study. The Behavioral Checklist was completed by two observers who watched each interview from behind a one-way mirror. The Likelihood of Victimization Scale was completed by the clinicians who interviewed the children. Observers as well as interviewers were blind to the referral status of the children. Statistically significant differences were obtained for two of the four categories of the Behavioral Checklist. The same two categories correlated significantly with the Likelihood of Victimization Scale. The results provided support for the assumption tested.

CHAPTER 1

INTRODUCTION AND RATIONALE FOR THE STUDY

Due to the tremendous increase in the reports of child sexual abuse in recent years, child protective services, the police, the courts and psychotherapists have been faced with the important task of helping child victims. As more of these cases have gone to trial, concern has been raised about the effects of testifying in court on the child and the credibility of the child witness (Berliner, 1985; Finkelhor, 1984; Von Hoffman, 1985; Zeanah, 1984). Berliner (1985) believes that children do not generally handle the difficulties of participating in the criminal justice system well and may become less effective without special consideration. There is research indicating that children can be effective witnesses and give valuable testimony if they are properly prepared for their courtroom experience (Berliner and Barbieri, 1984).

Communities interested in prosecuting sexual abuse cases have modified the criminal justice system in ways to accommodate the child witness. These modifications have included using audio or video-taped

interviews, allowing expert hearsay testimony on behalf of the child, and the use of interviewing aids such as drawings and anatomically correct dolls that permit the child to demonstrate the sexual abuse experience instead of describing it only in words (Berliner and Barbieri, 1984).

Authors disagree as to the need for such modifications. According to Gary Melton (1984, p. 10) in his presentation to a subcommittee of the United States Senate on sexually abused children and the legal system, "At the present time, however, there is insufficient evidence to justify substantial modifications of criminal procedures on psychological grounds." Other authors feel strongly about the need for the criminal justice system to do whatever possible to avoid the potential for retraumatizing the child sexual abuse victim (Berliner and Barbieri, 1984; Conte, 1984; Greenwood, 1981; Silas, 1985). Conte and Berliner (1981, p. 104) stated: "Accommodations within criminal justice procedures are necessary to lessen the trauma experienced by the child as a result of the sexual abuse and their involvement with the criminal justice process."

There is a need for research to determine whether the modifications which are being made for child witnesses are helpful in procuring accurate and detailed testimony,

whether they interfere with the child's testimony, or if they encourage elicitation of false information. Melton (1984) claimed that "would-be reformers" have an obligation to show that changes are needed as well as beneficial.

The use of anatomically correct dolls has become a controversial issue in validating child sexual abuse allegations. Concern has been expressed as to whether the interviews with the dolls lead to false reports of sexual abuse (Renshaw, 1985). One recent newspaper article referred to the dolls as "sexually explicit" (Von Hoffman, 1985), implying that they encourage sexual behaviors or verbalizations. Nevertheless, the anatomically correct dolls have been used in hundreds of sexual abuse cases in investigations and in court since 1976 in all fifty United States and some foreign countries (Friedemann and Morgan, 1985). In a recent case ("Court Accepts," 1985), a four year old's statements to a pediatrician regarding her sexual abuse experience were found admissable in court under the medical treatment exception. The court also admitted evidence of the child's reaction to anatomically correct dolls, holding that "the use of such dolls did not have to meet the requirements of a scientific test to be admissible since dolls are not used to elicit a particular

response, but instead are aids to enable children to communicate ideas which they are unable to describe verbally" (p. 4).

The format for interviewing children with the dolls is inconsistent from law enforcement to child protective services to mental health agencies and from one interviewer to another. The literature describing how to use the dolls in interviews reflects these inconsistencies (Adams-Tucker, 1984; Analeka Industries, undated; Clausen, 1985; Eaddy, 1981; Friedemann and Morgan, 1985; Harnest, 1983; Kepler, 1984). In some of the literature, the choice of whether to present the dolls clothed or unclothed is left to the interviewer (Friedemann and Morgan, 1985). Although not tested, it would appear that the manner of presentation of the dolls would have an impact on the response of the child interviewed. Furthermore, this and other variations in the presentation of the dolls make it difficult to develop general statements regarding experience in the use of the dolls.

Mental health professionals frequently make reports to the authorities when there is suspicion of child sexual abuse, and they are often called upon to testify in child sexual abuse cases (ie., State v. Clark, 1984). Play therapy interviews based on

Virginia Axline's Principles (1947) are commonly used as a method of assessing young children. The goal of therapeutic interviewing is to assess the child's psychosocial concerns while the goal of investigative interviewing as used in the justice system is to obtain thorough and accurate information. The courts frequently rely on mental health professionals to provide the information which the police and child protective service workers were unable to obtain from child sexual abuse victims. This can create difficulties for the mental health worker who has not been trained in investigative techniques and who typically has a different focus than the justice system in interviewing children. It would be possible, however, to combine aspects of both therapeutic and investigative interviewing in an attempt to improve the effectiveness of the various professionals who interview suspected child victims of sexual abuse.

Studies on child abuse typically focus on samples of victims. Jones, Gruber and Freeman (1983) emphasized the need for studies including "samples of children" rather than samples of "young victims exclusively." They provided some modest data that indicate that minors need not be affected negatively by research interviews regarding their sexual abuse experiences.

Although the anatomically correct dolls have been used in hundreds of cases of child sexual abuse since 1976, there were no published studies examining children's reactions to interviews with the dolls at the time this study was initiated. The widespread use of the dolls as interviewing tools by professionals neccesitated the gathering of data regarding the assumption underlying their use: that child sexual abuse victims react differently to interviews with the dolls than children who have not been sexually victimized.

Purpose of the Study

This study was designed to determine whether there are differences between the way children who are suspected of having been sexually abused react to interviews with anatomically correct dolls as compared the the way children not suspected of having been sexually abused react to the same interviews. Secondly, the study sought to compare scores of subjects on a Behavioral Checklist with ratings on a Likelihood of Victimization Scale in order to lay some foundation for further studies on predictive validity of the interviews and instruments.

Important Terms

Child sexual abuse in this study is defined as the intentional exploitation of a child by a person five or more years older than the child for sexual gratification. The abuse may include any of the following:

1. exhibiting of genitals;
2. sexualized kissing and touching;
3. vaginal and/or anal penetration;
4. oral copulation; and
5. involving a child in pornography.

This definition was borrowed from Dave Corwin (1985, p. 1) with the addition of the involvement of a child in pornography which reflects a more inclusive legal definition (A.R.S. 13-3506 and 13-3508, 1984).

This study examined behavioral symptoms which have been used to describe sexually victimized children (Kempe, 1984; Kepler, 1984; The National Center on Child Abuse and Neglect, 1980; Schultz and Jones, 1983; Sgroi, 1982). The symptoms were organized into four logical categories of behavior for the purposes of this research study. They include: 1) sexual behavior; 2) anger/aggression; 3) anxiety/regression; and 4) avoidant behavior. Subjects were rated in these four categories of behavior while they were interviewed

with the anatomically correct dolls. They were operationally defined as follows:

1. Sexual Behavior, including reporting sexual abuse; explicit knowledge of sexual parts and acts expressed in verbalizations, doll play or other ways; undressing of dolls or self; invitations to interviewer for sexual contact; and verbal or nonverbal hints about sexual activity.

2. Anger/Aggression, including hitting; yelling; name calling; threatening; and punishing.

3. Anxiety/Regression, including screaming; questioning about the location and activities of parent(s); pressured speech; stuttering; crying; separation anxiety; clinging; whining; thumbsucking; baby talk; rocking; fetal position; pulling on hair or clothing; picking at skin; and overly compliant behavior.

4. Avoidant Behavior, including walking away; looking away; significant decrease in verbalization and/or level of activity; and hiding.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter presents an historical/societal overview of child sexual abuse. In addition, it explores the role of children as victims/witnesses. The literature on clinical as well as investigative interviews with children is reviewed. Finally the most relevant studies, only one of which was published and some for which the results are not yet available, will be summarized.

Historical/Societal Overview

As far back as the time of Lot, incestuous relationships were documented (The Bible, Genesis 19:30-38). Lot reportedly had sexual relationships with both of his daughters. Both became pregnant by their father and were judged to be responsible for instigating the incest.

Louis XIII allegedly was played with sexually by many adults in his childhood (Rosensweig, 1984). Yet, in the 17th and 18th centuries there developed a moralistic tendency in Western civilization in which sexuality of any kind was not discussed (Rosensweig, 1984).

Freud heard many reports of child sexual abuse which he initially believed. But later, under pressure from colleagues, he attributed the reports to client fantasy (Freud, 1896; Tavris, 1984).

The first case of child abuse in the United States court system was that of Mary Ellen in 1874. Mary Ellen was an adopted girl who suffered incredible cruelty from her parents. Because there were no laws protecting children from abuse, laws for the prevention of cruelty to animals were utilized in developing a case on behalf of the child. Directly due to this case, the New York Society for Prevention of Cruelty to Children was formed in 1875.

In the 20th century, child physical abuse identification was advanced in the mid forties by radiologic findings of long bone fractures in children (Caffey, 1946). In 1962 Henry Kempe developed the term "battered child syndrome" which stirred concern in physicians and ohter professionals who worked with children. An in the same year, Cormier (1962) introduced the probability that the incidence of incest vastly exceeded the reported figures. Prior to 1960, the psychiatric literature viewed incest as a virtually negligible occurrence (Summit and Kryso, 1978).

The National Center for Child Abuse and Neglect was established in 1964. And in 1974 the Child Abuse Prevention and Treatment Act became law. Shortly thereafter, all fifty states enacted child abuse reporting laws (Adams-Tucker, 1984).

Gagnon (1965) interviewed 1200 college students and found that 26% of the females interviewed had been sexually abused by the age of 13. Finkelhor (1984) repeated Gagnon's study in six New England colleges and obtained similar results.

In 1976, Henry Giaretto designed and implemented a therapy program for incestuous families in Santa Clara, California. This program has been used as a model for similar treatment programs across the nation.

Diana Russell (1983) collected data from 930 adult women in San Francisco on the incidence and prevalence of child sexual abuse. Key findings include: 16% of the women reported at least one experience of intrafamilial sexual abuse before the age of 18; 12% reported at least one such experience of extrafamilial sexual abuse before the age of 18; and 20% reported at least one such experience before the age of 14 years. Only 2% of the cases of intrafamilial and 6% of the extrafamilial cases were ever reported to the police.

In the past decade or so, there has been a dramatic increase in public awareness of the problem of child sexual abuse. There has been a media explosion on the topic, including books, articles, film strips, movies and documentaries (Kempe, 1984; Mrazek, 1983). A survey by one researcher found that almost all American respondents remembered seeing a media discussion of the problem in the preceding year (Finkelhor, 1982).

The women's and children's advocacy movements and the victim/witness programs began in the 1970's (Berliner, 1985). Such groups helped create greater awareness of how to talk with children about sexual abuse and how to identify signs of potential sexual abuse situaitons. This has led to a dramatic increase in reporting. In the city of Tucson, Arizona, the police department investigated 51 cases of reported sexual abuse in 1981 and in 1984, the same department investigated over 200 such cases (Rosensweig, 1984).

Cultural Perspective

Sexual abuse is culturally defined (Nadelson and Rosenfeld, 1980; Rosensweig, 1984). Human cultures vary in the degree of sexuality of children. Currier (1981) described four categories of cultures regarding sexuality: 1) repressive, 2) restrictive, 3) permissive

and 4) supportive. The repressive culture tends to deny sexuality and prohibit it except for procreation. This approach is common throughout Europe and in the Cheyenne Indian tribe of the North American plains. The sexually restrictive culture provides limits on sexuality and is common throughout the world. The sexually permissive culture is tolerant of sexuality and provides loosely enforced formal prohibitions. This approach is common except in Europe. The sexually supportive culture is disposed toward the civilization of sexuality, providing customs and social institutions related to sexuality. This approach is common in equatorial Africa, Southern Asia and the South Pacific.

During the period from 1900 and 1950, Western society made a transition from a repressive to a restrictive culture in terms of acceptance of sexuality, according to Currier (1981). He further maintained that Western society is now in the process of another transition, from restrictive to permissive.

Current Approaches to Sexual Abuse

There are a number of factors that have made the problem of sexual abuse in the United States complicated. Finkelhor, Gomes-Schwartz, and Horowitz (Finkelhor, 1984) outlined four factors which follow.

First of all, the problem emerged suddenly. Prior to 1975 reported cases were relatively rare. Between 1976 and 1979 official reports of sexual abuse more than tripled (American Humane Association, 1981).

Secondly, the demand for services has over-burdened limited community resources. This has created delays in interventions in sexual abuse cases by the appropriate professionals.

Thirdly, since sexual abuse provokes strong emotional reactions, it tends to be either denied or treated as an emergency (Summit, 1981). These rush actions or denials are likely to create further problems in handling sexual abuse cases.

Fourth, sexual abuse falls into competing domains, including state child protective agencies, police, district attorneys, mental health workers and medical professionals. Many of these professionals have little experience cooperating with each other, and their goals may be in opposition in specific cases.

Various philosophies about the nature and handling of sexual abuse cases have developed (MacFarlane and Bulkley, 1982). There are those who see sexual abuse as a mental illness and prescribe therapy for the offender. There are those who see it as a form of family dysfunction and family systems interventions

as the solution (Furniss, 1983). And there are those who see it primarily as a crime and look to punishment as the main objective. The result is that sexual abuse cases are not always handled well.

A survey of helping professionals of various backgrounds in the Boston area indicated that they tended to operate in an isolated way within their own network (Finkelhor, 1984). The professionals disagreed in patterns and preferences of interventions in sexual abuse cases. Furthermore, the professional community was involved in controversy about such issues as whether it is important to bring criminal charges against the abuser and what priority should be given to removing the child victim or the offender to prevent further abuse. The need for social workers, police, county attorneys and other professionals involved in child sexual abuse cases to work cooperatively has been addressed in a project initiated in Seattle, Washington which was developed to facilitate such a working system (Conte, Berliner, and Nolan, 1980).

The Child As Victim/Witness

Until the early 1970's, child sexual assault cases rarely came to the attention of the criminal justice system. And although there has been a dramatic rise in the prosecution of cases, it is still nowhere

near comparable to the incidence of these crimes (Melton, 1984). Rogers (1980) tracked 261 cases over two years in Washington, D.C. and found that only 8 of the cases went to trial. In a study by DeFrancis (1969), 40% of "well-selected cases for prosecution" were dismissed before the trial, subjecting child victims to unproductive questioning. In addition, for the less than 200 cases which were actually prosecuted, the children involved were required to make over 1,000 court appearances.

The issues facing sexual abuse victims are complex. There is no societal agreement about what should be considered criminal sexual behavior or about the appropriate institutional response. There is general agreement about the extremes but a great deal less agreement about the gray areas (O'Brien, 1982). Children are perceived as likely to make false reports (Goodman, Golding and Haith, 1984). In addition, children's statements about sexual abuse are sometimes attributed to fantasy or programming of another adult such as a divorced mother or an overzealous social worker (Silas, 1985). The child's lack of knowledge may be blamed for causing a misinterpretation of innocent behavior. The different capabilities of children to recall and describe events is used to discredit their

statements (Johnson and Foley, 1984). This attitude of not believing child sexual abuse victims is reflected in legal writing and decisions (Bienen, 1983).

The credibility and the competence of the witness in sexual assault cases is the central issue (Berliner and Barbieri, 1984). For child victims, simply the fact of being a child leads others to perceive them as less credible (Berliner, 1985).

A number of factors which enhance or detract from a child's competency or believability have been identified and described (Terr, 1980). A technique called Statement Reality Analysis has been developed in order to verify reports made by alleged sexual abuse victims. Furthermore, methods of interviewing and assessing the credibility of alleged victims have been outlined (Weiss, 1984).

There is no consensus about the proper role of the criminal justice system in child sexual abuse. Furthermore, there are various levels of support for involving child victims with the legal system (Nadelson and Rosenfeld, 1980). In some states, there are requirements for establishing the competency of child witnesses. During the past ten years there has been increasing willingness to file charges based simply

on the statement of the child, and the trend has been to abolish competency hearings for children (Goodman, 1984; Abuse---Child's Evidence, 1985).

It has been argued that children should be permitted to testify without prior qualification (Melton, 1985). The competency hearings for children followed the Supreme Court's 1895 decision in Wheeler v. United States, in which the court held that the admissability of a child's testimony is dependent upon the trial judge's determination of the "capacity and intelligence of the child, his appreciation of the difference between truth and falsehood, as well as his duty to tell the former" (p. 524-525).

Legal requirements for competency of a child and psychiatric requirements for verification of a child's report are different (Terr, 1980). Psychiatrists and other mental health professionals consider a child's cognitive functioning, defense mechanisms, behavioral reenactments of events, play, dreams and consistency in reports (Terr, 1980).

The police and prosecutors frequently have misgivings about the ability of children to cooperate with the legal process (Berliner and Barbieri, 1984). The nature of the adversary system means that the child victim/witness's credibility will be challenged

by the defense counsel. Since the child's testimony is typically the only evidence, the case relies heavily on the victim's ability to communicate clearly about the sexual abuse experience.

The need for special training for those who question child witnesses has been stressed (Dent and Stephenson, 1979). There is evidence that free report provides more accurate information from a child than direct and general questioning (Dent and Stephenson, 1979).

Prosecutors use their discretion in not filing charges for cases in which achieving a conviction is unlikely, even though they may believe a crime was committed (Berliner and Barbieri, 1984). Sexual abuse cases are frequently time consuming and difficult to win (Berliner and Barbieri, 1984).

Families of victims and professionals involved with them often fear that the legal process will be more traumatic to the child than the assault itself (Holmstrom and Burgess, 1973; Nadelson and Rosenfeld, 1980). They worry about insensitive or untrained personnel, unnecessary interrogations, delays and costs. Such trauma has been labelled, "system induced trauma" (MacFarlane, Jones and Jenstrom, 1980) or "iatrogenic trauma" (Schultz and Jones, 1983). Greenwood (1983)

discusses effects of court proceedings on children and makes suggestions for court reform.

There is always at least a small percentage of cases that actually go to trial where children must testify. In a study by Rogers (1980), previously cited, it was discovered that only 8 out of 261 cases over a two year period in Washington, D.C. actually went to court. The study is limited in that the data may not be representative of the rest of the nation (Goodman, 1984).

Concerned law enforcement and mental health professionals have developed special approaches for handling cases involving child witnesses (Berliner and Barbieri, 1984; Burgess and Holmstrom, 1978; Nadelson and Rosenfeld, 1980). Children in some communities are prepared to testify by a trip to a courtroom, a practice session on the witness stand, and an explanation of the court process. A model for evaluation and preparation of children for trials has been developed (Harris and Samson, 1982). Some professionals recommend an advocate for the child and family and information pamphlets for the families who are involved in the court process (Conte, Berliner and Nolan, 1980).

In recent years, when a case of child sexual abuse went to trial, some prosecutors have promoted

the inherent credibility of children because the testimony of the child was so crucial (Berliner, 1985). Demonstrations by the child with dolls or drawings have been allowed and there have been limitations on direct and cross-examination of the child (ie., "Court Accepts," 1985). Prosecutors have introduced witnesses who enhance or support the testimony of the child (Berliner and Barbieri, 1984).

Many police departments now have sex crimes units in which the investigators may have special training in child sexual abuse and interviewing techniques with child witnesses (Berliner, 1985; Law Enforcement Commission, 1978; Nadelson and Rosenfeld, 1980; Stone, Tyler and Mead, 1984). Additional procedural reforms continue to be made in an attempt to accommodate the limitations of children and to minimize further trauma to them (Libai, 1977; Nadelson and Rosenfeld, 1980). The changes focus on reducing unnecessary interviews, delays and numbers of persons involved with the child witness (Law Enforcement Commission, 1978). Some communities videotape the interview of the child in order to minimize repeated questioning and occasionally, the videotape may be used in court (Berliner, 1985).

Clinical Interview Literature

Interviewing children typically requires departures from adult interview models, which may involve the provision of a play setting to encourage the child's spontaneous expression (Achenbach, 1982; Goodman and Sours, 1967; Looff, 1976; Rutter and Hersov, 1976). It has been recommended that the interviewer have a thorough knowledge of the following: normative behavior for developmental levels; how children typically separate from their parents and how they handle toys; and the potential effects of an unfamiliar situation which may include normal withdrawal, anxiety, or other behaviors (Achenbach, 1982). It is important to build a good relationship with the child (Looff, 1976). In interviews with suspected child sexual abuse victims, it is also important for the interviewer to possess knowledge of normal child sexual development and normal child sexual behavior (Constantine and Martinson, 1981).

Specific techniques and tools for interviewing child sexual abuse victims have been outlined (Adams-Tucker, 1984). Although portions of an initial interview by a therapist may be used by law enforcement professionals for prosecution, the primary purpose of a therapy assessment is to achieve a psychological understanding of the child; to learn about the sexual abuse and the

child's reactions; and to develop a sense of the child's coping and history before and after the sexual abuse. An interview that varies in technique based on the child's age, cognitive development and emotional style has been recommended (Adams-Tucker, 1984). The interview should focus on uncovering the child's symptoms, problems, worries, fantasies, dreams and making a diagnosis.

Specifically for the preschool child, "play" is considered the best mode for the interview (Adams-Tucker, 1984). Play allows for motoric enactment of what happened during the sexual abuse incidents and is the developmentally on-target technique for children so near their sensorimotor phase of cognition, following Piaget's model of development (Adams-Tucker, 1984). Some toys or play materials such as a doll house and a small-sized doll family and furniture and anatomically correct dolls are recommended. Paulson (1978) suggested a very similar approach to interviewing children. Other authors, Burgess and Holmstrom (1978) describe how to prepare for as well as how to conduct play interviews. The need to encourage the child to talk and to use appropriate media in play therapy assessments has been emphasized by Burgess, Holmstrom and McCausland (1978).

Rutter and Graham (1968) assessed the reliability and validity of standardized psychiatric playroom interviews for children aged 7 to 12. Interviews began in an unstructured fashion to help the child relax. Thereafter, the children were systematically asked about fears, worries, unhappiness, irritability and peer relationships. The interviewers chose the exact wording of questions but recorded their observations in predetermined categories, including: 1) no psychiatric abnormality, 2) some psychiatric abnormality, and 3) definite abnormality. When different interviewers assessed normal children on two occasions averaging 12 days apart, their ratings correlated .84 for the three categories. The ratings on specific items were much lower than the overall ratings.

Higher agreement on specific items was obtained when one rater interviewed disturbed children while the other rater watched, but the correlations between ratings on overall abnormality dropped to .74. Although adequate reliability could be obtained for the ratings in the three categories, reliability was still less for overall ratings of disturbed children than normals (Rutter and Graham, 1968). No such assessment of play interviews with children suspected of having been sexually abused has been done.

The same researchers (Rutter and Graham, 1968) assessed the validity of their procedure on children judged either normal or disturbed based on reports of teachers and parents. Blind to the teacher and parent reports, the interviewers diagnosed as abnormal only 25 percent of the boys and 43 percent of the girls in the "abnormal" group. This was significantly more than the proportion they diagnosed abnormal in the "normal" group (3 percent of the boys and none of the girls).

A structured interview composed of yes-or-no questions has been assessed for reliability. In addition, it was assessed for agreement between answers given by 6 to 16 year old children who were referred to a clinic and their mothers (Herjanic, Herjanic, Brown and Wheatt, 1975). Interrater reliability averaged 84 percent agreement, and test-retest reliability averaged 89 percent agreement where the same psychiatrist saw the child at two to three month intervals. Overall agreement between mothers and children was 80 percent, with the highest agreement (84 percent) being for factual items such as age, address, and reason for referral. Agreement was almost as good (83 percent) for symptoms such as phobias and somatic complaints, but worse (69 percent) for ratings of mental status, including memory,

insight and impulse control, based on the child and mother interviews. Another study by Herjanic and Campbell (1978) found that the interview can discriminate psychiatrically referred from nonreferred children.

Investigative Interview Literature

The investigative interview for alleged victims of crime has been well established (Blair, 1985; Royal and Schutt, 1979). The facts of a child sexual abuse case are usually obtained from the child victim, and it is rare that there are other witnesses or any physical evidence such as injury or infection (Sgroi, 1982). If necessary, the competency of the child may be evaluated during the investigative interview.

In order to elicit the most accurate and complete information from children, the interviewer must be sensitive and possess the necessary expertise (O'Brien, 1982; Friedemann and Morgan, 1985). The interview must be conducted in a way that the child understands the questions and feels comfortable enough to respond (Berliner, 1985; Law Enforcement Commission, 1978). Programs exist which provide interviewers with special training in effective communication with children about sexual matters, techniques for minimizing the child's fears, and explaining the criminal justice system.

The program in Seattle, Washington is an example (Conte, Berliner and Nolan, 1980). The Sexual Assault Center in Seattle, Washington has developed guidelines for criminal justice personnel who interview child victims (Schlesinger, 1982).

In addition to the interview guidelines which have been developed, aids to successful interviewing are often used, such as special interview rooms with or without a one-way mirror, toys and drawing materials and the presence of a support person (Berliner and Stevens, 1980; Friedemann and Morgan, 1985). Stember (1980) described the use of art therapy in the diagnosis and treatment of sexually abused children. Anatomically correct dolls can be made available to assist children in describing sexual activities (Analeka Industries, undated; Migima Designs, 1985; Harnest, 1983).

In discussing components of validation in child sexual abuse cases, Sgroi (1982) stated, "Validation hinges upon one's ability to interpret behavior, physical signs, and information elicited from investigative interviews within a conceptual framework for child sexual abuse" (p. 40). The author further stated, "It requires a fundamental understanding of the dynamics and mechanics of child sexual abuse, good interviewing skills, and a capacity to assess credibility of the

information elicited" (p. 40). She identified investigative interviewing as the most important component of the validation process, requiring the greatest skills and affording the best opportunity to collect information. It is Sgroi's contention that the emphasis on physical evidence and findings from physical examination of the victim has been misplaced since in most child sexual abuse cases there is little if any physical evidence.

A methodology was developed for investigative interviewing in child sexual abuse cases (Sgroi, 1982). The interview need not be done by a clinician but should be done by someone who has both investigative as well as clinical skills. Although the primary purpose of investigative interviewing is to uncover facts, the interview has the potential to be either therapeutic or traumatic to the child. The interviewer should concentrate on certain key issues: the continuum of exposure of the child to the reported sexual abuse; the child's terminology and clarification of its meaning; the child's sense of time, using special events to help date incidents; and the duration and type of sexual abuse (Sgroi, 1982). The setting for the interview should be neutral and the atmosphere relaxed. The interview has four phases, according to Sgroi (1982):

1) trust building; 2) fact finding; 3) exploring the child's expectations; and 4) planning for what will happen next.

Guidelines for interviewing sexually abused children have come from both mental health as well as law enforcement professionals. Because the purpose of mental health interviews is different than that of investigative interviews, the guidelines reflect the different emphases and may lead to inconsistencies. Several authors have described methods of using the anatomically correct dolls in interviewing children suspected of having been sexually abused (Adams-Tucker, 1984; Analeka Industries, undated; Clausen, 1985; Eaddy, 1981; Friedemann and Morgan, 1985; Kepler, 1984). However, none of these authors refer to any research supporting the methods which they recommend to professionals involved with suspected child sexual abuse victims. Furthermore, because the methods of using the dolls vary so much, it is difficult to formulate general statements about experiences with them.

Recent Research Using the Dolls

In reviewing the literature on the anatomically correct dolls, not one published study could be found;

however, one study was published in late 1986 when this study was in progress. A small number of unpublished studies was discovered through correspondence with the authors of the published study.

The published study was done at Celveland Metropolitan General Hospital by White, Strom, Santilli and Halpin (1986). The researchers compared responses of two groups of 2 to 6 year old children, 25 of whom were referred because of suspected sexual abuse and 25 of whom were nonreferred. They found significant response differences to the anatomically correct dolls. The children referred for suspected sexual abuse demonstrated significantly more sexually related behaviors when presented with the dolls than the other group. The authors argued for the use of a structured interview with the dolls and developed such an interview for their study.

Results were available on two unpublished studies involving the anatomically correct dolls. Jampole and Weber (1985) completed a study in Louisiana in which they compared behavior of ten children (determined to have been sexually abused) while they played with anatomically correct dolls with the behavior of ten children (not determined to have been sexually abused) while they played with the same dolls. They found

that significantly more children who had been sexually abused demonstrated sexual behavior with the dolls than did the other group of children. The level of significance reported was .005.

Sivan and Schor (1987) recently completed a pilot study in Iowa City, Iowa, in which they investigated the interactions of 144 nonreferred 3 to 8 year old children with the anatomically correct dolls under four conditions: 1) in the presence of an unobtrusive adult; 2) alone; 3) with an adult interviewer who conducted a standard interview; and 4) alone with the dolls undressed. They found that the dolls were not particularly interesting toys for these children. Also, aggression, in general and toward the dolls in particular was a rare event, even when the dolls were left undressed. The results suggested that the anatomically-correct dolls are are similar to other toys and that unusual behavior in interactions with the dolls should be taken seriously. The observations of the children in this study indicated that the doll play of non-abused children is not characterized by aggression and sexual concerns.

Four additional studies will be mentioned. The results for these studies were not available at the time of completion of this manuscript.

August and Forman (1985) compared the responses to the anatomically correct dolls of three groups of children (number of subjects unavailable): sexually abused, nonabused clinic population, and nonabused normals. They used three-minute videotape segments of the children in free play while left in a room alone with the dolls.

Esquilin (1986) investigated the differences in reactions to the anatomically correct dolls between 20 abused and 20 nonabused 2 to 6 year old children. The children were sampled from the inpatient population at Children's Hospital of New Jersey and were interviewed by a female psychology student under structured and unstructured conditions. A similar study was planned by Gundy (1986) in Little Rock, Arkansas.

Boat and Everson (1985) interviewed 315 professionals in North Carolina (attorneys, law enforcement personnel, protective service workers, mental health clinicians, etc.) as to how they did or did not use the anatomically correct dolls, what actions they interpreted to indicate sexual abuse and what behaviors were considered normal in interactions with the dolls. The results of this study are anticipated in Fall, 1987.

Summary

Because of the flood of reports of child sexual abuse cases in recent years, professionals have been put in the position of needing to develop methods for interviewing child sexual abuse victims without the benefit of research to support their methods. The need for research regarding interviews with the anatomically correct dolls is beginning to be addressed by the studies cited in the last section of this chapter and by this study.

This study represents an attempt to integrate mental health and criminal justice expertise in order to further our knowledge about the interview process with child sexual abuse victims. By reviewing clinical as well as investigative interview literature, important aspects of both were integrated into an interview format for this study. A model program in which mental health professionals work cooperatively with justice system personnel in handling child sexual abuse cases was developed by Conte, Berliner and Nolan (1980). The same authors argued that professionals who work with children have valuable knowledge of child development and techniques for interviewing children which can benefit the legal system.

There were no published studies dealing with children's reactions to the anatomically correct dolls when this study was begun. However, one study was published in late 1986 which provided some evidence that sexually abused children exhibit more sexual behavior when interviewed with the dolls than do nonabused children (White, Strom, Santilli and Halpin, 1986). A more modest study by Jampole and Weber (1985) provided similar results.

Sivan and Schor (1987) recently found that the doll play of nonabused children is not characterized by aggression and sexual concerns. The anatomically correct dolls appeared similar to other toys based on the nonabused children's reactions to them.

Four additional studies regarding the dolls were mentioned. However, results were not yet available for these four studies.

CHAPTER 3

METHODOLOGY

This study was designed to compare reactions of two groups of children during interviews with the anatomically correct dolls. Four categories of behavior were examined. The study attempted to test an assumption of professionals who use the dolls: that children who have been sexually abused respond differently to interviews with the dolls than do children who have not been sexually abused. The study also examined the children's behavior in structured versus free play situations with the anatomically correct dolls. The research methods employed are presented in this chapter, including the sample selection process, specification of the independent and dependent variables, instrumentation, data collection procedures and limitations of the study.

Description of the Sample

The sample consisted of 22 children, ages 2 to 6 years. The subjects were recruited from the outpatient clinic population of a mental health center in the southwestern United States. Half of the sample consisted of children who were referred to the clinic

because of suspected sexual abuse. The other half consisted of children who were referred for other reasons. Intake workers and children's clinicians at the clinic were primarily responsible for identifying potential subjects for the study. Cases involving children who were the focus of custody battles were eliminated from the study because they were believed to have a high frequency of false reports (Raskin, 1986). The study was explained to the parents of potential subjects by clinic staff in both verbal and written forms and the voluntary nature of participation emphasized (Appendix E). Confidentiality was insured by coding data rather than use of names identifying subjects. Parents of subjects signed parental consent forms prior to their child's participation in the study (Appendix D).

The 2 to 6 year old category was chosen for this study because this is the age group for which a play interview is most appropriate due to the young child's limited cognitive and verbal skills. Tools such as the anatomically correct dolls have been recommended for use in interviews with this age group (Adams-Tucker, 1984).

Procedures

The groups of children referred for suspected sexual abuse and children referred for other reasons were matched as they were referred as closely as possible with regards to sex, age, racial/ethnic group and developmental level. Subjects were randomly assigned to either of the two orders of presentation of the interview formats: 1) structured then free play or 2) free play then structured. The sample was divided into four groups of 5 or 6 for some comparisons. The four groups are as follows:

1. children referred because of suspected sexual abuse who receive the structured then free play interview formats;
2. children referred because of suspected sexual abuse who receive the free play then structured interview formats;
3. children referred because of other reasons who receive the structured then the free play interview formats; and
4. children referred because of other reasons who receive the free play then structured interview formats.

As indicated above, the children were interviewed using both a structured format and a free play format

with the anatomically correct dolls present in both interview formats. The complete structured and free play formats appear in Appendix A.

Prior to the interview each child was brought to the mental health clinic by either a parent or guardian. They were met in the waiting room by the interviewer who introduced herself and explained to the child that the parent would remain in the waiting room (which is in close proximity to the play interview room) while the child visited with the interviewer in the play room.

The basics of the structured interview included:

1. knowledge of body parts by name and function;
2. preliminary abuse evaluation; and
3. abuse elaboration.

The basics of the free play situation included;

1. the child led the play; and
2. the interviewer used reflective listening, as described in Virginia Axline's Play Therapy (1947).

Interviews

The total amount of time spent in each interview was 60 minutes, with approximately half of the time for the structured interview and the other half for

the free play situation. The interviewers were two female clinicians experienced in child sexual abuse interviewing and trained in the formats used for the study. Each interviewer was to complete a total of 20 interviews; however, one was unable to continue the study after only 2 interviews. The interviewers were blind to the referral status of the children who participated.

The interviews were observed by two trained raters from behind a one-way mirror. The raters were a graduate student in counseling and a master's level clinician who were trained prior to beginning the study in how to complete the Behavioral Checklist (Appendix C), an instrument designed for the study. The raters practiced completing the Behavioral Checklist while observing the interviewers role playing the interview formats for the study. Reliability coefficients were determined between raters for the practice sessions and then for the first five actual interviews before proceeding with the rest of the study. Interrater reliability was determined for the entire study and is reported in Chapter 4 with the other coefficients.

Design and Variables

This study is an example of ex post facto research. An experimental design was not feasible for this study

since the variable of victim status cannot be manipulated. Because of the inherent weaknesses of such research and the small sample, the results must be treated with caution.

Two groups were used for comparison: children referred to a local mental health clinic because of suspected sexual abuse and children referred to the same clinic because of other problems. All children were exposed to interviews using anatomically correct dolls. The interviews were varied so that half of each group received the structured interview format first and then the free play format and the other half of each group received the reverse presentation of the formats.

The independent variables included:

1. referral status
    a. referred because of suspected sexual abuse;
    b. referred because of other difficulties.
2. presentation of interview formats
    a. structured format then free play;
    b. free play then structured format.

The dependent variables included:

1. frequency counts of relevant behaviors;
2. clinical judgement of the interviewer as

to the likelihood of victim or nonvictim status of each child interviewed using a five point Likelihood of Victimization Scale (Appendix B).

The dependent variables bear further explanation. The frequency counts of relevant behaviors were completed by the trained raters who observed the interviews from behind a one-way mirror and recorded the behaviors specified on the Behavioral Checklist for each 3 minute segment of the interview. The behaviors listed were divided into four categories: 1) sexual behavior; 2) anger/aggression; 3) anxiety/regression; and 4) avoidant behavior.

The interviewers made clinical judgements following each interview as to the likelihood that the child interviewed was or was not a victim of sexual abuse. The five categories from which they chose in rating each case included: 1 - very unlikely a victim; 2 - somewhat unlikely a victim; 3 - difficult to determine; 4 - somewhat likely a victim; and 5 - very likely a victim.

Behavioral Checklist

The Behavioral Checklist was developed by compiling a list of behavior symptoms noted in the professional

literature to be indicators of child sexual abuse (Kempe, 1984; Kepler, 1984; The National Center on Child Abuse and Neglect, 1980; Schultz and Jones, 1983; Sgroi, 1982). Only symptoms which could be observed in an interview situation were included in the list; therefore, some symptoms such as bedwetting and nightmares had to be eliminated from inclusion on the checklist.

The list includes 30 behavioral indicators of child sexual abuse. Sgroi (1982) introduced her descriptions of behavioral indicators with the following statements: "A child's behavior may directly indicate or strongly suggest that he or she is a subject of sexual abuse. Recognizing behavioral indicators is an important part of the validation process and should begin in the initial interview. Although the presence of some of these indicators may be halpful, they are not conclusive" (p. 40). Sgroi noted that some combination of these behaviors may be seen in child sexual abuse victims.

The behavioral indicators lent themselves to organization into four logical categories: 1) sexual behavior; 2) anger/aggression; 3) anxiety/regression; and 4) avoidant behavior. The trained observers checked boxes for behaviors which occurred during three-minute intervals of each interview.

The observers were trained in the use of the Behavior Checklist first by discussing the items with the researcher and agreeing on what constituted the behavior listed. Then they observed role plays of the interview formats developed for the study and practiced completing the checklist forms. Interobserver reliability coefficients were determined for the role play interviews, the first five actual interviews, and the total study and are reported in Chapter 4. The correlations of the four categories of the checklist with the total checklist were computed as measures of internal consistency. The coefficients are also reported in Chapter 4. The Behavioral Checklist is in Appendix C.

Minnesota Child Development Inventory (MCDI)

Prior to a child's scheduled interview, the parent or guardian completed a Minnesota Child Development Inventory (MCDI). In some cases, the instrument was completed at the actual interview. The purpose of using this instrument was for matching subjects on developmental level. The answer sheet contained blanks to fill in for the child's sex, birth date and racial/ethnic group as well so that all matching criteria could be obtained from one form for each subject.

The MCDI (Ireton and Twing, 1972) measures the development of adaptive behavior for 1 to 6-year olds according to the parent/guardian's report. It provides a picture of a child's development on eight developmental scales. Results are interpreted in reference to age norms for each sex as developmentally retarded, borderline, or within normal limits. It must be noted that the norms are based on a sample of 796 white children, age 6 months to 6½ years, from Bloomington, Minnesota, and therefore, may not be a valid assessment tool for the population sampled in this study. However, the instrument was meant only to provide the researcher with a gross indicator of the level of each subject's development for the purposes of the study.

Limitations of the Study

The study contained a number of limitations which must be noted. As previously mentioned, ex post facto research contains some inherent weaknesses. Kerlinger (1973) pointed out three of these. First, there is the lack of control of the independent variable, in this study, the referral status of the subjects. Secondly, it is not possible to assign subjects randomly

to groups. And, thirdly, the results may be subject to improper interpretation if one is not cautious.

The sample was very small and reflected children in one age group from the outpatient clinic population of a mental health center in the Southwest during a period of several months from fall, 1986 through spring, 1987. Generalizability to other populations may be limited.

It is difficult to obtain external validation of the children's reports in order to determine which cases are true sex abuse cases and which are not. The researcher assumed that there were more true cases in the group referred because of suspected sexual abuse than in the other group.

Ethical Considerations

All children who participated in the study had parental permission to be involved (Appendix D). The children were interviewed as soon as possible following the initial referral for suspected sexual abuse victims to facilitate the child's memory of any sexual abuse experiences and to expedite the child's psychological treatment. When a child indicated that he or she had been sexually abused, a referral was made to the appropriate authorities and the child received necessary follow

up services. The parents were informed of this potential before they signed consent forms giving permission for their children to participate in the study.

Hypotheses

The following hypotheses were made regarding the interviews of the children using anatomically correct dolls.

H_1: Children referred to the mental health center for suspected sexual abuse react differently to interviews with anatomically correct dolls than do children referred for other reasons.

H_2: Children referred to the mental health center for suspected sexual abuse have higher scores on the Behavioral Checklist than children referred for other reasons.

H_3: Children who rate high on the Behavioral Checklist will tend to rate high on the Likelihood of Victimization Scale.

CHAPTER 4

RESULTS

The goal of this study was to test an assumption held by therapists who work with children. The assumption is that children who have been sexually abused react differently to interviews with anatomically correct dolls than children who have not been sexually abused. The findings are presented in this chapter.

A description of the sample is presented first, followed by a description of reliability and validity information concerning the Behavioral Checklist which was designed for the study. The results of the study are then presented.

Description of the Sample

Subjects were obtained from the outpatient population of a mental health center in a city in the southwestern United States. Subjects were recruited from two outpatient clinic locations, one on the west side and the other on the east side of the same city. The west side location serves a primarily Hispanic and low socioeconomic population. The east location serves a primarily white middle class population.

An attempt was made to obtain 20 subjects from each clinic, for a total of 40 subjects. However, only two subjects were obtained from the west clinic for a number of reasons. Shortly after the study was underway, an administrative decision was made at the west clinic to stop accepting new referrals for the preschool program for an unspecified period of time while therapists provided services to a particular population under a special contract. This unexpected change in the normal referral process was in effect during a good part of the time frame of the study.

An additional obstacle was posed at the west clinic. Four observers (two primary observers and two back up observers) and two interviewers were trained for the study during two instructional and two role play sessions. Shortly after the study was implemented and after completing only two interviews, the interviewer for the west clinic dropped out of the study due to pressures from additional job responsibilities. The interviewer for the east clinic did complete the 20 interviews planned for her. The total sample, therefore, was 22 instead of the hoped for 40 subjects.

Because of the unanticipated difficulty in obtaining referrals that met the original proposed age range of 3 to 5 years of age, the age range criteria

was expanded to include 2 to 6 year olds. This change in age criteria made it possible to include 8 subjects from the 2 and 6 year old categories who would not have otherwise been considered for the study. The expanded age range adds to the generalizability of the findings.

The subjects were matched on sex and then as closely as possible on age, racial/ethnic group and developmental level. Because subjects were matched as they were referred for the study, while it was actually in progress, exact matches on all criteria could be made in four of the eleven matched pairs. The variable of sex was matched in all eleven pairs. Racial-ethnic group was matched in nine of the eleven pairs. Age (within six months) was matched in seven of the eleven pairs. Developmental level was matched to within a year in five of the pairs and to within a year and a half in seven of the eleven matched pairs. The sample characteristics are presented in Table 1.

In two referrals for the study, parents refused to allow their children to be interviewed after hearing the description of the interview. In both cases the parents felt that their children had not been sexually abused and didn't want to expose them

Table 1. Sample Characteristics (n = 22)

	Suspected Sexual Abuse	Other
Sex		
Male	7	7
Female	4	4
Age		
2 years	1	3
3 years	0	3
4 years	2	1
5 years	6	2
6 years	2	2
Ethnic Group		
White	8	6
Hispanic	3	5
Black	0	0
Native American	0	0
Asian	0	0
Other	0	0
General Developmental Level (on MCDI)		
2 years 3 months	0	1
2 years 6 months	0	1
2 years 9 months	0	2
3 years	2	0
3 years 3 months	0	0
3 years 6 months	0	0
3 years 9 months	1	1
4 years	0	1
4 years 3 months	0	1
4 years 6 months	2	0
4 years 9 months	1	0
5 years	0	0
5 years 3 months	0	0
5 years 6 months	2	1
5 years 9 months	3	0
6 years	0	0
6 years 3 months	0	3

to the interview unnecessarily. Both cases were being recruited for the Other Referral category.

All twenty-two subjects obtained for the study completed the entire interview, which lasted approximately one hour. In two cases, interviews were rescheduled because in one case, the child was irritable and tired and in the other, the child was oppositional and refused to continue. Both children successfully completed the interviews upon their second visits.

Interobserver Reliability

The observers were trained by studying the Behavioral Checklist, discussing examples of the categories, clarifying some ambiguous items, and completing two role play sessions in which they filled in the Behavioral Checklist while the two interviewers role played the interview formats. Interobserver reliability was computed using Pearson Product-Moment correlation formula. The interobserver reliability coefficient was .4826 for the total checklist in the role play sessions. The observers were given feedback as to their level of agreement, and they discussed categories in which there were discrepancies and agreed on clearer definitions of the behaviors listed.

Interobserver reliability on the overall checklist for the first five actual interviews was

computed as a coefficient of .7162. For the four categories of the checklist the coefficients ranged from .5535 to .9792. Observers once again were given feedback as to the level of agreement on the categories and on specific items. They further clarified their understanding of the behaviors listed on the checklist.

Interobserver reliability coefficients were computed for the entire study on the Behavioral Checklist and on the four categories of the checklist using the Pearson Product-Moment correlation formula. The coefficients are presented in Table 2. The interobserver reliability coefficient for the checklist was .8769 while the range of coefficients for the four categories of the checklist was from .6894 to .9702.

Internal Consistency of Behavioral Checklist

Pearson Product-Moment correlation coefficients of the relationship between the total Behavioral Checklist and each of the four categories of the checklist were computed as measures of internal consistency. The coefficients for the categories were: Sexual Behavior, .5834; Anger/Aggression, .4163; Anxiety/Regression, .5345; and Avoidant Behavior, .5344.

Table 2. Correlations for Interobserver Reliability On All Interviews

Interview Format	Behavioral Checklist Category			
	S.B.	Ang.	Anx.	Avo.
Structured	.7807	.9373	.9425	.9031
Play	.6894	.9702	.9143	.8780
Both	.8769	.7351	.9284	.8906

Univariate Analysis of the Relationship Between Suspected Sexual Abuse Referrals and Other Referrals

Analysis of variance procedures were employed to test Hypothesis One: Children referred to the mental health center for suspected sexual abuse react differently to interviews with anatomically correct dolls than do children referred for other reasons. Anlyses were done on the total checklist scores, the scores for the four categories of the checklist, and on the play and structured portions of the interviews. Group differences on total checklist scores did not show significance at the .05 alpha level. However, the differences between groups for the Sexual Behavior and Anger/Aggression categories of the checklist were significant at .05. The group difference for Anxiety/ Regression was not significant. For the Avoidant category an effect occurred due to the interview format. The group which received the Structured/Play interview format scored significantly differently than the group which received the Play/Structured format. There was no significant difference between referral groups on the Avoidant category. The results are presented in Tables 3 through 7.

Analysis of variance procedures were used to examine the differences between the two referral groups

Table 3. Analysis of Variance Results Depicting the Relationship Between Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons on the Behavioral Checklist

Source	Sum of Squares	df	Mean Square	F	Level of Significance
Referral Group	627.41250	1	627.41259	2.49	.1318
Format Presentation	179.81856	1	179.81856	.71	.4090
Interaction	.00341	1	.00341	.00	.9971
Error	4530.04167	18	251.66898		

*Significant at < .05.

Table 4. Analysis of Variance Results Depicting the Relationship Between Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons on the Sexual Behavior Category of the Behavioral Checklist

Source	Sum of Squares	df	Mean Square	F	Level of Significance
Referral Group	101.24583	1	101.24583	4.87	.0406*
Format Presentation	48.27614	1	48.27614	2.32	.1450
Interaction	2.01856	1	2.01856	.10	.7590
Error	374.34167	18	20.79676		

*Significant at < .05.

Table 5. Analysis of Variance Results Depicting the Relationship Between Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons on the Anger/Aggression Category of the Behavioral Checklist

Source	Sum of Squares	df	Mean Square	F	Level of Significance
Referral Group	264.10038	1	264.10038	6.23	.0225*
Format Presentation	.98523	1	.98523	.02	.8805
Interaction	1.14583	1	1.14583	.03	.8713
Error	763.14167	18	42.39676		

*Significant at < .05.

Table 6. Analysis of Variance Results Depicting the Relationship Between Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons on the Anxiety/Regression Category of the Behavioral Checklist

Source	Sum of Squares	df	Mean Square	F	Level of Significance
Referral Group	1.27424	1	1.27424	.01	.9219
Format Presentation	107.20606	1	107.20606	.83	.3741
Interaction	18.00152	1	18.00152	.14	.7131
Error	2322.38333	18	129.02130		

*Significant at < .05.

Table 7. Analysis of Variance Results Depicting the Relationship Between Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons on the Avoidant Behavior Category of the Behavioral Checklist

Source	Sum of Squares	df	Mean Square	F	Level of Significance
Referral Group	0.01856	1	0.01856	.00	.9857
Format Presentation	317.13068	1	317.13068	5.62	.0291*
Interaction	44.56402	1	44.56402	.79	.3858
Error	1015.44167	18	56.41343		

*Significant at < .05.

for the structured and the play portions of the interviews. No significant difference was found between the two groups on either the play or the structured portions of the interviews. See Tables 8 and 9 for these results.

Two-way univariate balanced analysis of variance procedures were also used to test Hypothesis Two: Children referred to the mental health center for suspected sexual abuse have higher scores on the Behavioral Checklist than children referred for other reasons. The differences between the two referral groups on the total checklist and on the Anxiety/Regression and Avoidant categories were not significant and thus do not support the hypothesis. However, the differences between the two groups on the Sexual Behavior and Anger/Aggression categories were significant and were found to differ in the expected direction. On both of these categories, Sexual Behavior and Anger/Aggression, the group means of the Suspected Sexual Abuse Referrals were consistently higher than those of the Other Referrals for both interview formats, Structured/Play and Play/Structured. The relationships are graphed in Figures 1 and 2. Thus, some support is lent by the data for Hypothesis Two.

Table 8. Analysis of Variance Results Depicting the Relationship Between Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons in the Structured Portion of the Interview on the Behavioral Checklist

Source	Sum of Squares	df	Mean Square	F	Level of Significance
Referral Group	113.33674	1	113.33674	.98	.3358
Format Presentation	27.00341	1	27.00341	.23	.6351
Interaction	144.20038	1	144.20038	1.24	.2793
Error	2085.84167	18	115.88009		

*Significant at < .05.

Table 9. Analysis of Variance Results Depicting the Relationship Between Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons in the Play Portion of the Interview on the Behavioral Checklist

Source	Sum of Squares	df	Mean Square	F	Level of Significance
Referral Group	207.42424	1	207.42424	1.72	.2059
Format Presentation	67.45606	1	67.45606	.56	.4639
Interaction	145.60606	1	145.60606	1.21	.2860
Error	2167.48333	18	120.41574		

*Significant at < .05.

Figure 1. Graphic Representation of the Relationship Between Scores of Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons on the Sexual Behavior Category of the Behavioral Checklist in Play/Structured and Structured/Play Format Presentations

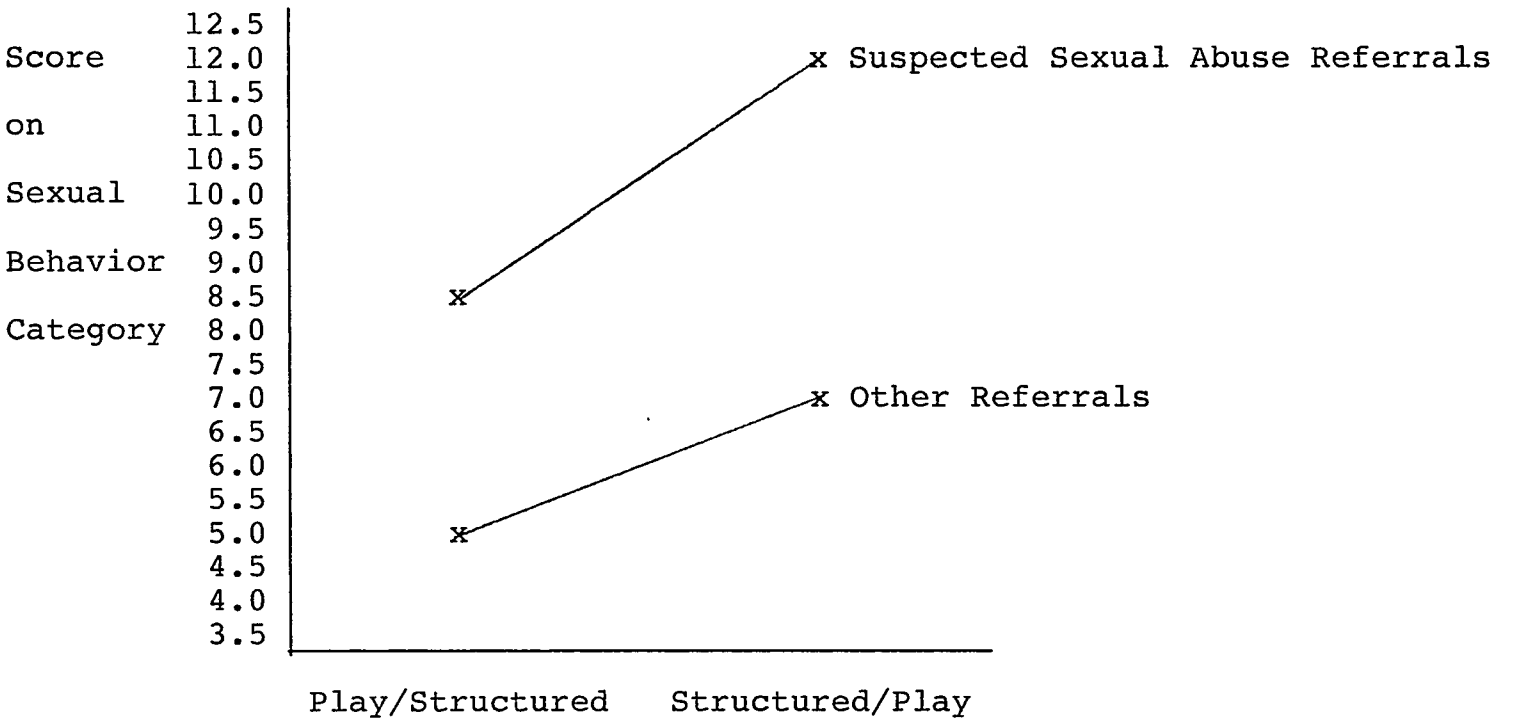
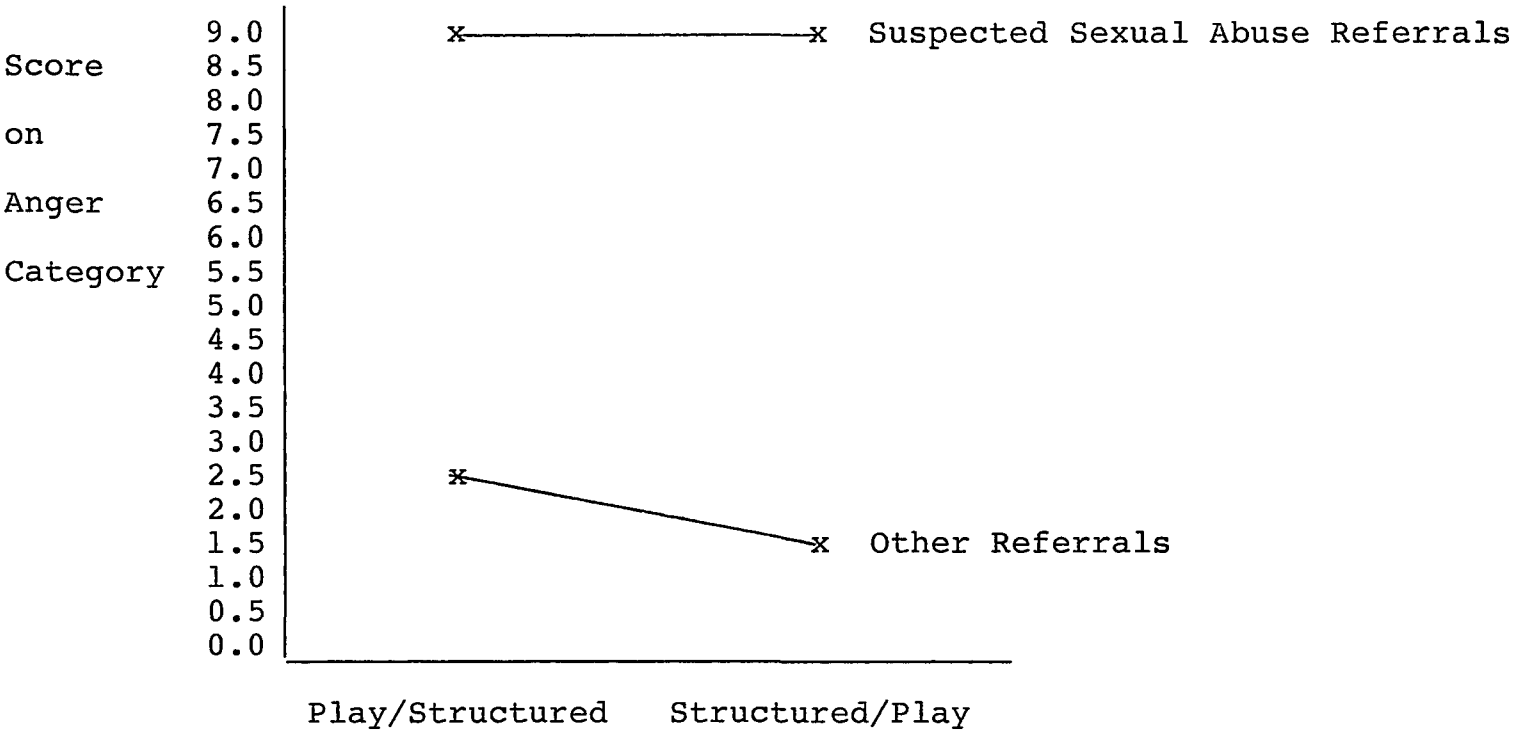


Figure 2. Graphic Representation of the Relationship Between Scores of Children Referred for Suspected Sexual Abuse and Children Referred for Other Reasons on the Anger/Aggression Category of the Behavioral Checklist in Play/Structured and Structured/Play Format Presentations



Hypothesis Three was tested by means of a Pearson Product-Moment correlation coefficient for the relationship between the scores on the Behavioral Checklist and the scores on the Likelihood of Victimization Scale as well as correlation coefficients for the relationships between scores on each of the four categories of the checklist and the Likelihood of Victimization Scale. The correlation coefficient for the overall checklist with the Likelihood of Victimization Scale was .0682, and thus, did not lend support for the hypothesis. However, the correlations for the two categories of Sexual Behavior and Anger/Aggression with the Victimization Scale were considerably higher, .0412 and .4139 respectively. These were tested for statistical significance using a one tailed test of critical r. The critical r value was determined to be .3599. Both correlation coefficients surpassed this critical value and were determined to be statistically significant. These results supported Hypothesis Three.

The Anxiety/Regression category of the Behavioral Checklist was unexpectedly negatively correlated with the Likelihood of Victimization Scale with a coefficient of -.4187. In other words, high scores on the Anxiety/Regression category were related to low scores on the

Likelihood of Victimization category and vice versa. The Avoidant category was very low in correlation with the Likelihood of Victimization Scale with a coefficient of .0788. These results failed to lend additional support for the hypothesis.

Summary

The results of the study of the reactions of two groups of children to interviews using the anatomically correct dolls were presented in this chapter. The sample characteristics indicated essential similarity of the two groups on the variables of sex, age, and racial/ethnic group and as close as possible similarity on the variable of developmental level.

Interobserver reliability was reported for the role play sessions, the first five actual interviews and the entire study. It improved dramatically from the role play to the first five interviews and improved further in the following interviews. Procedures utilized to improve interobserver reliability in this study were described. Overall interobserver reliability coefficients for the total checklist and the four categories in the play and structured portions of the interviews ranged from .6894 to .9702.

Internal consistency of the Behavioral Checklist was measured through Pearson Product-Moment correlation

coefficients between each of the four categories of the Behavioral Checklist and the total checklist. The coefficients ranged from .4163 to .5834.

Multiple univariate analyses of variance were employed to test Hypotheses One and Two. The data were analyzed by a comparison of the scores of the two referral groups on the Behavioral Checklist and on the four categories of the checklist. Also analyzed were the scores for the two groups on the play and the structured portions of the interviews. The data lent some support for both Hypotheses One and Two.

Hypothesis Three was tested by employing Pearson Product-Moment correlations for the relationship between scores on the Behavioral Checklist and the Likelihood of Victimization Scale and between each category of the checklist and the Likelihood of Victimization Scale. The data provided some support for Hypothesis Three.

CHAPTER 5

CONCLUSIONS AND IMPLICATIONS

Conclusions from the results obtained in the study are discussed in this chapter. The implications for clinical interviews using the anatomically correct dolls and for future research are examined.

The Sample

The generalizability of the results of this study are limited. The subjects were drawn primarily from the population of one outpatient mental health clinic in the southwestern United States. They represent a group of children of both sexes, between the ages of 2 to 6 years, of Hispanic and white ethnic groups. External validity limitations of this study can be resolved through replication with more diverse populations.

The sample characteristics suggested an internal validity threat due to greater than desired differences between referral groups in developmental level. Subsequently, a univariate analysis was conducted to ascertain the strength of the correlations between scores on the Behavioral Checklist and developmental

level as measured by the Minnesota Child Development Inventory (Ireton and Thwing, 1972). Obtained correlations ranged between -.3156 and .1125. None of the values were significant at .05 alpha, suggesting that developmental level did not significantly affect the scores on the Behavioral Checklist.

The difficulty in obtaining the expected number of subjects was unanticipated, yet one of the hazards of research in a field setting such as a community mental health center. The two cases in which the parents refused to allow their children to participate brought out a concern by some parents that exposure of children to a screening interview such as the one developed for this study could be harmful to their children. There was no indication of harm to any of the children who were interviewed either during or after the interviews. A number of children did report sexual abuse experiences and appropriate authorities were notified and the children in question were given appropriate follow up treatment.

A large number of the children attended the prevention program offered to the participants and their families at the conclusion of the study. The focus of the program was safety and assertiveness skills.

Two film strips, music and discussion were utilized in this presentation at the east clinic location in May, 1987 (Appendix F).

Differences in the Reactions of Two Groups of Children to Interviews with Anatomically Correct Dolls

Hypothesis One stated that children referred to the mental health center for suspected sexual abuse react differently to interviews with anatomically correct dolls than do children referred for other reasons. This hypothesis was supported by some of the data. Specifically, children who have been referred to a mental health center because of suspected sexual abuse exhibit more sexual and angry behavior during interviews with anatomically correct dolls than do children referred to a mental health center for other reasons.

Hypothesis Two stated that children referred to the mental health center for suspected sexual abuse have higher scores on the Behavioral Checklist than children referred for other reasons. The children referred for suspected sexual abuse scored significantly higher on both the Sexual Behavior and the Anger/ Aggression categories of the Behavioral Checklist. Mean scores on the Sexual Behavior category were 10.29 for the suspected sexual abuse referrals and 5.985

for the other referrals. Mean scores on the Anger/ Aggression category were 8.815 for the suspected sexual abuse referrals and 1.86 for the other referrals. The results regarding the Sexual Behavior category are consistent with those of White, Strom, Santilli and Halpin (1986) and with those of Jampole and Weber (1985). The results regarding the Anger/Aggression category indicate another way in which children referred for suspected sexual abuse react differently to interviews with anatomically correct dolls than children referred for other reasons. Sivan and Schor (1987) reported that normal children do not exhibit aggressive or sexual behavior when around the dolls, even when the dolls are undressed.

The scores on the total checklist and on the categories of Anxiety/Regression and Avoidant Behavior did not indicate significant differences between the two referral groups. However, on the Avoidant category there were significant differences in scores of the group which received the Structured/Play format as compared to the group which received the Play/Structured format across referral groups. The group which received the Structured/Play format scored higher on Avoidant Behavior than the group which received the Play/Structured format regardless of referral group.

In other words, avoidant behavior was more likely in a situation that was initially structured in which the anatomically correct dolls were used in interviewing a child.

One possible explanation for these results is that in such a situation, there was more of an immediate demand on the child to "perform" for the interviewer. Whereas, in the situation in which the child initially was allowed to play and explore freely, the child had time to become comfortable in the strange surroundings and with the interviewer and to explore the toys that might otherwise distract when he/she first entered the room. Children are likely to suffer from embarrassment from an interview with a stranger in which the interviewer starts almost immediately with questions about body parts.

If this is the case, clinicians and law enforcement personnel would be advised to allow the suspected child victim time to get accustomed to the surroundings and the interviewer before structuring the interview. Such an approach has been recommended by a number of authors (Achenbach, 1982; Looff, 1976; Rutter and Graham, 1968; White, Strom, Santilli and Halpin, 1986).

Hypothesis Three stated that children who rated high on the Behavioral Checklist will tend to rate

The correlation for the total checklist with the Likelihood of Victimization Scale was not statistically significant. However, the correlations for each of the two categories, Sexual Behavior and Anger/Aggression, with the Likelihood of Victimization Scale were significant at the .05 level. This data supports the hypothesis. It implies that children who exhibit a high frequency of sexual and angry behaviors are more likely to be judged by clinicians to be victims of sexual abuse than other children.

The Anxiety/Regression category was negatively correlated with the Likelihood of Victimization Scale. The Avoidant Behavior category was very low in correlation with the Likelihood of Victimization Scale. These results do not add further support for the hypothesis.

Implications for Future Research

Although the Behavioral Checklist designed for this study is a relatively unsophisticated instrument, it showed some promise in distinguishing children who may have been sexually abused from other children. The Sexual Behavior and Anger/Aggression categories were especially useful in this regard. These same two categories were significantly correlated with

the Likelihood of Victimization Scale which was completed by the interviewer.

A number of procedures would make for a more rigorous study of interviews of children using the anatomically correct dolls. A larger sample would be desirable. In addition, stricter criteria for the two groups would make for results which would apply more directly to the population of concern: children who have been sexually abused. The criteria for the Suspected Sexual Abuse Referrals might include only children who have made specific statements that they had been sexually abused, cases in which there was a witness to the sexual abuse or in which there were more than one alleged victim, and cases in which the offender confessed to the sexual abuse. A comparison group of nonreferred children from local preschools and kindergartens would be useful in addition to a group referred for other reasons as used in this study. Closer matching of subjects would provided greater control of variables. Particularly, developmental level could be matched more closely.

Videotaping of interviews would allow for better training and feedback for the observers and thus, improve interobserver reliability within the very first interviews. The observers could stop the

videotape at any point or review segments as many times as necessary in order to clarify ratings or behavior. Various professional groups could rate the videotaped interviews on the Likelihood of Victimization Scale and the ratings of the different groups could be compared to determine level of agreement. These groups might include: therapists, law enforcement personnel, child protective service workers, pediatricians, school nurses and day care workers. These are some of the professionals who detect signs of sexual abuse in children. As in this study, it is important for the raters to be blind to the referral status of the children in the interviews.

Implications for Clinical Interviews

The interview utilized in this study appeared helpful as a screening tool for children who are suspected of having been sexually abused. In fact, the interviewer who did the majority of the interviews has continued to use the interview format in the initial screening evaluations of the young children whom she evaluates. She adapted the interview for younger children by shortening the length of time spent with them as they tend to have shorter attention spans and to be more affected by separation anxiety and therefore, are not able to be away from their parents or caretakers as long as older children.

If equipment were available, clinicians could videotape interviews and use the Behavioral Checklist, or at least the first two categories of it in rating the behaviors which occurred during the interview. Videotapes would provide an audiovisual record of the behaviors listed on the Behavioral Checklist as well as other behaviors which the interviewer believes to be significant.

The findings regarding the Avoidant Behavior category of the Behavioral Checklist in which the group who received the Structured/Play format scored significantly higher in the Avoidant Behavior category regardless of referral group are worth emphasis. They support the recommendations by numerous authors who advise that the child be allowed some unstructured time before structuring an interview (Achenbach, 1982; Looff, 1976; Rutter and Graham, 1968; White, Strom, Santilli and Halpin, 1986). Such an approach would hopefully eliminate some avoidant behavior on the part of the child and put him/her at ease.

Summary

The assumption of professionals who interview children that sexually abused children react differently to interviews with anatomically correct dolls than

other children found support in the results of this study. Specifically, children suspected of having been sexually abused scored significantly higher on the Sexual Behavior and Anger/Aggression categories of a Behavioral Checklist. Furthermore, scores on these categories correlated significantly with clinical ratings as to the likelihood of victimization.

The results of the study raised questions about the significance of anxious and avoidant behavior in identifying children who have been sexually abused. Further investigation is recommended to clarify the role of such behaviors in the population of focus.

Further studies are recommended with stricter criteria for inclusion into the suspected sexual abuse referral category in order to obtain results that are more directly generalizable to the population of children who have been sexually abused. The use of a comparison group of normals can add to the generalizability of the findings. Discriminant analytic procedures appear well suited for the further development of more sophisticated and more sensitive instrumentation for identifying children who have a high probability of having been sexually abused.

APPENDIX A

STRUCTURED AND FREE PLAY INTERVIEW FORMATS

STRUCTURED INTERVIEW FORMAT
USING ANATOMICALLY CORRECT DOLLS

For use in research by Joyce A. DeVoss, M.A.

ENVIRONMENT FOR INTERVIEW

The interview is to be conducted in a playroom containing the following items:

- Doll house and toy people
- Crayons and paper
- Clay
- Play telephone
- Anatomically correct dolls
- Children's table and chairs

INTRODUCTIONS

The interviewer should introduce herself to the parent and the child and explain to the parent that she will be taking the child into the play room where they will spend a while playing while the parent waits in the waiting room. Some time should be spent chatting with the parent to help the child feel more at ease in the presence of the interviewer before leading the child to the play room. In order to keep the child at ease, the interviewer should point out the way to the play room to the parent. The child will then know that the parent is aware of where he/she is during the interview. When it is time to take the child to the play room, state to the child, "I'm very happy that you have come to play with me today. Mom/Dad will wait here for us. Goodbye, Mom/Dad."

NOTE: If the child is too anxious to separate from the parent, have the parent walk with the child to the play room and look into the play room. Tell the child you will see him/her on another day and at that time you and he/she will play together while the parent waits for him/her.

BEGINNING THE INTERVIEW
PHASE I

Upon walking into the play room ask the child, "What should we do first?" Let the child choose and follow the child's lead for five minutes. Use the reflective listening approach. After five minutes of nondirected play, introduce the dolls as helpers in talking to children. Explain that they have all the parts of the human body. Tell the child to hand one doll to you and say,

Let's look at this doll.

Starting from the hair on the doll's head and working down, have the child identify the following body parts by pointing to them and saying,

What part is this?
What is this part for?

REPEAT THE CHILD'S WORDS FOR VERIFICATION AND IF NECESSARY, FOR CLARIFICATION, SAY,

Show me with the dolls.

NOTE: ALLOW THE CHILD TO UNDRESS THE DOLL IF HE/SHE WISHES TO DO SO. OTHERWISE, OPEN THE DOLL'S CLOTHES AS NEEDED TO SEE THE BODY PARTS.

HAIR
EYES
NOSE
EARS
MOUTH
CHIN
NECK
SHOULDER
BREAST
ARM
HAND
FINGERS
NAVEL
PENIS/VAGINA/CLITORIS
ANUS
LEGS
KNEES
FEET
TOES

Write down the child's terms for the parts of the body. Have the child choose another doll from the two of the opposite sex of the one already examined. Repeat the above process.

PHASE II

Holding the juvenile of the same sex as the child, ask: (REPEAT THE CHILD'S WORDS IN THE FORM OF A QUESTION, IF NECESSARY, FOR CLARIFICATION)

Has anyone touched you where you did not want to be touched?

Has anyone asked you to keep a secret about touching?

IF CHILD ANSWERS NO, GO ON TO PHASE III.
IF CHILD ANSWERS YES TO EITHER QUESTION, CONTINUE WITH PHASE II (A).

PHASE II (A)

Who?
What was that person's name?
Show me what happened with the dolls.

Anything else you remember?

PHASE III

What else can you tell me about the dolls or show me with them?

Anything else?

TERMINATION (OR IF FREE PLAY FORMAT FOLLOWS STRUCTURED INTERVIEW, FOLLOW THE FREE PLAY FORMAT BEFORE TERMINATION).

Tell the child that it will be time to put things away in a few minutes but that he/she still has enough time to play with any other toy for a while. Then watch the child for a few minutes, using reflective listening. Let the child know when it is time to put the toys away and as he/she begins to do so, thank him/her for coming to spend time with you and for answering your questions. Then tell him/her that you are both going back to the waiting room to see Mom/Dad.

FREE PLAY FORMAT USING ANATOMICALLY CORRECT DOLLS

For use in research by Joyce A. DeVoss, M.A.

ENVIRONMENT FOR INTERVIEW

The interview is to be conducted in a play room containing the following items:

- Doll house and toy people
- Crayons and paper
- Clay
- Play telephone
- Anatomically correct dolls
- Children's table and chairs

INTRODUCTIONS

The interviewer should introduce herself to the parent and the child and explain to the parent that she will be taking the child into the play room where they will spend a while playing while the parent waits in the waiting room. Some time should be spent chatting with the parent to help the child feel more at ease in the presence of the interviewer before leading the child to the play room. In order to keep the child at ease, the interviewer should point out the way to the play room to the parent. The child will then know that the parent is aware of where he/she is during the interview. When it is time to take the child to the play room, state to the child, "I'm very happy that you have come to play with me today. Mom/Dad will wait here for us. Goodbye, Mom/Dad."

NOTE: If the child is too anxious to separate from the parent, have the parent walk with the child to the play room and look into the play room. Tell the child you will see him/her on another day and at that time you and he/she will play together while the parent waits for him/her.

FREE PLAY

Upon walking into the play room ask the child, "What should we do first?" Let the child choose and play with no direction except what is needed to keep the child from hurting himself or herself or destroying objects in the play room.

FREE PLAY FORMAT Continued

Use the following play interview techniques suggested by Virginia Axline (1947):

1. Develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.

2. Accept the child exactly as he/she is.

3. Establish a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. Recognize the feelings the child is expressing and reflect those feelings back to him/her.

5. Maintain a respect for the child's ability to solve his own problems.

6. Do not attempt to direct the child's actions or conversation in any manner. The child leads; the interviewer follows.

7. Do not attempt to hurry the interview session.

TERMINATION (OR IF THE STRUCTURED INTERVIEW FORMAT FOLLOWS THE FREE PLAY FORMAT, FOLLOW THE STRUCTURED INTERVIEW FORMAT BEFORE TERMINATION).

Tell the child that it will be time to put things away in a few minutes but that he/she still has enough time to play with any toy for a while. Then watch the child for a few minutes, using reflective listening. Let the child know when it is time to put the toys away and as he/she begins to do so, thank him/her for coming to spend time with you and for answering your questions. Then tell him/her that you are both going back to the waiting room to see Mom/Dad.

APPENDIX B

LIKELIHOOD OF VICTIMIZATION SCALE

LIKELIHOOD OF VICTIMIZATION SCALE

INSTRUCTIONS:

As soon as possible following each interview for this study, complete this form in which you use your best clinical judgment based on the limited information you have about the child just interviewed. Circle the number of the category which best fits your assessment to this point as to whether the child has been sexually abused.

1 - VERY UNLIKELY A VICTIM OF SEXUAL ABUSE

2 - SOMEWHAT UNLIKELY A VICTIM OF SEXUAL ABUSE

3 - DIFFICULT TO DETERMINE

4 - SOMEWHAT LIKELY A VICTIM OF SEXUAL ABUSE

5 - VERY LIKELY A VICTIM OF SEXUAL ABUSE

APPENDIX C

BEHAVIORAL CHECKLIST

		1	2	3	4	5	6	7	8	9	10
SEXUAL BEHAVIOR	REPORTING SEXUAL ABUSE										
	EXPLICIT KNOWLEDGE										
	DOLL PLAY										
	HINTS/CUES										
	INVITATIONS										
ANGER/ AGGRESSION	HITTING										
	YELLING										
	NAME CALLING										
	THREATENING										
	PUNISHING										
ANXIETY/ REGRESSION	SIGHING										
	SCREAMING										
	ASKING AB. PARENTS'										
	PRESSURED SPEECH										
	STUTTERING										
	CRYING										
	SEP. ANXIETY										
	CLINGING										
	WHINING										
	THUMBSUCKING										
	BABY TALK										
	ROCKING/ WIGGLING										
	FETAL POSITION										
	PULLING OR PLAYING W/ HAIR										
	PICKING SKIN										
	OVERLY COMPLIANT										
AVOIDANT BEHAVIOR	WALKING AWAY										
	LOOKING AWAY										
	DECREASE IN VERBALIZING										
	DECREASE IN ACTIVITY										
	HIDING										
		1	2	3	4	5	6	7	8	9	10

APPENDIX D

PARENTAL CONSENT FORM

PARENTAL CONSENT FORM

This research is being conducted to study the reactions of children to interviews with the anatomically correct dolls. The professionals involved in interviewing young children would like to provide as positive experience as possible for the child while obtaining accurate and complete information. Each child will spend about sixty minutes in a play interview room with a female clinician who will conduct the interview. The interview will be observed by a trained observer. Your child will be observed while interacting with the anatomically correct dolls and, possibly, with other toys available in the play room. Your child will be asked to identify parts of the human body in his or her own words. He/she will not receive any instruction about such subjects, however. The identity of your child will be kept confidential in reporting the results of the study. However, should your child report or indicate that he/she has been abused, by law, the information shared by the child as well as his/her identity must be reported to Child Protective Services or the Police.

I_____ (parent/guardian) give permission for my child _____ to participate in the research study described above which includes a play interview with anatomically correct dolls that will be observed. I understand that my child's name will not be used in reporting the results of the study. I further understand that if my child reports or indicates that he/she has been abused, the information shared by the child as well as his/her identity must be reported by the interviewer to Child Protective Services or the Police.

_____

Parent/Guardian's Signature

_____ _____

Date Witness

APPENDIX E

MEMO TO PARENTS OF PRESCHOOLERS

TO: PARENTS OF PRESCHOOLERS

FROM: JOYCE DeVOSS, M.A., DOCTORAL STUDENT IN COUNSELING AND GUIDANCE AT UNIVERSITY OF ARIZONA

RE: RESEARCH ON INTERVIEWS OF PRESCHOOLERS USING ANATOMICALLY CORRECT DOLLS

Subjects are needed for a study of play interviews of children, ages 3 to 5, using the anatomically correct dolls. The children will be interviewed by a specially trained and experienced therapist in a children's play room. Each child will spend about an hour in the interview and will be observed in play with the dolls and other toys. Each child will be asked to identify parts of the human body in his or her own words. They will also be asked some questions about inappropriate touching. They will not receive any instruction about human anatomy or inappropriate touching during the interview. A prevention program will be offered to all participants following the conclusion of the study. It will teach children when and how to say "No" to a person who intends to touch them inappropriately. If you are considering allowing your child to participate in this study, please let your child's therapist know or call Joyce DeVoss directly at 296-3296 (La Frontera East Clinic). Thank you.

APPENDIX F

LETTER ANNOUNCING PREVENTION PROGRAM

LA FRONTERA CENTER, INC.

PROVIDING MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES

IT'S O.K. TO SAY NO

What: Prevention Program For Parents and Young Children, ages 2-7

When: Wednesday, May 27, 1987 6-7 p.m.

Where: La Frontera East Clinic
7820 E. Broadway, # 120

Presenter: Joyce A. DeVoss, M.A.
296-3296

This presentation is for parents who want their children to be able to say "no" to uncomfortable touches and who want their children to come to them and tell them when anyone tries to touch them in an inappropriate way. Film strip, discussion and music will be used in the presentation.

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