STOPPING THE SILENCE;  
TAKING ACTION ABOUT 
CHILD SEXUAL ABUSE 

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Children’s issues are not front and center in the public eye. They are not as obvious as a slow line at a motor vehicle office or a congested highway... There is a lack of sound research or bipartisan education efforts to make the public and our policymakers aware of the critical issues facing America’s children... Children don’t have powerful lobbyists representing their interests and telling their stories in Washington and in statehouses across the country; there is no AARP for kids! And, because kids don’t vote, they have no political voice... What is needed now is a movement to mobilize public support for shaping new policies that will bring about sweeping change for children. 
The time is now. Our children, our future, cannot wait.

–Mario Morino, Chairman, Venture Philanthropy Partners, vppartners.org  
Chairman, Morino Institute, October 2003

Stopping the Silence

STOP the Silence: Stop Child Sexual Abuse, Inc. (“Stop the Silence”) has been addressing the needs of sexually abused children in a multifaceted comprehensive manner since 2002, first as a coalition and now as a national organization incorporated in Maryland. The Mission of the organization is two-fold: 1) to increase public and policymaker awareness about and conduct programming to address the prevention and treatment of child sexual abuse (CSA), and 2) to address the relationships between this issue and the broader issues of overall family and community violence, and, further, violence within and between communities. The goal is to stop CSA and related forms of violence by mobilizing public and private support to change public policies and societal relationships within and between groups that allow CSA to repeat generation after generation. It has not been easy, nor will it be, but the alternative of looking the other way is not an option if we want to protect children and build healthier, safer societies.

Child sexual abuse is an excruciatingly painful epidemic comprised of stories that are nearly too difficult to tell or to listen to. Research shows that it has been an epidemic for decades at least, and each generation perpetuates it. It currently affects approximately one in four girls and one in seven boys in the U.S. by the time they are 18 years old and 20% of women and 5 to 10% of men worldwide. The perpetration of most CSA (90-94 percent) occurs at the actions of individuals who the child knows well and who have access to and power over that child – many if not most perpetrators are family members. Ultimately, it affects us all.
PUBLIC outrage at the tragic murders of two Florida girls by convicted sex offenders last spring has sparked renewed interest in legislative reform designed to protect children from sexual victimization. Recently in Michigan, the state legislature unanimously passed House Bill 4937, which creates an exception to the general rule that a defendant’s past behavior is inadmissible at trial. Similar to laws currently in effect in California and Arizona, HB 4937 allows evidence of past abuse allegations against a defendant in cases involving sexual crimes against children. This legislative development raises several empirical questions ripe for examination by social scientists interested in balancing children’s welfare and defendants’ rights in the legal system.

Legislative Background
Historically the American judicial system has barred the introduction of prior misconduct to prove a defendant’s guilt, character, or propensity to commit a crime (Waltz & Park, 1999). The rationale behind excluding such evidence was that a defendant should be tried on the merits of the case at hand and not on his prior behavior. In 1975, this common law rule was codified in the Federal Rules of Evidence, Rule 404(b), which prohibits evidence of other “crimes, wrongs, or acts...to prove the character of a person in order to show action in conformity therewith.”

Nearly twenty years after FRE Rule 404(b) was enacted, Congress passed the Violent Crime Control and Law Enforcement Act of 1994, which included controversial FRE Rules 413 and 414. In stark contrast to common law tradition and Rule 404(b), the new rules declared that evidence of a defendant’s prior misconduct (including that for which the defendant was neither charged nor convicted) was admissible in criminal cases involving sexual assault and child molestation. For this to be admitted, a trial judge must rule that a jury could reasonably find by a “preponderance of the evidence” (more likely than not) that the defendant committed the alleged prior act.

Opponents of the new rules argued that introducing alleged prior misconduct would compromise defendants’ presumed innocence and would be extremely prejudicial given people’s visceral, punitive reactions to sexual crimes. Supporters, including David Karp (1994) who authored the new rules, cited the balancing test of FRE Rule 403 as a safeguard for defendants’ rights. According to Rule 403, even relevant evidence can be ruled inadmissible if its probative value is substantially outweighed by the danger of unfair prejudice, confusion, or undue delay.

The initial controversy surrounding Rule 413 and 414 has waned considerably over the past decade in part because most sexual assault and child molestation cases are tried in state courts, not federal. Although the FRE bind federal courts only, several states (Michigan being the most recent) have turned to Rule 413 and 414 when drafting similar legislation. In 1995, California amended its evidence code by adding Section 1108 to permit the admission of a defendant’s alleged prior sexual misconduct in criminal proceedings involving sexual offenses. Section 1108 received a great deal of publicity in the recent trial against Michael Jackson when the judge admitted testimony from several witnesses who claimed they saw Jackson engage in inappropriate physical contact with young boys years earlier. In 1997, Arizona codified a similar exception (Rule 404c) to its evidence rule that disallowed the use of relevant character evidence in sexual misconduct cases.

Recent Developments and Empirical Questions
As we ponder the recent legislative developments in Michigan, it is critical to question what role psychological science can play in providing empirical answers to questions raised by Rule 413 and 414. One approach worth pursuing is the use of trial simulation research to better understand what (if any) effects the admission of a defendant’s alleged prior misconduct has on jurors’ decisions in sexual assault cases. Is the probative value of such evidence substantially outweighed by juror prejudice or confusion? If so, what legal safeguards can be implemented to minimize or eliminate these undesirable effects? Both California and Arizona require judicial instructions to be administered when evidence of alleged prior misconduct is admitted at trial. Do these instructions have the intended effect on jurors? If not, do other viable alternatives exist and are they effective?
Section on Child Maltreatment

Empirical studies of how variations in the legal status of the defendant’s prior misconduct (i.e., alleged, charged, or convicted) influence jurors’ decisions would also be informative. As originally introduced, Michigan’s HB 4937 only allowed evidence of a defendant’s prior conviction for misconduct to be admitted; however, legislators eventually amended the bill in favor of more expansive language consistent with Rule 413 and 414. Allowing evidence of a defendant’s prior conviction represents an interesting compromise between the all (Rule 413 and 414) or nothing (Rule 404b) approaches currently in place and would appear to better protect defendants’ rights compared to other legislation currently in place. Whether jurors are sensitive to differences between “alleged” versus “convicted” misconduct and how that sensitivity might influence their decision making remains one of many unanswered empirical questions worthy of future exploration by legal researchers.

References


President’s Column

STORM TROOPERS: HELPING CHILDREN AFTER HURRICANE KATRINA

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HURRICANE Katrina has commanded the attention of the American public over the past weeks; however, relatively little discussion has focused on its impact on children, particularly in regard to the mental health issues associated with the trauma of not only the storm and its immediate aftermath, but also the loss of homes, friends, possessions, familiar routines, and even family members. Sadly, tragedies such as Hurricane Katrina only serve to add to the number of children who are already dealing with trauma and loss.

Nonetheless, numerous groups are working to ensure that the mental needs of children – in both the short- and the long-term – are addressed. Not only are there many opportunities for those with mental health expertise to volunteer their service, but there are also numerous resources available that can be helpful to you as you work to serve those in your community, wherever its location. Among several good sources is the National Child Traumatic Stress Network, which is also conducting important work specific to the field of child abuse and neglect. Funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, the National Child Traumatic Stress Network (NCTSN) is a coalition of 54 centers from across the country that bring together the valuable perspectives of researchers, practitioners, family members, and other stakeholders “to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.” The scope of child trauma addressed by the Network is broad, encompassing not only rare events, such as trauma and disaster, but also more chronic forms of trauma, including child maltreatment, exposure to domestic violence, and grief.

The NCTSN website offers numerous quality resources for professionals working to assist children and adolescents in dealing with a variety of traumatic experiences. Detailed information is available on the scope and nature of child trauma, developmental models, interventions for child traumatic stress, and barriers to care. Special information, including “tip sheets,” is available for parents and caregivers, school personnel, and the media. Professionals can also access take advantage of listings of training and job opportunities in their area.

For more information on NCTSN and the many resources it offers, you can go to the Network’s website, www.NCTSNet.org. Special Hurricane Katrina resources for parents and caregivers, medical and mental health professionals, educators, and relief workers are also available.
CONGRESS returns from the August recess with a full agenda of appropriations bills and budget measures. House and Senate attention to drafting major budget reconciliation legislation could threaten spending cuts to programs serving low-income families like Food Stamps and Medicaid, and at the same time impose tax cuts that, with the possibility of reduced federal revenues in future years, would make it more difficult to fund these programs. At the start of the fall legislative session, the political implications of the issues raised by the personal devastation suffered by the victims of Hurricane Katrina have still not fully developed.

The reconciliation instructions included in the FY06 budget resolution passed by Congress in April direct Senate and House committees to cut taxes by at least $70 billion and to reduce spending by at least $35 billion on programs under their jurisdiction, which include Medicaid, food stamps, Temporary Assistance to Needy Families (TANF), the Child Care and Development Block Grant (CCDBG), foster care subsidies, and the Earned Income Tax Credit. In rewriting the statutory authority for these programs, the committees could also decide to fold the program funds into block grants or develop legal authority for states to reduce benefits by redefining eligibility for the programs.

The child care block grant and TANF are especially vulnerable. Both programs are overdue for reauthorization, currently operating under a temporary extension to September 30. The House Ways and Means Committee is expected to add the TANF and child care reauthorization to its reconciliation bill. House and Senate committees have already approved bills reauthorizing the TANF public assistance, job training program. The House bill adds only $1 billion in new money for child care, compared to $6 billion in the Senate’s bill. Given the tight spending picture in Congress, assembling additional funds for child care remains a challenge. Other issues remain around work requirements and marriage promotion provisions.

The appropriations picture isn’t any brighter. Federal support for child welfare services comes up short in the fiscal 2006 appropriations legislation working through Congress this summer. Leaving behind a record from recent years of stalled budget negotiations and late-session passage of catchall funding measures, Congress this year has outdone itself in getting the appropriations bills to the floor for votes. In an otherwise contentious atmosphere centered on Senate approval of Presidential court appointments, Congress has steadily moved forward on approving a string of appropriations bills to fund the federal government in the coming fiscal year — including the Labor-HHS-Education Appropriations Bill for the 2006 fiscal year.

While the overall funding of $65.4 billion for the Department of Health and Human Services in the Senate bill, for example, is up by $1.64 billion over the 2005 level, none of that increase was handed around to services for protecting children and preventing harm to children at-risk of maltreatment. Major funding increases were given to health research, with support for the Centers for Disease Control and Prevention up by $1.33 billion in the House and by $1.48 billion in the Senate. Similarly, the National Institutes of Health were marked for increases, significantly in the Senate’s bill with an additional $1.05 billion penciled in for 2006.

Unfortunately, the fast action on congressional money decisions has not given a boost to underfunded child welfare services. Except for Head Start, which got a small increase in both bills, almost all child welfare programs are left with level funding. In fact, two programs aimed directly at the prevention of child abuse and neglect received short shrift in the Senate and House money bills.

Both measures eliminate completely the $35 million for the early learning fund to support community programs working with new parents and young children to promote cognitive development and learning readiness. Since its inception in 2001 the program has enjoyed the support of the Senate over the intentions of the House of Representatives to zero out its funding. This year, the Senate joined the House in eliminating the program.
The Promoting Safe and Stable Families program, also aimed at preventive and family support services, while level funded in the House bill was dealt a two percent cut in the Senate’s version. The President ran in 2000 on increasing the Safe and Stable Families money by $1 billion over five years. Congress has never gone along with that level of increase. While proposing a cut in funds for 2006, the Senate appropriations committee notes that “most of the Federal funding related to child welfare is provided for the removal and placement of children outside of their own homes” and the Promoting Safe and Stable Families program funds “are focused on supporting those activities that can prevent family crises from emerging which might require the temporary or permanent removal of a child from his or her own home”!

“The fast action on congressional money decisions has not given a boost to underfunded child welfare services”

Other administration initiatives fared better. The Children’s Bureau’s abstinence education fund gets a $2 million increase in the Senate bill, up to $105.5 million in 2006. The Compassion Capital Fund, which promotes grants to community and faith-based organizations, gets an increase in the House bill of $20 million and plus $40 million in the Senate, where $45 million of the $95 million total is earmarked for a new anti-gang initiative outlined by the President in his State of the Union address.

The tight budget resolution passed by Congress earlier in the year proposed billions of dollars in cuts to domestic discretionary programs, and imposed a three-year cap on discretionary spending. The appropriations bills working their way so expeditiously through Congress this summer follow that spending blueprint. The money bills in the House and Senate have locked in 2006 spending at the 2005 levels for the Child Abuse Prevention and Treatment Act state grants and discretionary grants for research and program initiation, as well as the community-based prevention grants. The same goes for the Title XX Social Services Block Grants, child welfare services, abandoned infants grants, adoption opportunities grants and child welfare training.

Curiously, the Senate Appropriations Committee in its report recognizes the “failings in the Child and Family Services Reviews [CFSRs] and the States’ continuing challenges in recruiting and retaining qualified child welfare personnel, particularly those who hold a degree in social work.” The report then goes on to encourage “grants to schools of social work and traineeships to social work students being trained in the specialty of child welfare” and “to provide funding for research into how specially trained social work personnel affect outcomes for children and families,” without offering any additional funds for the work of child welfare training.

HOUSE AND SENATE MONEY BILLS PROMOTE NIH CHILD ABUSE RESEARCH

The House and Senate appropriations committee reports on the FY06 Labor-HHS-Education Appropriations Bills both carry language drafted and submitted by the National Child Abuse Coalition, with support of the American Psychological Association, instructing the National Institutes of Health (NIH) to continue funding research in child abuse and neglect and to direct attention to research in treatment interventions.

In 1996, the Coalition appealed to Congress for leadership in calling upon NIH to develop a research agenda designed to address the problems and gaps that exist in child abuse and neglect research. That year, the FY97 appropriations legislation for NIH for the first time encouraged NIH to devote attention to addressing a research agenda in child maltreatment. The effort at NIH is significant because it represents a collaboration across several institutes to identify how they address, or might address, research needs in child maltreatment, and it represents a pooling of funds to support research activities and professional development. There is a focus on encouraging research proposals in topics areas identified as gaps by the NIH Child Abuse and Neglect Working Group’s (CANWG) ongoing review of the NIH grant portfolio.

The research agenda developed by the CANWG grew out of its analysis of the 1993 National Research Council report, Understanding Child Abuse, as an initial point of reference, which highlighted, among other concerns, the lack of information about the causes, prevention and amelioration of child neglect. The first round of research grants was given in this area.
Best Practices

BEST PRACTICES FOR FAMILIES WITH INFANTS WITH PRENATAL DRUG EXPOSURE

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THE number of infants exposed prenatally to illicit drugs in the United States is currently estimated at around 200,000 (Ebrahim & Gfroerer, 2003; National Institute on Drug Abuse [NIDA], 1996). Population studies indicate 15-18% of women in their childbearing years used illicit drugs in a year (NIDA, 1994), with about 3% of women aged 15-44 years reporting illicit drug use in the past month (Office of Applied Studies, 2003). Use of the legal drug, alcohol, during pregnancy is the leading known cause of mental retardation in children in the United States (Streissguth, 1997). The developmental effects of prenatal drug exposure often are compounded by a lack of prenatal care, poverty, prematurity, as well as tobacco exposure during pregnancy. However, well controlled studies have consistently found effects including low birth weight, reduced head circumference, feeding problems (i.e., sucking and swallowing), problems regulating arousal, and organizational/self-soothing difficulties. Later developing effects include behavioral disturbances, learning disabilities, language delays, poor self-regulation, and attention and concentration problems (see Ondersma, Simpson, Brestan, & Ward, 2000 for a review).

Prenatal drug exposure also is likely to result in a Child Protective Services (CPS) referral (Berrick, Needell, Barth, & Jonson-Reid, 1998; George & Wulczyn, 1998). In many states medical personnel are required by law to report newborns with a positive toxicology screen. This has contributed to an increase in the number of infants entering the CPS system from 12% of all foster care entries in 1977 to 23% in 1994 (U.S. General Accounting Office, 1994). In 2001, 26% of children awaiting adoption were under the age of 1 year (U.S. Department of Health and Human Services, 2003).

Concerns related to prenatal drug exposure extend into the postnatal period as caregivers who abuse substances are at high risk to abuse or neglect children (Chaffin, Kelleher, & Hollenberg, 1996; Ondersma, 2002). It has been estimated that substance abuse is involved in up to 60% of confirmed cases of child maltreatment (U.S. Department of Health and Human Services, 1999) and that substance abuse has also been shown to be associated with re-reports of child maltreatment in parents already known to CPS (Wolock & Magura, 1996). Evidence of poor child psychosocial outcomes following postnatal exposure to a caregiver’s substance abuse has continued to grow and has been associated with early alcohol use and/or drug use initiation among children (Clark, Kirisci, & Moss, 1998; Hoffmann & Cerbone, 2002) as well as behavior disorders (Loukas, Zucker, Fitzgerald, & Krull, 2003). In sum, substance abuse among caregivers is a crucial issue that increases the risk both for child maltreatment and behavioral problems.

Given the host of issues faced by families impacted by substance abuse, multiple challenges to clinicians and child welfare personnel exist when working with affected families. The following are suggestions to improve infant well-being based on current clinical practices supported by empirical findings.

1) Given the risks to infants and children associated with having a caregiver who continues to abuse substances, fostering sobriety is imperative. If the infant is going to remain with his or her mother, or if reunification is the goal, substance abuse treatment must be a central component of the parent’s treatment plan. Although substance use disorders may be difficult to overcome, in general, the more substance abuse treatment received the better the chances for achieving sobriety (NIDA, 1999). Chances for success also may be improved by women receiving gender-specific substance abuse treatment as well as a range of other services (e.g., assertiveness training, family planning, parenting training, child care, job training, interventions for intimate partner violence, treatment for co-morbid mental health problems, etc.)

2) The home environment should be structured with a focus on consistently identifying and meeting the needs of the infant. Stress should be placed on educating the caregiver about accurately identifying and responding to the infant’s “state” (i.e., fatigue, hunger, readiness to play or explore) as well as being responsive to the infant’s other signals and social initiations. The caregiver should be encouraged to engage in warm, positive interactions with the infant that involve gentle physical contact, talking to the infant, and providing opportunities and appropriate objects for the infant to safely explore and manipulate (Bronson, 2000).
3) Recognizing engagement and disengagement cues from the infant along with effective soothing strategies should be taught to the caregivers. Recognizing the infant’s threshold of overstimulation, and using soothing strategies such as reducing stimulation, can keep the infant in the quiet alert state so important for infant development. This will also help avoid the disorganized, chaotic, screaming episodes which can place infants at high risk for abuse and bonding/attachment problems (Griffith, 1992). Basic disengagement cues include the infant looking away and not maintaining eye contact, grimacing or frowning, frequent yawning, hiccupping, spitting up, changing color from pale to red and even to bluish and asymmetrical movements. Soothing strategies include swaddling, providing a pacifier or access to hands/fingers to suck, allowing the infant to look away and not forcing any eye contact, vertical rocking, carry the infant facing away from the caregiver’s body, petting or rubbing the infant’s back and massaging trunk or limbs, and reducing light and noise stimulation. Learning these cues can be empowering for the caregivers as they gain confidence in their ability to attend to their infants.

4) Some studies have supported using infant massage with both low and high risk infants (including infants with prenatal drug exposure) to promote greater weight gain and better performance on developmental assessments (Field, 2000).

5) Given the developmental delays and behavioral challenges often found in infants and children with prenatal drug exposure, comprehensive interdisciplinary evaluations should begin in infancy and continue on a regularly scheduled basis throughout childhood as indicated (Wolraich, Gurwitch, Bruder, & Knight, 2005).

6) Parenting skills training may help lower the risk for child behavior problems. Overall, families caring for infants with prenatal drug exposure can have multiple needs and face many challenges. However, infant well-being can be improved using strategies relatively simple to teach to caregivers and resources often found within the community.

References


Child sexual abuse occurs when the child is engaged in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society (American Academy of Pediatrics), and which often take place on an increasing continuum of abuse, from:

- Voyeurism and/or exhibitionism and/or pornography, to
- Inappropriate touch, rubbing, brushing, to
- Oral-genital, genital, or anal contact by or to the child, and rape.

Sexual abuse is especially problematic when children are involved. Multiple traumatic effects for sexually victimized children are documented, including fear, nightmares, and depression; other mental health problems, such as phobias, anxiety, and/or feelings of low self-esteem; feelings of confusion or dissociative experiences; sexual acting out behaviors; anti-social behaviors; sexually transmitted diseases including HIV; hostility and victimization; and physical injuries and self-destructive behaviors including suicide.

The pain does not end with childhood victimization. Decades of research consistently document that adults sexually violated as children have a higher likelihood of being negatively impacted in their adulthood. The range of abuse-violated as children have a higher likelihood of being negatively impacted in their adulthood.12 The range of abuse-related difficulties in adulthood includes depression, anxiety, self-mutilation, low self-esteem, eating disorders, interpersonal difficulties, and post traumatic stress disorder, multiple personality disorder.

“Most people do not grasp the full extent of CSA as a social and health problem”

In 2000, I tried to obtain basic resources to address the epidemic of CSA in a comprehensive manner, and was stunned to find out that those resources simply did not exist. I realized that if individuals, stakeholders, communities, organizations, and policymakers are going to deal with the issue, they must understand the extent to which it is a problem and they must be able to talk about it. To move toward that end, they must first be made aware of what it is, what it does, and what can be done about it. Breast cancer and AIDS, two issues not long ago discussed only behind closed doors as a result of shame, stigma, fear and other issues, have been brought out of the shadows with resulting policy and monetary attention. Increasing awareness and providing education and training activities are steps critically needed toward CSA prevention and treatment. A multifaceted program is crucial to its prevention.

Using Award-winning Research To Catalyze a Response (PRSA’s “Top Three Paper Award”)

Given the outcomes of CSA and the lack of resources, I became impassioned with the idea of building that response. I enlisted the assistance of the Communications Department at the University of Maryland to help carry out attitudinal research within the Washington, D.C. and surrounding areas toward gaining a better understanding of what could be done to raise awareness. The purpose of our study was to examine the extent to which members of the lay public (i.e., those who are not CSA prevention advocates) perceive CSA as a social problem and the extent to which public perceptions of CSA were related to media coverage of the issue, as well as to discover methods of heightening awareness using mass media.

In general, we learned that media coverage of CSA tends to focus on the most outrageous or stereotypic aspects of the problem, often to the exclusion or misrepresentation of scientific research on the issue. As a result, most people do not grasp the full extent of CSA as a social and health problem. A literature review showed that media reports primarily have been concentrating on various cases, and, up to the time of this research, little attention in the media has been on ‘what can be done’ to address the issue. Given the apparent success of some media programs (e.g., From Darkness to Light, STOP IT NOW!) that have provided specific information on CSA and an action contact, we realized that education campaigns might do better to focus not so much on CSA as a problem, but rather provide a specific call to action. This recommendation was consistent with research by Kinnick, Krugman, and Cameron (1996) and others, indicating that people want concrete information on actions they can take to stop various problems, rather than only information on the problems themselves.

The research conducted with the University of Maryland used a public relations theory that predicts whether a target public will become active on a particular issue. Again consistent with the findings of Kinnick, Krugman, and Cameron (1996), the results of our study suggested that excessive media coverage of CSA could result in a numbing effect on target audiences. Furthermore, media coverage should include a “what to do about the problem” component, to reduce perceived constraints or inefficacy in dealing with the issue of CSA. Additionally, incorporating an interpersonal component into education campaigns, rather than relying on mass media exclusively to convey the message, not only would be consistent with what we know about general communication theory and practice, but it also correlates with what has been shown specifically with regard to the use of mass media and CSA. That is, interpersonal communication increases the likelihood of public response, particularly when dealing with issues of extreme sensitivity, such as CSA. The public needs to believe that there is something that they can do to address the problem; they
In a very short time, *Stop the Silence* has developed important programming and relationships, and continues to maintain and promote the importance of individual and community action. It has at its disposal seasoned professionals who provide skilled assistance in all the areas on which it focuses, including nationally- and internationally-recognized educators and advocates such as Sharon Simone, Riane Eisler, best-selling author of the Chalice and the Blade, and Naomi Tutu, activist and daughter of Bishop Desmond Tutu, as well as skilled trainers. *Stop the Silence* is providing training to many types of individuals including social service workers, child protective agents, therapists, psychologists, police, and executive directors of social service groups so that they may reach others.

In cooperation with other organizations, *Stop the Silence* programming has been funded by the California Endowment ($274,000) for a multifaceted program focused on Latino survivors in California; Health and Human Services ($300,000) for multifaceted, comprehensive programming in Maryland; and by various foundations (e.g., Ms. Foundation for Women, the Joseph and Harvey Meyerhoff Family Charitable Funds), corporate groups and private companies (e.g., FedEx, Calvert Group, Gelman, Rosenberg & Freedman, Booz Allen Hamilton, the World Gym), and individuals. Current endeavors include the development of the National Children’s Bench Book for judges to educate them about the impact of CSA so that they are able to make fully informed decisions about the cases in front of them; the development of real-time software to help close the information gaps between services and individuals charged with keeping children safe; the national distribution of a powerful TV PSA; and educational outreach.

**A Call to Action**

These involvements are critical to changing the current state of affairs – for us all. There is no longer a question about the relationship of CSA to other forms of violence (e.g., 83.8 percent of convicted killers – both men and women – were physically and emotionally abused as children and 32.2 percent were sexually abused). Nor is there any longer a question about the relationship of CSA to other deleterious outcomes such as future victimization, prostitution (and trafficking), teen pregnancy, sexually transmitted diseases (including HIV), alcohol and drug abuse; and chronic disease. CSA costs our society tens of billions of dollars each year. Stigma, shame, fear, subject sensitivity, and the lack of resources available to address CSA have kept the issue in the shadows, and also rendered it difficult to study resulting in massive underreporting. It is the definitive experience of most individuals and organizations working on CSA prevention and treatment that there are far too few resources for any programming (let alone comprehensive programming) given the extent of the problem and its damage.

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**“The public needs to believe that there is something that they can do to address the problem”**

need to know how to do it; they need to know that there are individuals who are reaching out to them and/or waiting to respond to their calls, and they need to know that, once reported, something appropriate will be done to address the problem reported. This type of approach, in conjunction with a media campaign, may have the eventual effect of generating CSA as a hot topic issue – one on which media can generate action.18

One of the possible mechanisms identified in this research as having the possibility of raising awareness was a walk or run. The annual, national Race to Stop the Silence: Stop Child Sexual Abuse (www.stopcsa.org), which takes place each April in downtown Washington, D.C. (and is spreading to other states) was born with the assistance of many, including nationally known CSA survivor, activist, and educator, Sharon Simone about whom the movie *The Ultimate Betrayal* was made. It is now an annual event in Washington, D.C., which attracts greater than 1,000 people, has obtained the endorsement of a growing cadre of policymakers from Capitol Hill and elsewhere, conducts education and advocacy from the Race stage, garners substantial media attention (TV, radio, print, Web site announcements, and, this coming year, the *Stop the Silence* powerful PSA will be in theatres), and raises funds for local and national programming. It grows larger each year, with 1,500 to 2,000 expected in 2006. With the Race established, and CSA beginning to be addressed by various others due to a host of factors (e.g., AIDS and its affect on orphans and vulnerable children worldwide, trafficking), it was time to expand the programming, and we did.

**Moving Toward Comprehensive Agenda**

To this point, *Stop the Silence* has worked with groups in California, the District of Columbia, Florida, Maryland, Minnesota, Virginia, and elsewhere. The organization was incorporated in Maryland as a national organization in 2004. In collaboration with various groups (including Futures Group, a Constella Company, an international health and development company that has helped support the development of *Stop the Silence* work), it provides multi-faceted, comprehensive programming involving seven focal areas: 1) individual and group counseling (in collaboration with other groups); 2) training of service providers; 3) community education and outreach; 4) advocacy; 5) policy development and application; 6) research and evaluation; and 7) other prevention measures (e.g., appropriately dealing with offenders).
Here is what an article published April 22, 2005 in the American Association for the Advancement of Science urges:

We recommend interdisciplinary research initiatives and a series of international consensus panels on scientific and clinical practice issues related to CSA. This can promote (i) increased inclusion of CSA education in the curriculum in medical and mental health fields; (ii) improved education of the public, the media, and professionals who work with alleged CSA victims; (iii) greater visibility and improved dissemination of CSA research; (iv) increased focus on CSA by researchers in a range of disciplines; and (v) improved cost-benefit analyses of intervention, including prevention efforts.23

To effectively respond to the enormously complex issue of child sexual abuse, we need this call to action from the research community, and we also need a call to action from the informed private sector; from human service community-based organizations charged with treatment, prevention, and education; and from the public sector to educate policymakers and create new and relevant policies and legislation. As Mr. Morino, who is quoted at the beginning of this article, noted: we need a movement to mobilize public support to bring about sweeping change for the children. But, we also need it for the adults they become and our society as a whole.

Stop the Silence: Stop Child Sexual Abuse, Inc., its programs and the Race, are in place to help catalyze this movement.

References

“There are far too few resources given the extent of the problem and its damage.”

These efforts are a beginning only. There are ways for anyone and everyone to help. You or your organization can:
· Contribute to Stop the Silence programming with $1.00, $25,000, or anything in between;
· Learn more about CSA and talk to others about what you learn;
· Participant in the Race to Stop the Silence, and/or hold the Race in your community/state;
· Help train local communities about CSA (Stop the Silence can train other organizations);
· Help ensure that your local and national policymakers are aware of the issue and its affects on our society (e.g., see SOhopeful.org; PROTECT.org; justiceforchildren.org).

For further information, you may contact Pamela Pine, at Stop the Silence, 11904 Webb Ct., Bowie, MD 20720, 301-464-4791, at ppine@stopcsa.org, or through the “Contact Us” page of the Stop the Silence Web site at www.stopcsa.org. Help Stop the Silence. Help ensure the safety of the children. Help create a safer and more peaceful society.

“There are far too few resources given the extent of the problem and its damage.”


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