

## Practice Parameters for the Forensic Evaluation of Children and Adolescents Who May Have Been Physically or Sexually Abused

### ABSTRACT

These practice parameters describe the forensic evaluation of children and adolescents who may have been physically or sexually abused. The recommendations are drawn from guidelines that have been published by various professional organizations and authors and are based on available scientific research and the current state of clinical practice. These parameters consider the clinical presentation of abused children, normative sexual behavior of children, interview techniques, the possibility of false statements, the assessment of credibility, and important forensic issues. These parameters were previously published in *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36:423-442. *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36(10 Supplement):37S-56S. **Key Words:** child abuse, sexual abuse, forensic, evaluation, practice parameters, guidelines.

Individuals in private practice, as well as those employed by courts or other agencies, see children who may have been mentally, physically, or sexually abused. There are three distinct roles for them: forensic evaluator; clinician, who is conducting mental health assessments and providing treatment; and consultant regarding public policy.

Working as a forensic evaluator, the practitioner may evaluate children in a private practice for a forensic purpose, evaluate children and collaborate with other mental health professionals in a government agency such as protective services, or work with an interdisciplinary team at a pediatric medical center. He or she may assist the court in determining

what happened to the child, make recommendations regarding placement or treatment, or offer an opinion on the termination of parental rights. A forensic evaluation may involve critiquing the work that was previously done by another mental health professional or by a protective services investigator. The forensic evaluation may be used in a civil suit in which the child is a plaintiff seeking remuneration for damages related to the abuse. The evaluator may be asked to testify in a juvenile court (regarding the issue of abuse and neglect), in a civil court (if a civil suit is being pursued), or in a criminal court (if the alleged perpetrator comes to trial).

Working as clinicians, mental health professionals may provide assessments and treatment for abused children and their families in both outpatient and inpatient settings. Many psychiatric hospitals and residential treatment centers have specialized programs for abused children and adolescents. There are also programs for adolescent perpetrators of sexual abuse, many of whom were also victims of sexual abuse.

Mental health professionals may deal with these issues on the level of public policy by sharing information with and educating attorneys and judges about the psychiatric aspects of abuse and the developmental needs of children (Goldstein et al., 1973, 1979). In some states, clinicians have helped shape the laws that control how the legal system deals with abused children, including the criteria for reporting abuse and the methods of evaluation and procedures for hearing the child's testimony.

There are some differences in the method of evaluating children who may have been abused, depending on whether the evaluator is conducting a forensic or a clinical assessment. These parameters pertain to the process for forensic evaluations, i.e., evaluations that are intended to address a legal

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issue or question. Practice parameters regarding the clinical assessment and treatment of abused children will be provided in a separate document. Also, these parameters should be considered in the light of the more general guidelines for how diagnostic evaluations should be conducted, which are presented in "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" (American Academy of Child and Adolescent Psychiatry, 1995) and "Practice Parameters for the Psychiatric Assessment of Infants and Toddlers" (American Academy of Child and Adolescent Psychiatry, 1997).

Practice parameters provide guidelines for patterns of practice, not for the care of the particular individual being evaluated and/or treated. This document is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on all facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance. Parameters of practice should not be construed as including all proper methods of care or excluding other acceptable methods of care reasonably expected to obtain the same results. Adherence to these parameters will not ensure a successful outcome in every case. The ultimate judgment regarding any specific clinical procedure or treatment must be made by the physician in light of all the circumstances presented by the patient and family and the resources available. These practice parameters were approved as of the date indicated, and they should not be applied to clinical situations occurring before that date.

In this paper, the term "child" refers to both adolescents and younger children unless explicitly noted. Unless otherwise noted, "parents" refers to the child's primary caretakers, regardless of whether they are the biological or adoptive parents or legal guardians.

#### Review of the Literature

The list of references for this paper was developed by *Medline* and *Psychological Abstracts* literature searches, by reviewing the bibliographies of book chapters and review articles, and by asking colleagues for suggestions. The Medline search, conducted in August 1994, used the following text words in various combinations: child abuse, sexual abuse, forensic, and evaluation. The search covered 1990 to 1994 and yielded about 175 articles. These were reviewed and the most relevant were included in this list of references.

These practice parameters pertain to the evaluation of children who may have been physically and/or sexually abused. Child and adolescent psychiatrists are more likely to be involved in a forensic evaluation in instances of possible sexual abuse, so these parameters include more material

related to sexual abuse than physical abuse. Although the focus of this set of practice parameters is on the forensic evaluation of children who may have been abused, the following general and related works may be of interest.

General works regarding forensic child psychiatry have been written or edited by Benedek (1986), Herman (1990), Nurcombe and Partlett (1994), and Schetky and Benedek (1985, 1992).

General works regarding the identification, evaluation, and treatment of abused children have been written by Besharov (1990), Helfer and Kempe (1976, 1987), Kempe and Helfer (1972), Kempe and Kempe (1978), Pelton (1981), Schmitt (1978), and Wasserman and Rosenfeld (1985). The history of child maltreatment from ancient to contemporary time was described by deMause (1991) and Kahr (1991).

General works regarding sexual abuse of children have been published by Abright (1986), Bulkley (1981), Corwin and Olafson (1993), Faller (1988a), Finkelhor (1979, 1984, 1986), Friedrich (1990), Glaser and Frosh (1988), Haugaard and Reppucci (1988), Hunter (1990), MacFarlane and Waterman (1986), Nurcombe and UnÄtzer (1991), Olafson et al. (1993), Rosenfeld et al. (1977), Rush (1980), Schetky and Green (1988), and Sgroi et al. (1982). In its Debate Forum (Terr, 1989), the *Journal of the American Academy of Child and Adolescent Psychiatry* published a discussion by four experts of whether child sex abuse is overdiagnosed.

#### Definitions

The legal definitions of terms related to the maltreatment of children vary from state to state. Clinicians should be aware of the definitions used in their own locale. Broadly speaking:

*Neglect* is the willful failure to provide adequate care and protection for children. Physical neglect may involve failure to feed the child adequately, failure to provide medical care, or failure to protect the child from danger.

*Physical abuse* is the infliction of injury by a caretaker. It may take the form of beating, punching, kicking, biting, or other methods. The abuse can result in injuries such as broken bones, internal hemorrhages, bruises, burns, and poisoning. It is important to consider cultural factors in assessing whether the discipline of a child is abusive.

*Sexual abuse* of children refers to sexual behavior between a child and an adult or between two children when one of them is significantly older or uses coercion. The perpetrator and the victim may be of the same sex or the opposite sex. The sexual behaviors include touching breasts, buttocks, and genitals, whether the victim is dressed or undressed; exhibitionism; fellatio; cunnilingus; and penetration of the vagina or anus with sexual organs or with objects. Pornographic photography is usually included in the def-

initiation of sexual abuse. It is important to consider developmental factors in assessing whether sexual behaviors between two children are abusive or normative.

*Psychological abuse* occurs when a person conveys to a child that he or she is worthless, flawed, unloved, unwanted, or endangered. The perpetrator may spurn, terrorize, isolate, or berate the child. Psychological abuse may also be caused by repeatedly taking a child for unnecessary medical treatment. When psychological abuse is severe, it is often accompanied by neglect, physical abuse, and/or sexual abuse.

The maltreatment of children occurs in a wide range of circumstances. It may have happened only once or twice, or it may have constituted severe torture over a period of years. It may have been perpetrated by parents or other family members, by nonrelated caretakers, or by total strangers.

In American society there are wide variations in parenting practices. These variations are partly determined by the cultural heritage and religious beliefs of the family. The cultural context of the alleged act should be taken into consideration when one is evaluating suspected neglect and abuse.

#### Brief History of Child Maltreatment

In the 1860s, a French forensic pathologist described severe child abuse after performing autopsies on children who had been beaten to death (Tardieu, 1860, 1868). In the United States, child abuse came to public attention through the case of Mary Ellen, an 8-year-old girl who was severely maltreated (Ross, 1977). She was discovered by church workers in New York City in 1874, but they found that the only agency that was available to help was the Society for the Prevention of Cruelty to Animals. Thus, they founded the Society for the Prevention of Cruelty to Children. In 1875, New York was the first state to adopt a child protection law, which became the model for other states.

In the 20th century, the rediscovery of child abuse was signaled by a radiologist in a hospital emergency room. Caffey (1946) noticed a syndrome of children with multiple skeletal injuries and chronic subdural hematomas. Until the 1960s, it was thought that physical abuse of children was rare—partly because physical discipline of children was generally more acceptable and partly because of societal denial concerning violence toward children. In an important article in the *Journal of the American Medical Association*, Kempe et al. (1962) described the battered-child syndrome. In 1974 the federal government passed the Child Abuse Prevention and Treatment Act, which resulted in every state passing laws in which designated persons were required to report child abuse.

It took a separate societal realization during the 1970s to acknowledge the extent of sexual abuse. It was known that incest occurred, but most people believed that it must be very

unusual and that it happened primarily among very deviant families. We now know that incest and other forms of sexual abuse are not rare.

#### Epidemiology

The National Committee to Prevent Child Abuse (1995) collects data each year on the incidence of child maltreatment. The Committee estimated that in 1994 more than 3 million alleged victims were reported to child protective services. Of those reports about 1 million were found to be substantiated. The reported cases were distributed in the following manner: neglect, 45%; physical abuse, 26%; sexual abuse, 11%; emotional abuse, 3%; and other or unspecified cases, 16%. The Committee reported that in 1994 almost 1,300 children died as the result of maltreatment. The National Center on Child Abuse and Neglect (U.S. Department of Health and Human Services, 1995) also collects data each year on child maltreatment. The Center estimated that in 1993 the median age of the victim of child maltreatment was 7 years. Of the victims, about 53% were girls and 47% were boys. It was reported that 77% of the victims were abused by parents, 12% by other relatives, 5% by non-caretakers, and 2% by foster parents, facility staff, or child care staff. These figures are approximations because the actual amount of abuse is unclear. It is known that the reporting of abuse has increased in recent years.

Thompson (1994) reviewed the epidemiology and sociology of child maltreatment. Although child abuse occurs at all socioeconomic levels, it is highly associated with poverty and financial stress. Child maltreatment is strongly correlated with less parental education, underemployment, poor housing, welfare reliance, and single parenting. Child abuse tends to occur in multiproblem families, i.e., families characterized by domestic violence, social isolation, parental mental illness, and parental substance abuse, especially alcoholism.

Cicchetti and Toth (1995) emphasized that child maltreatment should be understood within a developmental psychopathology perspective. The probability of maltreatment may be increased by transient or enduring risk factors, such as the child's prematurity, mental retardation, and physical handicap. The probability of maltreatment may be reduced by transient or enduring protective factors, such as adequate parental support. These factors may relate to the perpetrator, victim, family, community, or culture.

#### Brief Review of Clinical Presentations

Abused children manifest diverse symptoms, including a variety of emotional, behavioral, and somatic reactions. These symptoms are neither specific nor pathognomonic, in that

the same symptoms may occur without any history of abuse. The symptoms manifested by abused children can be organized into clinical patterns. Although it may be helpful to note whether a particular case falls into one of these patterns, that is not in itself diagnostic of child abuse. The following studies are often cited as examples of clinical patterns associated with abuse. Since this is an evolving and developing area, these studies are not definitive. In general, the research on child maltreatment has been limited because of the wide variance in definitions of abuse and because of the absence of adequate control groups.

Schmitt (1987) described the characteristics of physically abused children and their parents: the parents have delayed seeking help for the injuries; the history given by the parents is implausible or incompatible with the physical findings; there is evidence of repeated suspicious injuries; the parents blame a sibling or claim the child injured himself or herself; and the parent has unrealistic expectations of the child.

DeAngelis (1992) described a number of behaviors associated with abuse that should arouse the suspicions of the health professional. For example: the child is unusually fearful or docile, distrustful, and guarded; shows no expectation of being comforted; is wary of physical contact; is on the alert for danger, continually sizing up the environment; attempts to meet parents' needs by role reversal and superficial relationships with adults; and is afraid to go home.

Cicchetti and Toth (1995) reviewed the literature regarding the psychological effects of physical abuse and neglect. They noted a wide range of effects: affect dysregulation; disruptive and aggressive behaviors; insecure and atypical attachment patterns; impaired peer relationships, involving either increased aggression or social withdrawal; academic underachievement; and psychopathology, including depression, conduct disorder, attention-deficit/hyperactivity disorder, oppositional disorder, and posttraumatic stress disorder.

Sgroi (1982, 1988) described a pattern that is typical of intrafamilial sexual abuse and other sexual abuse that occurs over a period of time. The process evolves through five phases: (1) the engagement phase, when the perpetrator induces the child into a special relationship; (2) the sexual interaction phase, in which the sexual behaviors progress from less intimate to more intimate forms of abuse; (3) the secrecy phase; (4) the disclosure phase, when the abuse is discovered; and (5) the suppression phase, when the family pressures the child to retract his or her statements.

Summit (1983) described the child sexual abuse accommodation syndrome. He characterized the sexual abuse of girls by men as having five characteristics: secrecy; helplessness; entrapment and accommodation; delayed, conflicted, and unconvincing disclosure; and retraction. The process of accommodation occurs because the child learns that she

"must be available without complaint to the parent's sexual demands." The child may find various ways to accommodate: by maintaining secrecy in order to keep the family together, by turning to imaginary companions, and by employing altered states of consciousness. Others may become aggressive, demanding, and hyperactive. This "syndrome" is intended to help clinicians understand the dynamics of abuse, not to diagnose abuse. There is no such thing as a "child sexual abuse syndrome," that is, a specific cluster of symptoms that are diagnostic of sexual abuse.

Browne and Finkelhor (1986) reviewed and summarized almost 30 empirical studies that described the emotional and behavioral effects of child sexual abuse. They concluded that some sexually abused children show initial reactions of fear, anxiety, depression, anger, hostility, and inappropriate sexual behavior. The inappropriate sexual behavior included open masturbation, excessive sexual curiosity, and frequent exposure of the genitals.

Friedrich et al. (1987) and Friedrich and Grambsch (1992) found that the child who has been sexually abused is more likely than the normal child to manifest inappropriate sexual behaviors, such as trying to undress other people, talking excessively about sexual acts, masturbating with an object, imitating intercourse, inserting objects into the vagina or anus, and rubbing his or her body against other people. It is possible for a normal child who has never been abused to exhibit these behaviors. For the behaviors to suggest sexual abuse, they would need to be numerous and persistent. Friedrich and colleagues' studies were notable in that they compared abused children with normal controls.

Beitchman et al. (1991) reviewed the short-term effects of child sexual abuse. They found that victims of child sexual abuse are more likely than nonvictims to develop some type of inappropriate sexual behavior. In children this preoccupation with sexuality was manifested by sexual play, masturbation, seductive or sexually aggressive behavior, and age-inappropriate sexual knowledge. In adolescents, there was evidence of sexually acting out, such as promiscuity and possibly a higher rate of homosexual contact. They also found that the following factors were associated with more severe symptoms in the victims of sexual abuse: greater frequency and duration, sexual abuse that involved force or penetration, and sexual abuse perpetrated by the child's father or stepfather. Beitchman et al. (1992) also reviewed the long-term effects of child sexual abuse.

Green (1993) reviewed the immediate and long-term effects of child sexual abuse. He found that the major psychological problems found in sexually abused children were the following: anxiety disorders, such as fearfulness, nightmares, phobias, somatic complaints, and posttraumatic stress disorder; dissociative reactions and hysterical symptoms, such as periods of amnesia, trance-like states, and multiple per-

sonality disorder; depression, low self-esteem, and suicidal behavior; and disturbance of sexual behavior, including sexual hyperarousal and aggressive sexual behaviors, as well as avoiding sexual stimuli through phobias and inhibitions. Green did not believe that there is a specific child sexual abuse syndrome with predictable sequelae.

Kendall-Tackett et al. (1993) reviewed 45 studies regarding the impact of sexual abuse on children. They found that sexually abused children have more symptoms than non-abused children. The symptoms included fears, posttraumatic stress disorder, behavior problems, sexualized behaviors, and poor self-esteem. No one symptom characterized a majority of sexually abused children. Approximately one third of victims had no symptoms.

Terr (1990, 1991) described the psychological sequelae of children who have experienced acute and chronic trauma. Her work may be relevant in some cases of physical and sexual abuse. Terr listed four characteristics that occur after both types of trauma: (1) visualized or repeatedly perceived memories of the event; (2) repetitive behaviors; (3) fears specifically related to the trauma; and (4) changed attitudes about people, life, and the future. Children who sustained single, acute traumas manifested full, detailed memories of the event; a sense for "omens," such as looking for reasons why the event occurred; and misperceptions, including visual hallucinations and peculiar time distortions. On the other hand, many children who experienced severe, chronic trauma, such as repeated sexual abuse, manifested massive denial and psychic numbing, self-hypnosis and dissociation, and rage. In some of her work, Terr compared traumatized children (the children of Chowchilla who were kidnaped from their school bus) with normal controls (children from other towns).

### The Forensic Evaluation

*Normative Sexual Behaviors of Children.* It is important to be aware of normative sexual behaviors of children for two reasons. First, normal sexual play activities between children should not be taken to be sexual abuse. In assessing this issue, the evaluator should consider the age difference between the children, the developmental level of the children, whether one child was coercing the other child, and whether the act itself was intrusive, forceful, or dangerous. The second reason to be aware of normative sexual behaviors of children is that sexually abused children manifest more sexual behaviors than normal, so it is important to know what the baseline is. For a more detailed discussion, the reader is referred to Green (1988) and Johnson and Friend (1995). Rosenfeld et al. (1986) studied a nonclinical population and found that it is not uncommon for children, aged 2 to 10, to sometimes touch a parent's genitals. Rosenfeld et al. (1987) also studied

bathing practices for children of various ages. Friedrich et al. (1991) studied the normative sexual behavior of children by asking parents whether specific behaviors had occurred in the last 6 months. For example, they reported that at least 15% of the boys in the sample, aged 2 to 6, manifested the following behaviors: shows sex parts to children and adults, masturbates with hand, touches sex parts in public and at home. They reported that at least 15% of the girls in the sample, aged 2 to 6, manifested the following behaviors: talks flirtatiously, masturbates with hand, shows sex parts to adults, touches sex parts in public and at home.

*Guidelines for the Forensic Evaluation of Children Who May Have Been Abused.* Guidelines for the forensic evaluation of children who may have been abused have been published by several individuals and organizations. The American Academy of Child and Adolescent Psychiatry (1988) published "Guidelines for the Clinical Evaluation of Child and Adolescent Sexual Abuse," which had been formulated by the AACAP Committee on Rights and Legal Matters. These parameters are based, in part, on that AACAP position paper. The American Professional Society on the Abuse of Children (APSAC) (1990) developed guidelines for the psychosocial evaluation of suspected sexual abuse in young children, with a view that "the results of such evaluations may be used to assist in legal decisionmaking and in directing treatment planning." APSAC (1995a,b) has also published guidelines on the use of anatomical dolls and on the psychosocial evaluation of suspected psychological maltreatment. Jenkins and Howell (1994), proposing guidelines for child sexual abuse examinations, noted that "the position of the examiner is not to be a therapist or child advocate, but one to arrive at objective conclusions based on unbiased data." Gardner (1995), Ney (1995), Sgroi et al. (1982), Terr (1989), Walker (1988, 1990), Weissman (1991), and Wideman (1989, 1990) have contributed to the literature on this topic.

*Interview Techniques.* Daly (1991), Goodman and Saywitz (1994), Jones and McQuiston (1985), Lamb et al. (1995), Raskin and Yuille (1989), Sgroi et al. (1982), and Yuille et al. (1993) have proposed interview techniques for evaluating children who may have been abused. Dent and Stephenson (1979) studied the effectiveness of different techniques of questioning child witnesses. White and Quinn (1988) and Quinn and White (1989) described how statements and behaviors of the interviewer affect the outcome of the interview and may cause distortion of the data. Hibbard and Hartman (1993) showed that individuals from different professional groups (physicians and nurses; child protective service workers; lawyers, judges, and law enforcement officers; and psychologists) emphasize different topics when they investigate these cases.

In general, the professional who conducts forensic evaluations of children who may have been abused is faced with

several important tasks: finding out what happened, evaluating the child for emotional disorders, considering other possible explanations for these disorders, being aware of developmental issues, avoiding biasing the outcome with one's own preconceptions, pursuing these objectives in a sensitive manner and taking care not to retraumatize the child, being supportive to family members, and keeping an accurate record that will be useful in future court proceedings.

The Step-Wise Interview described by Yuille et al. (1993) presents a systematic approach to achieve these goals. It is not known scientifically or empirically whether the Step-Wise Interview is preferable to other interview methods in eliciting accurate reports. This method is presented here as an illustration, since individual evaluators may develop their own ways to achieve the goals of the interview. The Step-Wise Interview consists of the following components:

1. Rapport Building. During this time the interviewer makes informal observations of the child's behavior, social skills, and cognitive abilities.

2. Describing Two Specific Events. The interviewer asks the child to describe two specific past experiences, such as a birthday party or a school outing. In doing so, the interviewer models the form of the interview for the child by asking non-leading, open-ended questions, a pattern that will hold through the rest of the interview.

3. Telling the Truth. The interviewer establishes the need to tell the truth, in a stepwise fashion. Start with asking general questions and proceed, if necessary, to more specific questions. Reach an agreement that in this interview only the truth will be discussed, not "pretend" or imagination.

4. Introducing the Topic of Concern. Start with more general questions, such as "Do you know why you are talking with me today?" Proceed, if necessary, to more specific questions, such as, "Has anything happened to you?" or "Has anyone done something to you?" Drawings may be helpful in initiating disclosure. That is, either the child or the interviewer makes an outline of a person. Then the child is asked to add and name each body part and describe its function. If sexual abuse is suspected, when the genitals are described the interviewer could ask whether the child has seen or touched that part on another person and who has seen or touched that part on the child. If physical abuse is suspected, the interviewer could ask whether particular parts have been hurt in some way.

5. Free Narrative. Once the topic of abuse has been introduced, the interviewer encourages the child to describe each event from the beginning without leaving out any details. The child is allowed to proceed at his or her pace, without correction or interruption. If abuse had occurred over a period of time, the interviewer may ask for a description of the general pattern and then for an account of specific episodes.

6. General Questions. The interviewer may ask general questions in order to elicit further details. These questions should not be leading or suggestive and should be phrased in such a way that an inability to recall or lack of knowledge is acceptable. A leading question is: "Uncle Joe touched your bottom, didn't he?" A suggestive question is: "Did Uncle Joe touch your bottom?"

7. Specific Questions, if Necessary. It may be helpful to obtain clarification by asking more specific questions. For example, the interviewer may follow up on inconsistencies in a gentle, nonthreatening manner. If the child has used a term that seems inappropriate for a child, the interviewer may ask where he or she learned that word. In asking specific questions, one should avoid repetitive questions. Also, one should avoid rewarding answers in any way, particularly with praise.

8. Interview Aids, if Necessary. Anatomical dolls (with representation of genitals) may be useful in understanding exactly what sort of abusive activity occurred. The dolls are not used to establish a diagnosis, but they may be used to clarify what happened. A more detailed discussion of anatomical dolls is in a subsequent section.

9. Concluding the Interview. Toward the end of the interview, the interviewer may ask a few leading questions about irrelevant issues, such as "You came here by taxi, didn't you?" If the child demonstrates susceptibility to the suggestions, the interviewer would need to verify that the information obtained earlier did not come about through contamination. At the end, the child is thanked for participating, regardless of the outcome of the interview. The interviewer should not make any promises he or she cannot keep.

*Use of Drawings in Interviews.* Children's drawings are useful as an associative tool for assessing and accessing traumatic memories (Burgess and Hartman, 1993). Drawings are helpful in forensic assessments, including spontaneous drawings, asking the child to draw a male and female, kinetic family drawings, self-portraits, what happened and where it happened, or even a picture of the alleged offender. The usefulness of drawings lies in the affect and information they elicit and certain findings that may be suggestive of sexual abuse such as depiction of genitalia or avoidance of sexual features altogether. They should be interpreted in the context of the overall clinical picture.

*Use of Anatomical Dolls in Interviews.* It is not necessary to use anatomical dolls in the assessment of sexual abuse. They may be useful for eliciting a young child's terminology for anatomical parts and for allowing the child, who cannot tell or draw what happened, to demonstrate what happened. The dolls may also trigger memories of sexual events. Care should be taken not to use these dolls in a way to instruct, coach, or lead the child. They should not be used as a short cut to a more comprehensive evaluation of the child and the child's family.

Boat and Everson (1988a,b), Leventhal et al. (1989), and Skinner and Berry (1993) described how anatomical dolls may be used in these evaluations. Everson and Boat (1994) described how these dolls might be used in specific ways: as a comforter, as an icebreaker in the interview, as an anatomical model, as a demonstration aid, as a memory stimulus, as a diagnostic screen (in which the child's sexualized behavior is taken as a possible indicator of abuse that warrants further evaluation), and as a diagnostic test (from which an evaluator can draw definitive conclusions about the likelihood of abuse). These authors noted that no authority in this field has advocated the use of anatomical dolls as a diagnostic test. Realmuto et al. (1990) also concluded that anatomical dolls were a poor source of information to rely on in deciding whether a young child had been abused, in the absence of other pertinent history.

Several small studies (August and Forman, 1989; Cohn, 1991; Jampole and Weber, 1987; White et al., 1986) have compared sexually abused and presumably nonabused children as to their play with anatomical dolls. In general, these studies found that both abused and nonabused children explored these dolls in a sexual way (such as inserting their fingers into doll openings), but that abused children were more likely to demonstrate sexually related behavior.

Several authors have reported normative data, i.e., descriptions of anatomical doll play by normal children. Everson and Boat (1990) found that about 6% of 223 normal children, aged 2 to 5, manifested explicit sexualized play. It occurred more often when the interviewer was absent from the room than when he was present and was more likely to occur among poor African-American males. On the other hand, Sivan et al. (1988) observed 144 presumably nonabused children in a playroom with anatomical dolls. They reported that "nonreferred children found these dolls no more interesting than other toys" and that "no explicit sexual activity was observed."

Britton and O'Keefe (1991) showed that children manifest sexually explicit behavior with nonanatomical dolls as frequently as when they are interviewed with anatomical dolls. They concluded that either type of doll provides similar information in the interview setting.

*Interviewing Young Children.* The evaluation of an infant (aged less than 12 months), toddler (aged 12 to 36 months), or preschool child requires more specialized techniques. It is important to collect a developmental history from the parents or other caregivers. This includes the parents' perceptions and attitudes toward the child and the child's role in the family. The evaluator may want to see the child alone and in a joint meeting with one or both parents. This allows the evaluator to conduct an age-appropriate mental status examination and to assess the style of the parents and the relationship between the parent and the child. For further information, see Practice

Parameters for the Psychiatric Assessment of Infants and Toddlers (0–36 Months) (American Academy of Child and Adolescent Psychiatry, 1997).

*Other Interviews.* It is usually important to interview, separately, the individual making the allegation and the alleged perpetrator. In some cases, such as divorce-related allegations of sexual abuse, these interviews are the best way to reach an understanding of the case.

It is not appropriate to interview the child jointly with the alleged perpetrator to assess the validity or nature of the accusation. A joint interview is indicated only in helping to assess the possibility of reunification of the child and accused parent when the initial assessment reasonably suggests that the allegation of sexual abuse is false. The evaluator should consider the potential impact of such an interview on the child before proceeding. This issue has been addressed by Faller et al. (1991), Corwin et al. (1987), and Ehrenberg and Elterman (1995).

*Psychological Testing.* Psychological testing does not diagnose child abuse, but testing may be useful as part of the evaluation process. Waterman and Lusk (1993) reviewed the topic of testing in the evaluation of child sexual abuse and concluded that there are systematic and significant differences between sexually abused and nonabused children in many research studies. They thought that these differences in most tests are not the result of sexual abuse per se, but are the result of more generalized psychological distress or trauma. Leifer et al. (1991) described the Rorschach assessment of sexually abused girls. They found that sexually abused female subjects showed more disturbed thinking and experienced a higher level of stress relative to their adaptive abilities than did nonabused females.

*Behavior Checklists.* Testing that involves an assessment of sexual behavior may indicate the possibility of sexual abuse. For example, Friedrich et al. (1987, 1988) found that sexually abused children had higher scores than normative controls on the Sexual Problems scale of the Child Behavior Checklist. Kolko et al. (1988) used the Sexual Abuse Symptoms Checklist to discriminate children who were sexually abused from those who were physically abused. Friedrich and colleagues (Friedrich and Grambsch, 1992; Friedrich et al., 1991) used the Child Sexual Behavior Inventory to discriminate sexually abused children from nonabused children. Chantler et al. (1993) used the Louisville Behavior Checklist and the Emotional Indicator Scoring System for Human Figure Drawings to discriminate sexually abused children, clinic patients who were not abused, and community controls. Although the group scores were clearly different, some individual patients would have been misclassified by these measures. In using checklists, it is important to differentiate between sexual behaviors that were manifested during the time frame of the alleged abuse and the time frame since dis-

closure. That is, children who were not abused and were subjected to repeated interrogations may develop sexual symptoms that resemble the symptoms of children who were actually abused.

*False Statements and the Possible Explanations of Abuse Allegations.* Children may make false statements in psychiatric evaluations. Sometimes they make false denials regarding abuse (Sgroi, 1982; Sorenson and Snow, 1991; Summit, 1983). Children may make a false denial or recant a previous disclosure for many reasons, including pressure from the perpetrator or the family and fear of the judicial process. The child may "forget" what happened, may minimize the abuse, or may defend against bad feelings by empowering himself or herself ("He used to touch me but I hit him and ran away."). The child may deny the abuse because of fear of having done something wrong ("I was afraid you wouldn't love me if you knew what I did.").

Children may also make false allegations. Bernet (1993) reviewed this topic and developed a differential diagnosis of abuse allegations. Benedek and Schetky (1985), Everson and Boat (1989), Gardner (1992, 1995), Goodwin et al. (1978, 1980), Quinn (1991), Schuman (1986, 1987), and Yates and Musty (1988) have contributed to the literature on this issue. The evaluation of these children is complex because there are a number of distinct mental processes, both conscious and unconscious, that may result in false allegations. Long before the current interest in false allegations, Healy and Healy (1915) described how some of the children they evaluated in the first juvenile court clinic manifested pathological lying in making allegations of abuse. Green (1986) described how a delusional mother, who believed that her ex-husband had been molesting their daughter, induced the girl to state that the father had rubbed against her in bed. Clawar and Rivlin (1991) presented many examples of "programming" of children, especially in custody disputes. In some cases inept interviewers, by repeatedly asking leading or suggestive questions, have induced children to make false allegations of abuse. Bernet (1993) described how children may knowingly lie about abuse. Young children may tell "tall tales," and these innocent lies may result in false allegations of abuse. Older children may lie about abuse for revenge or for some personal advantage. For example, an adolescent girl, who became pregnant by her boyfriend, tried to accuse her stepfather of molesting her. In some cases, multiple allegations of abuse may have been generated through group contagion or epidemic hysteria (Ceci and Bruck, 1995; Kenner, 1989).

Sexual abuse allegations that occur in the context of a child custody dispute may be particularly complex. Faller (1991) identified four scenarios that result in allegations during or after divorce: abuse leading to divorce, abuse revealed during the divorce, abuse precipitated by the divorce, and improbable allegations during custody and access disputes. In these

cases, Derdeyn (1994) has said that there should be serious consideration of alternative explanations for phenomena reported by a parent as indicative of abuse.

*Research on Memory and Suggestibility of Children.* Several research studies have examined the suggestibility of children. For example, Cohen and Harnick (1980) compared how well younger children (grade 3), older children (grade 6), and college students remembered the events in a film and how resistant they were to suggestive questions. They found that the younger children were less accurate in their memory and much more likely to be influenced by misleading suggestions. Goodman and Reed (1986) compared how well very young children (3-year-olds), young children (6-year-olds), and adults recalled their interaction with an unfamiliar adult and how well they resisted suggestive questioning. They found that the very young children were less accurate on answering objective questions and were more likely to be misled by suggestive questions. They also found that on free recall the number of correct recollections increased with age. Johnson and Foley (1984) found that young children (under age 8) had more difficulty than did older children and adults in distinguishing between imagined events and those that actually occurred. Tobey and Goodman (1992) studied 4-year-olds who interacted with a "baby-sitter" and, in some cases, with a "policeman," who suggested that the "baby-sitter" may have done something wrong. In a subsequent interview the children who were exposed to the "policeman" were more likely to make incorrect comments after misleading questions. Loftus and Ketcham (1994) related an experiment in which a 14-year-old boy came to believe that he had been lost in a shopping mall as a child, when actually he had not. Ceci et al. (1994) showed how some children who repeatedly thought about a "non-event" (for example, that the child's fingers had been caught in a mousetrap) came to believe that the fictitious event actually happened. Surveys of the research in this area were presented by Ross et al. (1987, 1989), Doris (1991), Goodman et al. (1986), and Goodman and Helgeson (1988). Ceci and Bruck (1993, 1995) presented a historical review of this issue.

*The Child's Competency.* Competency refers to the child's ability to testify in court in a reliable, meaningful manner. Benedek and Schetky (1987a), Goodman and Bottoms (1993), Goodman et al. (1986), Melton (1981), Nurcombe (1986), Quinn (1986), Ross et al. (1989), and Zaragoza et al. (1995) have addressed this issue. Weissman (1991) summarized the four criteria that are generally required to establish competency: "the capacity to perceive facts accurately (e.g., mental capacity at the time of instant occurrence to observe or receive accurate impressions of the occurrence); the capacity to recollect and recall (e.g., memory sufficient to retain an independent recollection of the observation); the capacity to understand the oath (e.g.,

capacity to differentiate truth from falsehood, to comprehend the duty to tell the truth, and to understand the consequences of not fulfilling the duty); and the capacity to communicate based on personal knowledge of the facts (e.g., capacity to communicate the memory of such observation, and to understand simple questions about the occurrence)."

*The Child's Credibility.* Credibility refers to the child's truthfulness and accuracy. The child's credibility is ultimately determined by the jury or the judge, not by the forensic evaluator. Benedek and Schetky (1987b), Faller (1988b), Faller and Corwin (1995), Green (1986), Nurcombe (1986), Quinn (1988), Raskin and Esplin (1991, 1992), Rogers (1990a,b), and Steller (1989) have addressed how mental health professionals can assess credibility. For example, Benedek and Schetky (1987b) listed factors in the child that they thought enhanced credibility: the child uses his or her own vocabulary rather than adult terms and tells the story from his or her own point of view; the child reenacts the trauma in spontaneous play; sexual themes are present in play and drawings; the affect is consonant with the accusations; the child's behavior is seductive, precocious, or regressive; there is good recall of details, including sensory motor and idiosyncratic details; and the child has a history of telling the truth. Rogers (1990a) described the application of statement validity analysis and criteria-based content analysis to the evaluation of children who allege sexual molestation. She said that the following characteristics occur in unreliable or fictitious allegations: the child's statements become increasingly inconsistent over time; the statement is often dramatic or implausible, such as relating the presence of multiple perpetrators or situations in which the perpetrator has not taken ordinary steps against discovery; and statements progress from relatively innocuous behavior to increasingly intrusive, abusive, aggressive activities. These criteria for assessing credibility have been based on clinical experience and on limited preliminary research. They should not be taken to be infallible and could be misunderstood or misused. Finally, it should be noted that a child's spontaneous statement made while he or she was emotionally upset may have substantial value later in court (White v Illinois, 1992).

*Physical Examination of Children Who May Have Been Abused.* The physical findings in children who were physically and/or sexually abused were described and illustrated by Reece (1994), Monteleone (1994), and Monteleone and Brodeur (1994). The pattern and significance of physical findings in children who were sexually abused were described by Durfee et al. (1986), Finkel (1988), McCann et al. (1988, 1989, 1990a,b), Muram (1986, 1989a-c), and Muram and Elias (1989). The American Academy of Pediatrics (1991) has published guidelines for the evaluation of sexual abuse of children. In most cases of sexual abuse there are no abnormal physical findings. In Adams et al. (1994) the genital

examination in sexually abused girls was clearly abnormal in only 14% of cases. Dubowitz et al. (1992) emphasized the importance of the interdisciplinary team approach in the assessment of child sexual abuse, which includes both psychological evaluation and medical examination. They found that "both a disclosure by the child and abnormal physical findings were significantly and independently associated with the team's diagnosis of sexual abuse, whereas the presence of sexualized behavior, somatic problems, and the child's response to the [physical] examination did not make an additional contribution to the diagnosis."

*Testimony by Children.* In some instances when allegations of child abuse have been made, a criminal trial occurs and the child may need to testify. Child advocates have been concerned that the trial procedures may retraumatize the child, especially having to relate the abuse experience and being in the courtroom with the alleged perpetrator. Although testifying may be traumatic for some children, it is helpful for others. Kermani (1991, 1993) explained how the Supreme Court has tried to balance the constitutional rights of the defendant (to have a face-to-face confrontation with the child witness) with the best interests of the child (to avoid being retraumatized by the process). In *Maryland v Craig* (1990), a slim majority of five justices decided that the Sixth Amendment indicates a "preference," but not an "absolute" right, for the defendant to have a face-to-face meeting with the accuser. As a result, the Supreme Court said it was acceptable in that particular trial to use closed-circuit television, which allowed the defendant to see the child, but protected the child from seeing the defendant. Another way to deal with the issue of the child's testimony is to make a videotape of the child early in the investigation. The videotape protects the child from repeated questioning and, in some states, may substitute for testimony in court.

### Important Forensic Issues

*Role Definition.* The evaluator needs to know whether he or she is conducting a forensic evaluation intended to be read by attorneys and used at court or a clinical assessment for treatment purposes. These practice parameters pertain to the forensic evaluation of children who may have been abused. The child's therapist should not be the person who is conducting the forensic evaluation. However, the child's therapist should be available to share information with the independent evaluator.

The evaluator also needs to know who has hired him or her and to whom he or she owes professional responsibility. This is the issue of agency. That is, in most clinical situations the evaluator is serving as the agent of the patient. In most forensic situations, the evaluator is serving as the agent for someone or some institution other than the individual being

examined. Regardless of who has hired the evaluator, the process remains the same and the conclusions remain the same; what changes is who receives the report. The evaluator should have a clear understanding of what is expected, such as the preparation of a report and a willingness to testify in court.

*Clear Communication.* The forensic evaluator should make sure that the child who is being assessed and the parent understand the reason for the evaluation and the role of the evaluator. The child should understand, consistent with his or her level of development, that this is an evaluation and is not therapy, that this evaluation is being done at the request of a particular person or agency, and that the results will be sent to the appropriate people.

*Confidentiality.* Forensic evaluations are frequently performed on behalf of some person or agency other than the child and parents. It is important for the parent and child to know that the evaluation will not be confidential. If a clinician has reason to believe that physical or sexual abuse has occurred, the federal government and all states require that the circumstances be reported to the agency that is legally authorized to investigate the matter. Finlayson and Koocher (1991) have studied how professional judgment affects the decision to report child abuse. Since there are so many exceptions to the doctrine of confidentiality, the clinician should be aware that any written record may be read in the future by the individual being evaluated and by many other people.

*Privilege.* Privilege is a form of confidentiality that may arise in a judicial setting. A person has the right of testimonial privilege when he or she has the right to refuse to testify or to prevent another person from testifying about specific information. For instance, a person may claim that his or her therapy is covered by clinician-patient privilege, preventing the clinician from testifying about him or her. The person may waive the right to clinician-patient privilege and allow the clinician to testify. The clinician ordinarily should testify only if the patient has waived his or her right to privilege. In some circumstances, however, the court can order the clinician to testify in spite of the patient's objections.

*The Problem of Bias.* It is important for the clinician to be aware of his or her own motivations, as well as the agendas of the other professionals involved in the case. Despite all that is known about countertransference, therapists sometimes base conclusions on their own preconceived assumptions rather than on the data that have been presented. Bias is important in forensic cases in two ways. First, bias creates a distorted filter through which the evaluator views the situation. Second, a clinician who enters a case with a particular bias is likely to change the situation that should be studied objectively. For example, mental health professionals often see themselves as healers and caretakers; this perspective may affect their ability to consider a case completely objectively.

To guard against bias, clinicians should be aware of their own motivations. Another way for the clinician to safeguard against bias is to indicate in detail the reasons for the conclusions in the written report, so that the court will fully understand the basis for the opinion. The clinician should also preserve a record, the raw data, that another person can review. If in doubt about the possible role of bias in an evaluation, the clinician should discuss the case with a colleague.

*Awareness of Limitations.* It is important for mental health professionals to recognize the limits of scientific knowledge in this area. Horner et al. (1993a,b) questioned the reliability of clinical opinions in cases of alleged child sexual abuse. They found that experienced clinicians arrived at widely different conclusions after considering the same case. Divergent opinions may be the result of subtle biases, different emphases that clinicians attach to components of the evaluation, and the withholding of crucial information from the evaluators. Another factor to recognize is the influence of the many participants in these cases. The individuals involved may be extremely opinionated and may try to influence the evaluator through comments or behaviors that may be either subtle or blatant.

*Degrees of Certainty.* There are several standards of proof or levels of certainty that must be established in order for a judicial decision to go a particular way. (1) The least exacting level of certainty is "probable cause." In clinical practice, that may be a sufficient level of certainty to report a suspected instance of child abuse. (2) In civil cases, the side prevails that establishes a "preponderance of the evidence." This can be expressed quantitatively as being 51% certain. (3) In some cases that involve psychiatric evidence, the level of certainty is "clear and convincing proof," which is proof necessary to persuade by a substantial margin, which is more than a bare preponderance. For example, the proof that child abuse has occurred or the basis for terminating parental rights must be clear and convincing. (4) Criminal cases require proof that is "beyond a reasonable doubt," or beyond question. To convict a specific person of child abuse would require proof beyond a reasonable doubt. (5) When physicians testify in court, they frequently are asked whether their opinions are given with "a reasonable degree of medical certainty." Rappoport (1985) has proposed that reasonable medical certainty is a level of certainty equivalent to what a physician uses when making a diagnosis and starting treatment. The implication is that the degree of certainty would depend on the clinical situation.

*Knowledge of the Law.* In performing a forensic evaluation it is important to know the legal issue that is the original basis for the dispute and the evaluation. The attorney involved in the case can provide the relevant legal information. The pertinent legal issue may be defined in an actual law that the federal or state legislature has passed, or it may be embodied in case law. For example, the concept of the best interests of

the child was enunciated by Justice Benjamin Cardozo in *Finlay v Finlay* (1925). The requirement that physicians report suspected abuse was reinforced in *Landeros v Flood* (1976). The creation of false recollections of abuse through suggestive interviews was criticized in *State v Michaels* (1994). The reader may wish to consult *Legal Issues in Child Abuse and Neglect* (Myers, 1992).

### Scientific and Clinical Ratings

Decisions regarding the appropriateness of either diagnostic or treatment recommendations in these parameters were made by considering both the available scientific literature as well as the general clinical consensus of child and adolescent psychiatry practitioners. The validity assigned to any particular scientific finding was judged using the routine criteria by which research is assessed, that is the appropriateness of design, sample selection and size, inclusion of comparison groups, generalizability, and agreement with other studies. The limitations in the available research literature as well as the relative indications for specific interventions are noted in both the literature review and the specific parameters.

The recommendations regarding specific diagnostic evaluations and treatment interventions reflect those methods of practice that are either supported by methodologically sound empirical studies and/or are considered a standard of care by competent clinicians. However, the general paucity of sound scientific data regarding childhood psychiatric disorders and their treatment necessitated that most of the recommendations set forth in these parameters were based on clinical consensus. Those practices that are described as having limited or no research data and also lack clinical consensus regarding their efficacy may still be used in some selected cases, but the clinician should be aware of the limitations and document the rationale for their use.

Clinical consensus was initially derived by the members of the Work Group on Quality Issues in preparation of these parameters. A preliminary draft was sent to experts for review and their comments were incorporated. A draft was distributed to the entire membership of the American Academy of Child and Adolescent Psychiatry for review. In addition, the proposed recommendations were discussed at an open forum held at the Academy's 1995 annual meeting. The Work Group incorporated suggested revisions into the final version of the parameters, which then was sent to the Academy's Council for review and approval.

Those practices that are not recommended represent areas in which there is neither sound empirical data nor high clinical consensus that such practices are effective, or their potential risks are not justified. If such practices are to be used, the clinician should clearly document the justification for that decision.

### OUTLINE OF PRACTICE PARAMETERS FOR THE FORENSIC EVALUATION OF CHILDREN AND ADOLESCENTS WHO MAY HAVE BEEN PHYSICALLY OR SEXUALLY ABUSED

The evaluator of a possible victim of abuse should adhere to the same basic principles as those employed in any thorough psychiatric evaluation. That is, the examiner should take a history and strive to collect data that are as complete and accurate as possible. The interview of the child should lead to observations about both conscious and unconscious processes and should address both form (the way the child communicates and how he or she relates to the interviewer) and content (what he or she actually says), and the examiner should keep an open mind regarding the differential diagnosis and the possible explanations for the data that have been collected. The forensic evaluation differs from the usual psychiatric evaluation in that it relies more heavily on collateral data, such as police reports, statements from witnesses, medical reports, and assessments of other family members.

#### I. Role definition and clarification.

- A. Explain evaluator's role to the parents, to the other adults and systems, and to the child in an age-appropriate manner.
- B. Explain who has requested the evaluation, the purpose of the evaluation, and confidentiality issues, such as who gets the report.
- C. Clarify that the forensic evaluator and the child's therapist should be separate individuals.
- D. Be prepared to testify in court.
- E. Clarify payment issues prior to performing the evaluation.

#### II. Diagnostic assessment.

- A. Obtain a history from parents, child, and other pertinent informants. Refer to the "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" with added emphasis on:
  1. How the allegation originally arose and subsequent statements that were made. Determine the emotional tone of the first disclosure, such as whether the disclosure arose in the context of a high level of suspicion of abuse.
  2. Sequence of previous examinations, techniques employed, and what was reported. Try to determine whether the previous interviews were likely to have distorted the child's recollections. For instance, review transcripts, audiotapes, and videotapes of earlier interviews.
  3. Symptoms and behavioral changes that sometime occur in physically abused children,

- such as depression, aggressive behaviors, and dissociative symptoms.
4. Symptoms and behavioral changes that sometimes occur in sexually abused children.
    - a. Anxiety symptoms, such as fearfulness, phobias, insomnia, nightmares that directly portray the abuse, somatic complaints, post-traumatic stress disorder.
    - b. Dissociative reactions and hysterical symptoms, such as periods of amnesia, daydreaming, trance-like states, hysterical seizures, and multiple personality disorder.
    - c. Depression, manifested by low self-esteem, suicidal and self-mutilative behaviors.
    - d. Disturbances in sexual behaviors, including sexual hyperarousal manifested by frequent or open masturbation, excessive sexual curiosity, imitating intercourse, inserting objects into vagina or anus, sexual promiscuity, and sexually aggressive behavior toward others. Age-inappropriate sexual knowledge. May also avoid sexual stimuli through phobias and inhibitions.
    - e. Somatic complaints, such as enuresis, encopresis, anal and vaginal itching, anorexia, obesity, headache, and stomach-ache.
    - f. Nonabused children may exhibit any of these symptoms and behaviors.
  5. History of overstimulation, prior abuse, or other traumas. Consider other stresses besides abuse that could account for the child's symptoms.
  6. Exposure to other possible male and female perpetrators.
  7. Confounding variables, such as psychiatric disorder or cognitive impairment, that may need to be considered.
  8. Family's attitude toward discipline, sex, and modesty.
  9. Developmental history, from birth through periods of possible trauma to the present.
  10. Family history, such as earlier abuse of the parents; substance abuse by the parents; spouse abuse; psychiatric disorder in the parents.
  11. Underlying motivation and possible psychopathology of adults involved.
  12. History from the perspective of each parent.
- B. Consider requesting collateral information from the following, after obtaining authorizations.
1. Protective services.
  2. School personnel and past school records.
  3. Other caretakers, such as baby-sitters.
  4. Other family members, such as siblings.
  5. Pediatrician.
  6. Police reports.
- C. Process of the interview with the child, including mental status examination.
1. Choose a relaxed and neutral location.
  2. If possible, audiotape or videotape the interview.
  3. Establish rapport, which may require two or three interviews. Keep the number of interviews to a minimum, as multiple interviews may encourage confabulation.
  4. Test the child's ability to describe historical events accurately.
  5. Assess the child's understanding of telling the truth, as opposed to pretending.
  6. Encourage spontaneous narrative.
  7. Proceed from more general statements to more specific questions.
  8. Avoid repetitive questions, either/or questions, multiple questions. As much as possible, avoid leading and suggestive questions.
  9. Use restatement, i.e., repeating the child's account back to the child. This allows the interviewer to determine whether the child is consistent and to make sure the interviewer understands the child's account.
  10. In general, the examination should take place without the parent present.
  11. If child is very young, consider having a family member in room. Utilize observations of the child's language and behavior rather than direct questioning.
  12. The examination technique used should be appropriate to the child's age and developmental level.
  13. Determine the child's terms for body parts and sexual acts. Do not educate or provide new terms.
- D. Content of the interview with the child. The following areas should be explored during the interview, but not in the form of an interrogation. Note the child's affect while discussing these topics and be tactful in helping the child manage anxiety. Young children may not be able to report all of the relevant information.
1. Whether the child was told to report or not to report anything.
  2. Who the alleged perpetrator was.
  3. What the alleged perpetrator did.
  4. Where it happened.

5. When it started and when it ended.
  6. The number of times the abuse occurred.
  7. The method of initially engaging the child and how the abuse progressed over time.
  8. How the alleged perpetrator induced the child to maintain secrecy.
  9. Whether the child is aware of specific injuries or physical symptoms associated with the abuse.
  10. Whether photography or videotaping was involved.
- E. Other procedures.
1. Consider the risks and benefits of drawing pictures to identify body parts, to show what happened. This should be considered only one part of the entire forensic evaluation.
  2. Consider the risks and benefits of using anatomical dolls to identify body parts, to show what happened. This should be considered only one part of the entire forensic evaluation.
  3. The following are contraindicated in forensic evaluations of children who may have been abused: hypnosis, Amytal interviews, facilitated communication, guided imagery to enhance memory, and either rewards or negative reinforcement that are used to encourage openness or communication. It should be possible to be generally supportive without rewarding the child's statements.
- F. Psychological testing.
1. Consider culturally appropriate intelligence testing and educational testing if the child has manifested academic problems or if retardation may be a factor in assessing competency.
  2. Consider personality testing if it might be helpful in clarify diagnostic issues.
  3. Consider parent questionnaires that assess sexual behaviors, such as the Child Behavior Checklist, the Sexual Abuse Symptom Checklist, and the Child Sexual Behavior Inventory. If these checklists are used, it is essential to differentiate between sexual behaviors during the time frame of the alleged abuse and sexual behaviors after disclosure.
  4. The results of psychological testing should be considered as only one part of the entire forensic evaluation. Do not rely on testing by itself to make conclusions regarding abuse. Psychological testing does not by itself distinguish true and false allegations.
- G. Physical examination of the physically abused child. Ordinarily the mental health professional would review the examination that has been done by a pediatrician. Photographic documentation may be useful. Among the potential signs of abuse:
1. Injuries commonly seen after physical punishment, such as bruises on the buttocks and lower back, perhaps at different stages of healing.
  2. Bruises with the configuration of hand marks, pinch marks, and strap marks.
  3. Certain types of burns, such as multiple cigarette burns and scalding of the hands, feet, perineum, and buttocks.
  4. Subdural hematoma.
  5. Abdominal trauma, leading to ruptured liver or spleen.
  6. Fractures, when there is no plausible explanation for how the injury occurred.
  7. Radiological signs of multiple broken bones.
  8. Retinal hemorrhages, which occur in shaken baby syndrome.
- H. Physical examination of the sexually abused child. Ordinarily the mental health professional would review the examination by a pediatrician or by another qualified clinician. It is important to take precautions to preserve evidence.
1. Most sexually abused children do not have any corroborating physical findings.
  2. Findings that are consistent with sexual abuse but are nonspecific: inflammation, scratching, purulent discharge, small skin fissures or lacerations in the area of the posterior fourchette, or foreign bodies in genital, anal, or urethral openings.
  3. Findings that strongly suggest sexual abuse: recent or healed lacerations of the hymen, vaginal mucosa, or anal mucosa; enlarged hymenal opening; teeth marks; laboratory reports of sexually transmitted disease that was not acquired perinatally, including gonorrhea, syphilis, human immunodeficiency virus, *Chlamydia*, *Trichomonas vaginalis*, condylomata acuminatum, and herpes.
  4. Findings that are definitive that sexual activity occurred: presence of sperm or of acid phosphatase; pregnancy.
- I. Other interviews.
1. If possible, interview the person who is raising the concern about the possibility of abuse.
  2. If possible, interview the alleged perpetrator, to elicit his or her version and explanation for what has happened.

3. A joint interview of the child and alleged perpetrator is not appropriate to assess the validity or nature of the accusation. It may be useful, however, for assessing the possibility of reunification when the initial evaluation reasonably suggests the allegation of sexual abuse is false. Keep in mind the effect of such an interview on the child.
- J. Consider an in-home evaluation by the evaluator or a child protection team member.
- III. Possible explanations of denials of abuse. Sometimes children may deny or retract allegations of abuse. This may occur for several reasons, including the following:
- A. The alleged abuse did not occur.
  - B. The child was pressured by the perpetrator or by family members to recant the allegation. The pressure may consist of bribery, mockery, or threats of injury.
  - C. The child may be protecting a parent or other family member, even without external coercion. That is, the child may be taking on this responsibility through role reversal.
  - D. The child was frightened or distressed by the investigation process and decided to withdraw his or her participation. For instance, an interviewer could have induced a false denial by asking overly challenging questions.
  - E. The child did not want to testify because of shame or guilt.
  - F. The child may have mistakenly assumed that he or she may be responsible for what happened.
  - G. The child consciously or unconsciously took the role of "accommodating" to the abuse rather than objecting to it.
  - H. The interviewer could have triggered a false denial by questioning the child in the room with the alleged perpetrator.
- IV. Possible explanations of allegations of abuse. Sometimes children make false allegations. Although most allegations made by children are true, the evaluator should consider the ways in which false allegations might come about. An allegation may be partly true (that the child actually was abused), but partly false (as to who was the perpetrator). An allegation may have a nidus of truth, but may have been inaccurately elaborated in response to repetitive questioning.
- A. A false allegation arises in the mind of a parent or other adults and is imposed on the child.
    1. Parental misinterpretation and suggestion. The parent has misinterpreted an innocent remark or neutral piece of behavior as evidence of abuse and induced the child to endorse this interpretation. This happens sometimes in child custody disputes as well as other settings.
    2. Misinterpreted physical condition. The parent has assumed that an unremarkable rash or insect bite, for instance, is a sign of abuse.
    3. Parental delusion. The parent and child may share a *folié a deux* or the child may simply give in and agree with the delusional parent.
    4. Parental indoctrination. The parent fabricated the story and induced the child to collude in presenting it to the authorities.
    5. Interviewer's suggestion. Previous interviewers have asked leading or suggestive questions.
    6. Misinterpreted parental behavior. The parent's behavior, though not abusive in itself, becomes problematic and perhaps overstimulating in the context of parental separation and divorce (for example, sleeping in the same bed with an older child).
    7. Group contagion. In epidemic hysteria people modify what they have heard in a way that meets their own emotional needs. The rumor may become more convincing as it is retold.
  - B. The allegation is produced by mental mechanisms in the child that are not conscious or not purposeful.
    1. Fantasy. A younger child may confuse fantasy with reality.
    2. Delusion. Although rare, delusions about sexual activities may occur in older children and adolescents in the context of a psychotic illness.
    3. Misinterpretation. The child may have misunderstood what happened, so he or she later reported it inaccurately.
    4. Miscommunication. The child may misunderstand an adult's question; the adult may misinterpret or take the child's statement out of context.
    5. Confabulation. The child fills gaps in his or her memory with whatever information makes sense to him or her and others at the time.
  - C. The allegation is produced by mental mechanisms in the child that are usually considered conscious and purposeful.
    1. Fantasy lying. Children who understand the significance of lying may nonetheless fabricate because of frustration or disappointment.
    2. Innocent lying. Children make false statements because that seems to be the best way to handle the situation. Developmentally, this happens more with younger children.

3. Deliberate lying. Children may choose to avoid or distort the truth for some personal advantage. This happens more with older children.
- D. Perpetrator substitution. The child actually may have been sexually abused and manifests symptoms consistent with abuse, but identifies the wrong person as the perpetrator, resulting in a false allegation. The child may do this to protect the actual offender or the child may displace the memories and accompanying affects onto another individual.
- V. Issues regarding the child's testimony.
- A. Competency refers to the child's ability to testify in court in a reliable, meaningful manner. The following factors should be considered in evaluating competency.
1. Child's capacity to perceive facts accurately.
  2. Child's capacity to recollect and recall.
  3. Child's capacity to distinguish truth from falsehood, fantasy from reality; to comprehend duty to tell the truth.
  4. Child's capacity to communicate based on personal knowledge of the facts.
- B. Credibility refers to the child's truthfulness and accuracy, the assessment of which is ultimately the province of the judge or jury. The following factors may indicate that the child is more credible, but none is definitive. It has not been shown scientifically that these factors distinguish true from false allegations.
1. Spontaneity, in that the child volunteers information spontaneously rather than after the parent admonishes him or her to tell the story.
  2. Detailed descriptions in the child's own language and from the child's point of view, using age-appropriate terminology.
  3. Realistic account, in that the story is plausible and physically possible.
  4. Idiosyncratic sensory detail, such as a verbatim conversation and specific memories that are peripheral to the main event.
  5. Generally consistent account, but having slight variations with retelling.
  6. Relating story bit by bit, rather than all at once. This means that the credible child may relate the story piecemeal over several interviews, until the account is complete. However, the child who endlessly adds more and more information (more perpetrators, more acts, increasingly bizarre information) may be engaging in confabulation or fantasy lying.
7. Appropriate affect, although there may be many reasons why the child is anxious, fearful, or defensive or manifests isolation of affect.
  8. Candid style, such as making spontaneous corrections, admitting there are details he or she cannot recall.
  9. Favorable comparison of the history of the child's symptoms and behaviors with the content of the interview.
- C. Whether the child should testify.
1. Consider making a statement as to whether the child should testify, weighing the psychological risks and benefits to the child.
  2. Consider alternatives to face-to-face testimony, such as taping the evaluation and using closed-circuit television, consistent with local law.
- VI. Recommendations regarding placement and treatment.
- A. The clinician should follow state law in determining whether the case should be reported to protective services. If in doubt, call protective services and discuss the case without giving the patient's name. Keep a record of any contact with protective services.
- B. If the child is considered at risk, the decision regarding placement of the child is usually made by protective services or by the court. The clinician may be asked to make recommendations. A variety of options should be considered, such as:
1. Remove the alleged perpetrator from the home. The court may specify that the alleged perpetrator undergo treatment and/or incarceration before returning to the home.
  2. Remove the child from the home. When rehabilitation of the abuser is under way, the court may allow the child to return home under the supervision by a child protection agency. If efforts at rehabilitation are unsuccessful, the court may decide to terminate parental rights.
  3. It might be possible to keep the family together if the parents are highly motivated and appear responsible, if active treatment is under way, and if the perpetrator accepts responsibility for his or her actions and is capable of controlling his or her behavior.
- C. If asked, the clinician may make general recommendations regarding referral for further assessment and treatment. This may involve a multidisciplinary treatment plan, including crisis intervention, individual therapy, group therapy, family therapy, inpatient treatment, residential treatment, and pharmacotherapy. Consider further

evaluation, especially if there is comorbidity with other psychiatric conditions.

- D. Consider whether other children, such as siblings and close friends, are at risk. If so, recommend evaluations of these children by protective services.

#### VII. Written report.

- A. Identifying information, such as names and birth dates.

B. Referral information.

1. Name, agency of referral source.
2. Circumstances of the referral.
3. Current status of the case.
4. Statement of specific purpose of evaluation.

C. Procedure for this evaluation. Document:

1. The discussion of the evaluator's role and the lack of confidentiality.
2. The various meetings and interviews that were held. Mention special circumstances, such as who was present and whether the evaluation was electronically recorded.
3. Psychological testing utilized.
4. Outside information that was considered.

D. Current situation. In the context of a chronological account, address:

1. Circumstances of the alleged abuse (who, what, when, where, how).
2. Symptoms that might be related to the alleged abuse.
3. How disclosure came about.
4. What happened then, including a statement regarding previous evaluations and interviews of the child. Comment on whether the previous evaluations employed appropriate techniques.

E. Past history, especially prior level of functioning and information that might be related to the possible abuse or alternative explanations for the symptoms.

F. Family history, especially information that might be related to the possible abuse.

G. Developmental history.

H. Medical history, including the findings from the forensic pediatric examination.

I. Mental status examination, including comments regarding competency and credibility.

J. Psychological testing.

1. Performed when, where, and by whom, and which tests were administered.
2. Summary of testing results.

K. Diagnoses.

1. *DSM-IV*. Abused children do not necessarily have posttraumatic stress disorder or any other

mental disorder. Use the diagnoses, if any, that most accurately reflect the condition of this individual.

2. If a false denial or false allegation is likely, discussion of the possible explanations.

L. Conclusions.

1. A list of specific statements that are supported by the data in the report.
2. Express an opinion about whether abuse occurred and the degree of certainty. The evaluator should keep in mind that in some cases it is not possible to arrive at conclusions that are certain enough to be helpful to a court.
3. Use language that will be understandable in court. Avoid professional jargon.

M. Recommendations that are realistic and follow logically from the conclusions.

#### Conflict of Interest

In keeping with the requirement that practice parameters be developed by experienced clinicians and researchers, some of the contributors to these practice parameters are in active clinical practice. Through their practices, it is likely that some of these child and adolescent psychiatrists have received income related to services discussed in these parameters. Some contributors are primarily involved in research or other academic endeavors; it is possible that through such activities, many of them have also received income related to services discussed in these parameters. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest: first, the development process calls for extensive review of the document before it is finalized. All members of the Academy have the opportunity to comment on the parameters before they are approved. Comments have been solicited and received from a broad group of reviewers from child and adolescent psychiatry, psychology, and the legal profession. Second, the contributors and reviewers have all been asked to base their recommendations on an objective evaluation of the available evidence. Third, we ask that any contributor or reviewer who believes that he or she has a conflict of interest that may bias or appear to bias his or her work should notify the Academy.

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