THE CRIMINAL DEFENSE OF CHILD MOLESTATION ALLEGATIONS:

THE PSYCHIATRIC KNOWLEDGE BASE FROM

WHICH TO EVALUATE YOUR CASE

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It is a great pleasure and an honor to be asked to speak with you today – a psychiatrist among a sea of attorneys. You are probably wondering what I can offer you in your real-world day-to-day work, and I plan to rise to that challenge with some very pointed information and facts. You live in an adversarial system, with innocence and guilt and with crime and punishment. Your job is to provide the best defense you can for your client, and in a case of child molestation you find yourself in an enormously charged context. Unfortunately, the accused in our society is often assumed by a jury to be guilty, despite our legal system in which you are innocent until proven guilty. Juries and judges most often have only a marginal grasp of how to evaluate testimony in sexual abuse cases, or others, involving children and mental health experts. In order to defend your client you must challenge the prosecutor's case and that means challenging the credibility of testimony and offering the court other explanations for the testimony they hear. I will give you some important concepts derived from child development and psychiatric expertise in order to do just that.

I am a child psychiatrist, devoted to the care of children and an advocate for them. I was at first somewhat conflicted about providing my expertise about sexually abused children to defense attorneys, who defend alleged perpetrators. Why would I want to do this? Well, it became so poignantly clear as I prepared. Your understanding could protect innocent adults, and children from losing their innocent fathers to long incarceration. One afternoon while riding a stationary bike before playing tennis, I mindlessly watched the Montel show on January 26th. His topic was the Northern California Innocence Project and, its work for men, fathers, who had been falsely accused and then imprisoned for child sexual abuse. Some of these men had been

abused as children themselves. They appeared on Montel, with their children and gave heartfelt thanks that someone, attorneys like you, went to bat for them. They were now reunited as a family; they and their children were tearful. They needed smart, informed, diligent hard-working defense counsel. I believe you need information from the world of a child psychiatrist. I do not want falsely accused adults convicted. I do not want children to lose a parent to incarceration unjustly.

My experience in this is primarily clinical, and my forensic work has been in civil and family litigation. Allegations of abuse are increasingly common in family court matters. The critical issues that relate to the "outcries," child testimony, forensic child sexual abuse evaluations, credibility of reports and testimony are the same. The focus of this presentation is what you need to know in order to evaluate the reports of the children, their videotapes, their parents, and other adults, C.P.S., and the results of expert mental health evaluators. You need to understand how children communicate in interviews, proper conduct of an assessment, the suggestibility of children, their understanding of the "truth", and how their testimony is given and is properly cross-examined.

Let me share a sample of my own forensic consultations in relevant cases that I have considered in trying to organize the issues for you.

1. A priest is accused of sexually abusing a 14 year old girl by intercourse. They believe they are in love, and the priest is a close and trusted friend of the girl's parents. I was consulted by the defense attorney.

2. A male dorm supervisor in a boarding school is accused of mutual masturbation and voyeurism with a 13 year old previously troubled male student sent to the school for treatment. In this case I was consulted by the plaintiff's counsel.

3. A bus driver for a school district is accused of fondling a number of girls age 8-12. They allege he touched their privates through their panties. One alleged he tried to have intercourse with her at his home, and another alleged he made her touch his penis. I was consulted by the defense.

4. I was a court appointed expert in a terrible family court modification/custody case, a 4 year old boy told his teacher that his father, an attorney, had put his finger in his "butt" since he was 2 years old. There were multiple family court hearings. A hired last minute expert testified in behalf of mother. And then after multiple outcries all probably initiated by his angry, very disturbed mother, the boy, at the time 7 years old, called to testify in criminal court. Political pressure led to D.A. to pursue this prosecution almost without doubt. Mother had a long history of alleging sexual harassment and abuse by males throughout her youth. She repeatedly had perceived men as having been sexually inappropriate, aggressive and frightening. From an affluent family with influential, powerful connections, they were able to influence the police, District Attorney and F.B.I. After multiple outcries the D.A. with a grand jury indictment against the father, goes to trial. The child testified he did not remember being abused by his father. I served as a consultant to the criminal defense attorney in this case.

5. I was a court appointed family evaluator in a family court matter in which issues of abuse arose, because a 6 year old boy exhibited inappropriate behavior

suggestive of sexual abuse. After a careful psychiatric evaluation, I diagnosed him as suffering a bipolar disorder. While his father had a severe personality disorder and was an unreliable parenting figure, there was no evidence of sexual abuse. However, his mother with some good reason was very concerned her son was being sexually abused both because of his behavior and his father's callous and intimidating behavior. Treatment of the child with appropriate medication relieved him of his symptoms. Father was given supervised visitation by the Court due to his irresponsibility and hostility with the child; no charges of sexual abuse were filed.

6. I have been an expert consultant in a malpractice case against a psychiatrist accused of sexually inappropriate conduct with an 8 y/o girl. I'll speak to this matter later.

The venue for me today is somewhat unusual. I am accustomed to attorneys' trying at least to spin my testimony if not discredit and humiliate me on the stand. You may be just as skeptical about what I, a psychiatrist, have to offer you.

Nevertheless, let's work together today. Have an open mind and see if my information can be useful to you; not only in sexual molestation cases but in a variety of ways with children testifying as well as adults. I will try to speak plainly, understandably and touch squarely on many of the major issues you must address in mounting a defense. I hope to leave you more than a few pearls of critical information and instead to offer you a foundation from which you will understand the data, the evidence, far better and know how to address it.

I. INTRODUCTION:

I have over 30 years of experience with child sexual abuse as a practicing child psychiatrist. I have seen a small group of perpetrators but have considerable experience mostly from family litigation relevant to your work. There is a vast amount of literature regarding abuse, child development, children's memory and suggestibility, children's responses to sexual abuse, the conduct of a proper evaluation, and on pedophilia and child molestation. There's pertinent information available from very disparate sources, and I will try to address the most important issues in an organized way. Some cases have adult eye witness and supporting medical examinations, and in those situations the information I have may be of less importance. However, many allegations are made by children, by an angry divorced mother, by a teacher with second hand information or who observed sexualized behavior and presumed abuse, or by a professional who has followed the law and reported to C.P.S. A mental health evaluation of the child, a C.P.S. interview may or may not derive appropriate conclusions, reports and testimony. I will provide a sound foundation for you to study these reports and cross-examine witnesses.

In order to prosecute or defend, the D.A. and defense counsel need to understand how to interpret the available information regarding the child, the alleged perpetrator and the witnesses including experts. As in any case you must evaluate the evidence, its weight and its credibility. In some of these highly charged cases in which the story alleged is so shocking to the jury that it seems it almost must be true (if you tell a lie make it a big one, and people will believe you). It is imperative for you have the

tools necessary to evaluate this evidence. I would guess very few people in your arena have this foundation.

Let's consider the following topics:

1. The History and Definition of Child Sexual Abuse
2. Child Developmental Stages and Memory.
3. Sexual Abuse – Types, Parameters in Regards to Sequalae
4. Child Psychiatric Assessment
    a. Outcry and Presentation
    b. Interview of Parents/Adults
    c. Interview of the child
        i. Types, including question types
        ii. Repetitive
        iii. Source of information
        iv. Videotaping
5. Interviewing Clinical vs. Forensic Assessment
6. Factors Associated with "True" and "False" Allegations
7. Children's Level of Cognition, Memory, "Lies" and Misinformation
8. C.P.S., Police and other Testimony
9. Family Court and Criminal Court Actions in Parallel
10. Pedophilia and the Child Molester;
11. The Accused Molester – Your Client;

II. CHILD SEXUAL ABUSE – OVERVIEW:

There is a broad base of reports on the sexual abuse of children as well as pedophilia in the professional literature in journals and books. From this knowledge base one can drawn information that allows for a case by case evaluation. Relevant data includes the type of alleged behavior, the number of episodes, the use of force or threats, the child's age, and personality. The alleged perpetrator's history and personality are helpful but often only tangentially relevant.

To put this topic in context, let's be reminded that in the United States laws were enacted to protect abused animals, before they were in place to protect abused children. Child abuse was not recognized by medicine, psychiatry or the legal system until the 1960's. In 1981 of all the abuse/neglect reports approximately 17% involved sexual abuse, a figure that doubled by 1993 (Poole and Lamb, pg. 13). Neglect and physical abuse are more easily identified and often have visible evidence. Our society's emotions stirred are reflected in a blind eye to child abuse and particularly to child sexual abuse. The evaluation of sexual molestation poses specific problems for investigators, victims, perpetrators, prosecutors and defense attorneys. Sexual abuse, especially within the family, is shrouded in secrecy, and confounded by denial, minimization, deflection upon others, exaggeration, and disbelief. And more confounding is that a child's psychiatric illness may cause him to exhibit sexual behavior suggestive of abuse.

The emotions around sexual abuse have caused both popular and professional opinion to swing from one extreme - the belief that children's outcries must always be true and their allegations correct, to the other - that children are unreliable, have poor

memories and are hardly ever credible. The current and most informed position takes an objective view; it recognizes children's reports must be analyzed carefully. Their allegations may be genuine, truthful, and conform with reality. They may be genuine but misperceived and therefore incorrect and not conform with reality. They may be purposefully dishonest and manipulative for a variety of reasons. It is too simplistic to think that false allegations include only those that are deliberately deceitful. Many false allegations are due to misperceptions, implanted thoughts or suggested memories, or otherwise are genuine but not accurate accounts. False sexual abuse allegations are estimated to represent from 5 to 23% of allegations (Jones & McGraw, 1987), and in the context of heated family court litigation estimates of false allegation are 35% or higher (Poole & Lamb, 1998, pg. 18).

The psychiatric literature reports almost two-thirds of sexually abused children develop a psychiatric diagnosis. There are specific sequalae and unique pathologic alterations in sexual behavior and gender identity (Noshpitz, 1997). Sexually abused children often exhibit sexual acting-out and hypersexuality in their effort to obtain pleasure and to master the anxiety of the trauma (Noshpitz, 1997). Sexuality, intimacy and affection become confused and conflicted. Erotic behavior may be stimulated by routine closeness. Disturbances in gender identity are reported in sexually abused boys and adult males (Noshpitz, 1997). Further, there is evidence that victims of childhood sexual abuse struggle with the object (gender) of arousal and are more likely to become involved in subsequent homosexual activity (Noshpitz, 1997). Incestuous molestation is considered more damaging than non-incestuous molestation (Haugaard and Repucci, 1989). Coercion and threats result in greater

short and long-term negative consequences (Haugaard and Repucci, 1989). The child's reaction to the abuse is well-known to be shaped or mediated significantly by the reaction (e.g. support or lack thereof, hysteria, etc.) of parents and others (Haugaard and Repucci, 1989). Long-term sexual molestation with an extrafamilial authority figure with whom the child has had a close relationship or has idealized is far more damaging than a single episode with a stranger. The ongoing sexual contact with an important adult involves over-stimulation, an inflated sense of importance and ultimately a devastating sense of betrayal. Some are threatened with being killed or with their family's death. Sexual abuse relies on secrecy, threatens the child and his family, while it isolates him putting him in the role of caretaker of his family. The child's life is filled with feelings of helplessness, shame, guilt, fear and confusion (especially about their responsibility and their sexuality).

Sexual conversation, touching and abuse by an adult authority figure is especially damaging when perpetrated by a highly trusted figure – a minister, physician, parent or teacher. Such behavior by a trusted authority figure can impact serious psychological damage through boundary violations, undermining of morals and integrity, betrayal and confusion, a deep sense of mistrust, and a pervasive legitimizing of illegal, maladaptive, rebellious, and inappropriate sexual behavior.

Since the child often admires, enjoys, idealizes and relies on the support of the perpetrator yet also develops fear of the perpetrator, the child victim may develop the "Child Sexual Abuse Accommodation Syndrome," which is characterized by allegations being made and then withdrawn, only to be elaborated again, and then withdrawn repeatedly as the child deals with his shame and sense of responsibility.

A common scenario of sexual abuse begins with “grooming.” The child victim is befriended. He is then groomed or prepared, and then seduced. Grooming follows a pattern. The child is entertained, fed, taken to theme parks and swimming, and given gifts. He may be tickled, cuddled and bathed. Appropriate swimming turns to nudity in the shower room. The child enjoys the attention, but fears the secrecy and threats. Victims are often vulnerable children who are needy and cannot recognize and resist inappropriate sexual behavior.

The child’s admiration of the adult interferes with his holding the adult responsible for inappropriate behavior. Thus, the blame for the “secret activity” (which must be wrong) is assigned by the child to himself. The victim develops a self-concept filled with guilt, shame, and helplessness (Haugaard & Repucci, 1989). The child’s trust both in adults and his own capacity to judge relationships is badly shaken. He feels powerless and out of control of his own body. The stigma of being <u>different</u> solidifies in his identity (Haugaard & Repucci, 1989), and all this makes him more vulnerable to phobias, learning problems, somatic complaints, employment difficulties, running away, aggressiveness, and promiscuity.

Common diagnoses include Depression, anxiety, insomnia, and Post Traumatic Stress Disorder (P.T.S.D.). P.T.S.D. is a common symptom picture in sexually abused children characterized by anxiety, panic attacks, intrusive thoughts about the events, numbing of responsiveness, flashbacks, sleep disturbance, suspiciousness and hyper-alertness, poor concentration and focus, and the avoidance of those specific activities and situations which trigger flashbacks and painful memories. Flashbacks and intrusive

thoughts are highly indicative of the diagnosis of P.T.S.D. Flashbacks are a re-experiencing of an event; the child feels as though it is occurring to him again.

A broad review of the sequalae of sexual abuse (Green, 1989) includes regressive symptoms, school avoidance, enuresis, sleep disturbances, mistrust, depression, panic, poor self-image, hysterical symptoms and character traits, social withdrawal and impaired peer relationships, poor school performance and cognitive impairment, substance abuse, acute or delayed Post Traumatic Stress Disorder, precocious sexual arousal, and both hypersexuality and sexual inhibition.

III. CHILD DEVELOMENTAL STAGES

a. Infants, Toddlers and Preschoolers

Children before age 5 or 6 rarely maintain memories of specific occurrences. In fact, the best psychoanalytic and developmental understanding suggests that the emotions and conflicts of early childhood are the most powerful of ones life, thus shaping one's personality in early development through the normal, exaggerated or aberrant developmental challenges and through the compromises and defenses the child employs to negotiate these enormous excitements, joys, frustration and pains. These lead to pain that requires repression. While sexual abuse and other trauma may be repressed as well, an emotional tone of fear, trauma, disappointment, shame, guilt and dirtiness may remain consciously or especially unconsciously.

b. Early School Age 6 - 10 or 11 y/o

Children of early school age will repress less as they have better emotional and cognitive capacity to integrate events and tolerate their memories. They also

have a better capacity to know right and wrong, to remember events as such, and to input, store and recall these events.

c. Pre-Adolescence and Early Adolescence 11 – 14 y/o

Preadolescents and early adolescent children are again in a developmental emotional storm, often impairing their perception and cognitive capacity. They may be histrionic in both daily life and in their remembrance of it. They may exaggerate or they may be stoic, isolate from affect and be very defended and minimize events.

d. Adolescence 14 – 17 y/o

Adolescents have a level of cognition including abstract thinking. Though adolescents may be forced into sexual interaction or seduction, often ongoing sexual abuse is no longer tolerated by the adolescent as he or she reaches puberty. It is not uncommon for girls at adolescence to begin to refuse submitting to sexual abuse and make their first “outcry”.

e. Two Lines of Development – Cognitive and Emotional

“Cognitive development” studies the growing level of intellectual functioning and with it the better appreciation of facts and events. Events can be understood through a growing perspective which relies upon judgment and a store of experiences. Psychological advancement allows for self-observation and psychological mindedness.

"Emotional development" focuses on the emotions of normal child development and the influence of emotions on the child's accurate appraisal and integration of reality.

1. Cognitive – abstraction, memory
    a. Memory involves intake, storage and retrieval.
    b. Understanding is limited by the lack of abstract thinking, the lack of perspective supported by previous experiences, the child's small knowledge base, the child's emotional development and the child's family reactions.
2. Emotional Development
    a. The level of emotional development colors the original intake of experiences, thus the input of memory.
    b. The level of emotional development also affects the way events are connected, the way they are described, and the way the memories are retrieved.

IV. SEXUAL ABUSE – TYPES, SPECIFICS, DAMAGE, RESPONSE

Sexual abuse includes touching outside clothes on the outer thigh to the buttocks, to the breasts and then in the crotch area. Touching the skin is even more arousing.

Sexual abuse that is forceful, painful, and frightening is more traumatic.

Threats to maintain activities as secret are also much more damaging. Threats to kill the child or his parents are terrifying.

Abuse which includes pain and penetration perpetrated by a parent or an admired authority figure which is chronic, and accompanied by threats of death to keep it secret are most damaging and often confusing to the child.

V. INTERVIEWING: FORENSIC AND NON-FORENSIC EVALUATION

The guidelines and issues applicable to a proper forensic evaluation pertain not only to mental health evaluations, but also to those conducted by investigators and C.P.S. workers. These concepts are useful for your consideration in cross-examination. Most psychiatrists, psychologists, and other mental health professionals are trained as clinicians to provide assessment and evaluation of children for treatment. Without special forensic training and experience, clinicians are more competent in the clinical setting than in the forensic one. Clinicians generally assume their patients are telling the truth. They tend to accept allegations of deprivation, mistreatment and sexual abuse as true, at least as genuine. Forensic evaluation requires a different mindset. Forensic work requires the recognition of perceived truth, authenticity, suggestibility, and manipulation. Clinical interviews employ techniques that elaborate the child's experience in the interest of treatment, but less often focus on discriminating the credibility of the child's recall. Clinical interviews focus on the child's experience as perceived. Forensic evaluators are keenly aware of the distinction between perception and fact, and must make efforts to discriminate these when they are not the same.

Forensic interviewing is undertaken with skeptical neutrality in an effort to obtain credible facts, and it employs techniques grounded what we have learned from the study of development, memory, language, and validity. A heightened sensitivity to the

possibility of “interviewer influence” in collecting data allows the forensic evaluator to avoid guiding or shaping the findings. Conducting the assessment requires great effort to use the most minimal “interpretation” of the data presented by the child. Some clinicians believe this is an exaggerated emphasis. Some misguidedly believe that in their clinical evaluation they are collecting information which can be translated directly as evidence in court despite their simply recanting an allegation. An important point for us is the recognition that it is inappropriate for clinical narrative material to be offered as “expert opinion” unless competent expertise has been employed. (Freud’s error in confusing women’s childhood erotic love for their fathers with actual incestuous behavior is the most poignant early illustration, something to his credit he recognized himself).

MEMORY

General Issues:

Memory involves three core operations - input, retention and recall. Input is storing the information in the brain. The memory must then be retained, and then recall is the process of retrieving it. All are necessary; a dysfunction of any one of the three results in a memory deficit. And certainly each process is vulnerable to a variety of factors.

Initial input is affected by perception – accurate and inaccurate – and is affected by immaturity, emotional influences and other subjective factors. It is well known that the memory of highly emotional events are more likely to change over time; these kinds of memories are subject to both input and reconstructive errors (Wescott, Davies, Bull,

2002, p. 23). People who witness violent crimes or car accidents often can hardly remember the events in any detail. Psychology has long understood that memory input is influenced by a person's knowledge base, emotions and beliefs. That which is stored in memory is a product of subjective reality.

Further confounding the realistic recall of memory is that these stored representations are affected by later experience. Some compare "altered recall" to "reconstructive history." Children are particularly susceptible to errors due to their immaturity, suggestibility, and emotionality. A large body of studies which have been well constructed and replicated, have clearly established the child's suggestibility and memory error (esp. Loftus). Studies demonstrate that memories can easily be suggestively planted, even memories that are not plausible. Young children often cannot distinguish between suggestively incorporated memories and actual memories of an event. Other studies (Wescott, Davies and Bull; 2002) demonstrate that contamination of memory occurs with emotional pressure, especially on a preschool child, and raises the suggestibility factor significantly. The young child's ability to distinguish whether he was told that something had occurred to him or whether it actually occurred is very limited. This is known as a source error.

An instructive example is that of a 6 year old child, with divorced parents, who alleges sexual abuse by his father at age three, about which he has been repeatedly told about since he was 3 y/o by his mother. This may easily represent the recanting of history he has been told, rather than what he recalls. A careful interview attempts to help the child discriminate what she "remembers having occurred" and what he "remembers having been told occurred." Suggestibility decrease in children age 9

though children as a group are more suggestible than adults. Children do not need to be led in order to provide their history. Research demonstrates that when properly interviewed on the first occasion, even very young children are generally accurate in their reports and continue to be so in follow-up interviews (Westcott, Davies and Bull; 2002). Why is this so important to you? It emphasizes why there is no excuse for improper interview techniques - those that are suggestive, leading, and often conducted to confirm the interviewer's belief that the child has been abused.

SUGGESTIBILITY ABOUT BODILY TOUCH:

What do we know that deals more specifically with the memory of a child and their body being touched? Bruck, et al (1995a), studied children's memories after visits to their pediatrician and the effects of suggestibility on their memory for receiving an immunization injection – a reasonable comparison with some similarity to sexual abuse. It is stressful, unfamiliar and involves pain and discomfort. While conventional thinking might assume a child's memory for this to be resistant to suggestion, this proves not to be the case. Children receiving a routine inoculation (a D.P.T. shot) were randomly divided into three groups. The first group was told that the shot did not seem to hurt. In the second cohort, the pain was affirmed as real, and the third group was given the neutral feedback - simply that the immunization was over. One year later, the children were interviewed at three cross-sections of time. They were given either "no hurt" feedback (i.e. told that they had been brave and had not cried at the time of the shot) or "neutral" feedback (i.e. not told how they acted). For ethical reasons the pain affirming "hurt" conditioning was not used in order to not induce a phobia of doctors. Then in a

fourth interview, the children were asked to rate how much the shot had hurt and how much they cried. The results demonstrate reports that were highly influenced by the suggestion. The children of the "no hurt" condition reported significantly less pain and crying than children given the neutral feedback. These findings do not conform with conventional thinking.

Another finding is relevant. Children even when given misleading information, were fairly accurate during early initial questioning one week after the immunization. Children making allegations are often questioned repeatedly, over extended periods of time and this process can certainly shape their memories, especially if these are suggestive.

REPRESSED MEMORIES

The phenomenon of uncovering repressed memories is largely wrong-headed, especially in the context our considerations today. Memories that appear from therapy releasing them from repression – memories with great detail, from years past and from early childhood are highly unreliable with respect to objective validity. Some argue that even at a preverbal age a child's body can have "behavioral memories." While there may be minor controversy, the reports from the American Psychological Association, the American Medical Association and the American Psychiatric Association are extremely skeptical of the credibility of repressed memories unearthed in therapy. A report by the British Psychological Association – and the three American reports – acknowledge the possibility. One indication of validity is if one had never completely lost contact with the experience, i.e. some part of it has always been available to the

person's memory. When dealing with recalled memories, one is highly suspicious that aggressive, highly suggestive techniques have been employed.

VI. FORENSIC AND NON-FORENSIC EVALUATIONS

Steller, et al (1989) outlines the very important differences in Forensic and non-Forensic evaluations.

1. The assumption of honesty. Nonforensic interviewing seeks narrative truth rather than historical truth. Narrative truth is used to describe a social consensus about truth that evolves in the context of a specific relationship. In other words, the clinician therapist is interested in understanding his patient's reality and operates under the assumption that patients are telling the truth (i.e. they are genuine) as they perceive it. The clinician is interested in the child's perceptions. Therapists try to organize the information provided by their patients using play and interview techniques in an effort to derive this narrative truth including consistent themes which may then be reflected and interpreted back to the child. The clinician's goal is to understand the child and relieve his symptoms; whether they get the facts right is more tangential. The goal is health. Some students of therapy and human relations would hold (I believe correctly) that the child and therapist together create this narrative truth. The interaction between clinician and child involves repeated clinical reformulations of what is going on inside the child. This interview style runs the risk of the therapist's organizing the material and leading the child to incorporate the therapist's understanding as if it were his own. Seasoned, well trained clinicians are acutely sensitive to this. And,

psychiatrists and all mental health professionals should be aware that they cannot determine the “truth” from interviewing their patient.

In contrast, a forensic interview is looking for facts and support for or against the narrative presented. The forensic interviewer makes every effort to be a neutral conversational guide who provides as little directive or guiding feedback as possible. Every response is measured to facilitate the child’s continued production of material without suggesting what that material should be. The child is guided as little as possible and the interviewer attempts to provide no cues.

2. The Role of Intuition. Nonforensic interviewing often involves considerable interpretation (or organizing) of the child’s behavior, statements, and emotional reactions. Forensic interviewing strives to minimize interpretation (reframing) while in the search for information. Information through play or interview that is explored with open-ended, child centered remarks which allow for the widest range of response from the child provides the data most valuable in the forensic context.
3. Scientific Validation. Nonforensic interviewing involves techniques that lack scientific design and validation. They are derived from clinical training and experience. Forensic interviewing should be characterized by techniques that have some basis in field research.
4. Physical environment and materials. Clinical assessment takes place in environments that may be child centered or adult centered interview offices. Clinical settings are often playrooms with numerous toys and dolls; and medical examinations are conducted in sterile, threatening medical settings.

A forensic interview should take place in a setting that discourages fantasy play and maximize the child's ability to interact in an interview format without distraction or intimidation. Appropriate toys and props must be readily available, so that when needed these age appropriate vehicles of expression can be used. A playroom might be important for a very young child.

5. Interviewer Demeanor. Clinical interviewing emphasizes certain verbal reinforcement and expressions of empathy, as the clinician is concerned with rapport building, the impact of events on the child, his perception of events, and less so with an objective realistic recall of events. The forensic examiner adopts a neutral but relaxed tone, and avoids communicating expectations or emotional reactions which may shape the information the child produces. Even expressions such as "I know this may be hard for you to talk about" are used cautiously in an effort not to shape the child's response. It suggests that there must be something hard to talk about.
6. Concern About Suggestibility. Forensic evaluators are very patient. The child is facilitated to produce his own chosen information. Forensic interviewers abstain from suggestive responses and are highly aware of the child's desire to satisfy or please. They refrain from asking direct, focusing questions as much as possible, instead choosing open-end queries. Videotaped primary investigative interviews provide a permanent record of the interview, and the child's disclosure. It allows a review of exactly how it was conducted and the child's productions.

VII. FORENSIC INTERVIEWING:

HYPOTHESIS -TESTING AND CHILD CENTERED:

There are two broad themes in the forensic interview: “hypothesis testing” and “child centered.” From the very beginning a forensic evaluation is “hypothesis testing” rather than “hypothesis confirming”. Interviewers should prepare by gathering information about the alleged incident and generating a set of alternative hypotheses about the sources and meaning of the allegations. When the child uses terms suggesting sexual touching or bad touching, the interviewer should test (with an open mind regarding his hypothesis) the child’s understanding and the use of these terms. Similarly, if the child reports contradictory or inconsistent information, the interviewer tries to determine whether these events could have occurred as described.

Secondly, forensic interviews are child centered. Although interviewers facilitate the flow of the conversation, the child should determine the vocabulary and specific content of the conversation as much as possible. A wide range of material about the child’s life may be obtained. Questions are open ended allowing the child to provide the narrative. More direct exploration which narrows the focus should be employed only after a methodical effort using non-directive techniques is exhausted.

FLAWED ASSESSMENT TECHNIQUE

There are a number of interview techniques that while more subtle, than leading in nature, are yet very effective in shaping a child’s allegations. The “induction of stereotypes” is one in which the interviewer transmits to the child a negative characterization of a person or event. The interviewer suggests a man “does bad

things" and "scares" children under the misconception that this only helps the child feel comfortable and forthcoming. It is a terribly flawed technique in a forensic evaluation.

Another type of suggestive interview error is made when in the initial preparatory, rapport-building phase of the interview certain very influential, suggestive statements are made, e.g. "It isn't good to let people touch you", "We know if something bad happened, you'll fell better after you tell us," or "Don't be afraid to tell me what you did." These statements create very significant validity problems. Studies have shown that these kinds of "supportive statements" cause some children to fabricate reports some of which are sexual most probably in their effort to please the adult interviewer (Ceci & Bruck, 1993).

Similarly, telling a child that the alleged perpetrator, e.g. his teacher, "is in jail so it is safe to tell the whole story now", establishes an "accusatory atmosphere."

Awards and bribes even subtle must be avoided. Telling a child he's doing a good job for informing the interviewer of certain information risks the interviewer's guiding the child to those "good" responses and away from those that do not receive a reward. Asking the child to sit on the evaluator's lap, offering food or badges, compliments and breaks, all risk shaping the child's story. These technical errors occur all too commonly, possibly with the best of intentions, but greatly misguided in the interviewer's effort to comfort a child whom he perceives as damaged and vulnerable. The parent's presence is problematic. They can too easily influence the child with the reassurance of a smiling face or the disapproval in their threatening countenance. An evaluator's suggesting "we will be here until you've told me everything, sweetheart" may

sound compassionate and open, but the child may hear that she's yet to tell the right story to get the interview over and go home.

In an effort to obtain the confirming report an evaluator expects, the child may be told "But your friends already told us it happened", or "But your mother said you told her it happened" without leaving the child the freedom to offer his own response. The more objective evaluator could instead say "Now, I understood you told your mother it happened, but I want you to just tell me exactly what you remember about Mr. Jones and you on Saturday at the movie. Let's just see what you remember. I'm really interested in that."

VIII. VIDEOTAPING:

The videotaping of initial interviews is widely accepted and standard practice in most jurisdictions. Some prosecuting attorneys may oppose videotaping, as it can be used to focus attention on the skill and practices of the interviewer. And indeed that is one reason videotaping is important. Prosecutors should be reassured that one cannot expect a perfect interview; in many evaluations some direct inquiries may be required late in the evaluation. The videotape record allows others to review the information and its interpretation. The experts can opine about the interviews meaning and credibility, and the jury can make its own judgment. Defense attorneys may have reservations about videotaping fearing it will be used as evidence to persuade a jury untrained in understanding the meaning of the data presented in it.

Identifying the advantages and disadvantages of videotaping evaluations is not just theoretical, but may help in evaluating allegations. The tape itself certainly is.

Advantages:

1. Can reduce the need for repeated interviews.
2. Should encourage evaluators to use proper technique using remarks which are neither suggestive nor leading.
3. Can be used to reflect the spontaneous productions of the child and his emotional reactions.
4. May discourage recantation.
5. Can refresh a child's memory before Court testimony (also a disadvantage).
6. Can be used to convince non-offending parents that the abuse occurred and may aid in eliciting a confession from the perpetrator.
7. Can document an improperly suggestive interview or be used to contradict the interviewer's reported opinion.

Disadvantages:

1. Videotaping may shift the focus to the style and skill of the interviewer allowing defense counsel to exaggerate the impact of the interviewer's techniques. (also an advantage in holding the assessment procedure to a competent standard).
2. Videotaped interviews used in Court may be misleading. Greater weight may be given to the statements recorded in them, than to other statements made, and they may be used to allow alleged victims to testify twice.

3. Videotaping focuses attention on inconsistencies in a child's reports and other behaviors that reduce credibility. This is due to the cognitive and emotional immaturity of the child. A child may be tangential, silly, or demonstrate inappropriate affect – all developmentally and context age-appropriate behavior.
4. Videotaping may make a child uncomfortable and reticent.
5. Poor quality tapes may induce questions about the competence of the entire assessment and its conclusions, though these are simply technical problems.
6. Videotaping children (not adults) who report sexual abuse may be used to indicate that children are more suspect and potentially dangerous witnesses than adults. (The argument which supports videotaping of children applies just as well to other vulnerable classes of witness including the elderly and the mentally disabled.)

The Child Victim Witness Investigative Pilot Project's final report in 1994 includes an excellent data based evaluation of these arguments (Poole and Lamb, 1999, p. 117). In this study, videotaping was associated with a reduction in the number of formal interviews. In this survey, many of the interviewers emphasized that the videotapes allowed them to defend the quality of their interviews. The tapes also captured the children's initial emotional responses, before these became blunted by repeated interviews and hearings. No clear data dealt with recantation, but the study did find the tapes helped induce confessions. Tapes were determined useful in judging the strengths and weakness of the child as a witness. Finally, the tapes did not appear to provide defense counsel any inappropriate evidence with which to impeach children by focusing unduly on interviewer errors.

IX. THE EVALUATION INTERVIEW

INITIAL INTERVIEWER RAPPORT BUILDING:

Initially the child must be oriented to the setting and the context of the interview. Children have developmentally normative fears and expectations that interfere with their capacity to focus on the interview and trust the interviewer. Children assume that an adult would already know a great deal about them and their circumstances. The school-aged child perceives the atmosphere as most similar to a prearranged visit in the principal's office and that they must be in trouble. They may believe they are expected to repeat certain allegations which were accepted favorably by their parents, a therapist, teacher or policeman. Their focus on pleasing the interviewer and avoiding discipline may easily override any effort to recall events realistically. This is obvious on the face of it.

We have to examine the semantics and definitions of the word, "truth." "Truth" can refer to an accurate representation of what a child perceives and believes as accurate, but this is more usefully referred to as genuineness rather than objective, reality based truth. "True" reports may refer to the child's not knowingly changing the facts as they remember them, i.e. they are not purposefully misreporting reality. "Truth" however in the legal arena refers to accurate, objective reality. A child may be "genuine," yet be either accurate or inaccurate and thus telling the truth or not.

An interviewer's introductory comments help the child acclimate to the setting, the interviewer, and the context of the interview. The interviewer must identify himself, i.e. as a child care worker, a police officer, detective, social worker, psychologist, or psychiatrist. The assessment might be explained with: "I want to get to know you, and I

am also interviewing you about your relationships with the people in your life. We have a video camera to record everything that we say and everything you tell me, and the tape lets us go back and watch and listen to what we have talked about."

The evaluator should set some ground rules about telling the truth for the child. Interviewers too often prematurely begin with an interrogatory process without an appropriate introduction. The introduction helps the child relax, and sets the tone. The interviewer early on demonstrates great patience, as he allows the child adequate time to provide a lengthy, even rambling narrative in his own words.

INTERVIEWER STYLE AND DEMEANOR:

1. Appears relaxed and does not react with surprise to disclosures of abuse or other material.
2. Avoids touching the child.
3. Does not ask the child to demonstrate events that require the child removing his/her clothing.
4. Does not make reinforcing comments such as "good girl," which can interfere with obtaining objective facts by selectively reinforcing specific types of answers.
5. Avoids questions regarding why the perpetrator or child behaved in a particular way. These questions are difficult, often speculative to answer, and may convey to the child that he was somehow responsible for what has occurred.
6. Refrains from using words like "pretend" or "imagine" that may suggest a fantasy or play mode, unless it is to question a reported event.

7. Asks the child to repeat inaudible comments by inquiring “What did you say?” or “I couldn’t hear that, could you please repeat it?” Does not assume what was meant.
8. Diffuses a child being overwhelmed by focusing on less stressful topics when necessary. Deeply empathic responses are avoided in order to avoid the child’s being so upset as to disrupt the interview, though reasonable and reflective empathy is appropriate.
9. Is cautious about using breaks, drinks, or candy as reinforcement for talking. When such rewards are employed, the child’s answers may be considered less credible because the child may have been more focused on receiving the reinforcement than on providing a correct answer.

Practice Interview:

A practice interview focused on content free from anxiety is helpful in establishing some comfort. The evaluator’s goal is to establish rapport that can empower the child and encourage free flowing detailed narratives (i.e. richer responses to open-ended questions). The preparatory work begins with inquiries about the child’s daily life e.g. “What is your favorite food?”, “Where do you go to school?”, “What do you like to play?”, “What is your favorite T.V. show or toy.” Open-ended rapport building greatly improves the quality of the child’s responses to subsequent target questions.

The results of studies in which children were to provide elaborate narratives (Saywitz and Snyder, 1993) demonstrate that children read evaluators’ expectations and shape their responses in accord even in the early minutes of an interview.

Unfortunately, interviewers often must dominate the early part of the interview and even more unfortunately too quickly employ specific and leading questions which are much less effective in gaining reliable data for a forensic evaluation. Such interviewing minimizes the applicability of any real expertise as the first step must be the proper gathering of material. Thus, if a psychiatric opinion is to be useful to the Court, the interview must have been done properly, so that the child's responses can be judged meaningfully – PERIOD. Otherwise, it is simply an interrogatory interview, the credibility of which is to be assessed by the Judge or jury, and the development of psychiatric opinion is hamstrung. Expert opinion is easily attacked if it is simply a recantation. This relates as well to the expert, who simply testifies that "he can tell it's the truth" based on an overzealous sense of intuition. Such testimony is offered occasionally by well meaning, mental health professionals with poor judgment and little forensic experience.

Evaluators may be greatly aided by following a previously designed protocol, which emphasizes a child centered discussion of neutral events early in the interview and avoids suggestion. While rapport is being built, and one can assess the cognitive, linguistic, and activity level of the child as well as his emotional tone and ability to relate. These early judgments are helpful as a baseline against which some of his later responses may be gauged. For example, if a child regresses to infantile language and speech when topic of sexual body parts is raised, this can be compared to the earlier baseline interaction. The early phase also helps the evaluator learn the child's language. If this preparation is not conducted, children may try to read the evaluator and provide the "proper" answers. Small children especially have great difficulty producing narrative answers to questions about specific events and may answer "yes"

or “no”. While older children are more able to elaborate a free narrative, a mental health professional can never absolutely know the objective truth regarding events; he hasn’t observed them. He is not a fact witness. The interviewer must always be clear during an assessment that he cannot obtain objective truth from the child who only knows his perception of it. (Illustration: sexual familiarity/boundary malpractice case: child vs. her psychiatrist).

Introducing the Topic:

After rapport is established open-ended questions elicit the most reliable data. Questions should be “hypothesis testing,” trying to rule out the less intuitively accepted hypothesis, rather than confirming it. This means not mentioning a particular person or action early in the interview and avoiding as long as possible words such as “hurt”, “bad”, “abused” or “bad touch”. Inquiries are open-ended, and they are about the child’s general relationships and interactions with people. Open-ended prompts are easy to use. Then inquiry should be of the form: “I wonder if someone has been bothering you,” before “Your mother says that daddy tried to touch your privates and upset you last weekend.” Interviewers must make stringent efforts to discriminate what the child has been told happened (what he has heard from others) and what he actually remembers. This bears on the “source” of the information. Source errors are prominent in false allegation situations.

The introductory work prepares the child for the next level of inquiry. These are somewhat suggestive, but may include, “What do you think would happen if you told me about something that you should not have been involved in or should not have

happened to you?", "What if you told me about something that someone had done to you and you were afraid they would be in trouble or you might not be believed?" "What if you told me about something that was secret?" How would you feel about it?" These inquiries after more open-ended ones may seem laborious and oblique, but are very useful in gaining the information in a useful format in a forensic evaluation. A poor interview provides little data for a lot of time and work. And the old saying "bad data in, bad results out" applies here. A criminal defense attorney should use these guidelines when scrutinizing videotapes, reading expert reports and examining children.

To emphasize how effective this interview is let's look at a study. Using a non-directive approach, disclosures were obtained from 96% of the alleged victims in a study by Sternberg et al (1997): "Now that we know each other a little bit better I want to talk about the reason that you are here today. I understand that something may have happened to you. Please tell me everything that happened, every detail, from the beginning to the very end" (p. 1146). These were children who had already made some type of disclosure to someone such as a parent. Different prompts may be necessary for children referred because of suspicion rather than previous disclosure. The data indicate that a non-directive interview is in fact effective in eliciting reliable allegations and leaves precious little support for a suggestive interview, driven by the examiner's presumption of the facts, lack of training or hurried time frame. A poor interview just does not help elucidate the forensic data needed.

The question of abuse is raised by the interviewer without stating the allegation and after the child has been both properly prepared and had ample opportunity to bring it up on his own initiative. The evaluator starts with the most general, open-ended

introductions and questions, and moves slowly towards more specific topics as it becomes necessary. Boat and Everson (1986) describe a progression of increasingly directive questions beginning with inquiries about critical times or events (when the abuse might have occurred), then open-ended questions about particular individuals suspected of being perpetrators (without mentioning sexual abuse), and then questions about different types of abuse (without mentioning specific individuals). Kuehnle (1996) warns that questions about allegations can contaminate the memories of young children, should be used with caution, and should always be followed by prompts for children to elaborate in their own words.

Research has shown that a percentage of young children will falsely respond "yes" to direct questions about events (even events involving bodily touch).

INTERVIEWING: NARRATIVE AND CLARIFYING INQUIRIES:

Free flowing narratives are well known as the best source of information. The interviewer encourages the child to provide these narrative descriptions in their own words about a variety of family, social, school, recreational and other activities. Open-ended questions lead to responses that are more accurate than information elicited by specific questions which are influenced by the child's attempt to provide the approved answer. Broad inquiries are most helpful when the topic of sexual behavior is explored. The topic can be approached slowly. Good inquiries are "I'd like to understand everything about that" after a child responds that someone has touched them on a private part. A good inquiry is "Tell me everything that happened, even things you may not think are very important." While the child is speaking, the

interviewer should remain interested, relaxed and convey an atmosphere of acceptance and comfort. The client-centered approach, simply reflecting the child's words back to him, is neutral, acknowledges what is heard and provides the most reliable data. If a child were to say "He came and laid in bed next to me and watched television", a good response might be "So he laid down next to you and watched television", rather than "And what did he do next?" If the child says, "And then he touched my. . .", the interviewer's best response would be "Go ahead, it's okay to tell me all about it" rather than "Where did he touch you?" Pauses in conversation may be responded to with "Go ahead and tell me whatever you would like" or "And then what happened?" The interviewer's sense of urgency may cause an error by interrupting the more free-flowing narrative of the child. Only when it is clear that the child is not going to volunteer additional information should the inquiry shift into the questioning and clarification phase. In the real world, a rare interview could meet the standard but understanding it helps one gauge the interaction and the child's productions.

Attempts may now be made to obtain additional details. The interviewer begins to seek specific information – locations and other details about specific incidents, what the child remembers and felt, the identity of the perpetrator and so forth. The general guides still apply: 1) avoid suggestion and cues, 2) use the child's terms, 3) avoid volunteering details the child has not mentioned, and 4) select open-ended questions rather than more directive ones whenever possible. Even as the evaluation shifts, it should always seek detail without suggesting that there must be more behavior to report. (And if the evaluator has asked "Were your clothes off or on?" it should be

followed up with a more open-ended question such as “Tell me more about that”, which shifts the responsibility quickly from recognition to recall memory).

Interviewers can use clarifying questions which focus on specifics but without being leading. Whether a question is suggestive depends in part on the child’s prior responses. Thus, a question is not suggestive if it reiterates what the child has already reported. However, a question can be suggestive by something as seemingly innocuous as the gender of the pronoun used, if the perpetrator has yet to be identified. Leading questions are those which imply an answer or assume facts that might have not been presented by the child. Questions which allow for a “yes” or “no” response are suspect and suggestive, especially if the child has demonstrated a pattern of answering “yes.” Any question is “leading” (or at least not “hypothesis testing,”) if the evaluator knows there is pressure upon the child to answer a certain way due to the context (e.g. parental alienation, fear of retracting a previous allegation, or fear that the allegation will result in retaliation). These evaluations are indeed hard work.

In summary, one could look at interviewing as a progression in style which begins with open-ended inquiries and reflections, specific inquiries without leading the child, closed-end inquiries and leading inquiries. The latter are to be avoided generally. There is no specific way to define each of these on a question-by-question basis, but conceptually they are useful in observing and in analyzing an interview or a videotape. Prompting for additional information in an open-ended style is always a high priority, though difficult because children are often hesitant to elaborate.

PHASES OF THE INTERVIEW*

The Introduction

- Repeat identifying information in tape.
- Introduce yourself to the child by name and occupation.
- Explain the taping equipment and permit the child to glance about the room.
- Answer spontaneous questions from the child.

The Truth/Lies Ceremony

- Ask the child to label statements as “truths” or “lies.”
- Get a verbal agreement from the child to tell the truth.

The Ground Rules

- Explain the child’s right to say “I don’t know.”
- Explain the child’s responsibility to correct the interviewer when he or she is incorrect.
- Allow the child to demonstrate an understanding of the rules with a practice question (e.g., I: “What is my dog’s name?” C: “I don’t know.”).

The Practice Interview

- Ask the child to recall a recent significant event (e.g. a birthday celebration) or describe a scripted event (e.g. what he or she does to get ready for school each morning).
- Tell the child to report everything about the event from beginning to end, even things that might not seem very important.

* Poole, Debra A., Lamb, Michael, E. (1998). Investigative Interviews of Children: A Guide for Helping Professionals, American Psychological Assn., Washington, D.C.

- Reinforce the child for talking by displaying interest both nonverbally and verbally (e.g., “Really?” “Ohhh”).

Introducing the Topic

- Introduce the topic with the least suggestive prompt.
- Avoid words such as hurt, bad, or abuse.

The Free Narrative

- Prompt the child for a free narrative with general probes such as, “Tell me everything you can about that.”
- Encourage the child to continue with open-ended comments such as, “Then what?” or “Tell me more about that.”

Questioning and Clarification

- Cover topics in an order that builds on the child’s prior answers, to avoid shifting topics during the interview.
- Select less directive question forms over more directive questions as much as possible.
- Do not assume that the child’s use of terms (e.g., “Uncle,” “pee pee”) is the same as an adult’s.
- Clarify important terms and descriptions of events that appear inconsistent or improbable.

Closure

- Revert to neutral topics.
- Thank the child for coming.
- Provide a contact name and telephone number.

The Hierarchy of Interview Questions

There is a hierarchy of question types from least suggestive to most suggestive. Whenever possible questions from the top of the hierarchy should be employed.

Free Narrative and Other Open-Ended Questions

Free-narrative question are used at the beginning of the interview, after the topic has been introduced, to encourage children to describe events in their own words.

Examples: "Tell me everything you can about that."

"Start with the first thing that happened and tell me everything you an, even things you don't think are very important."

Open-ended questions allow children to select the specific details they will discuss. Open-ended questions encourage the multiple-word responses.

Examples: "You said he took you into a room. Tell me about all of the things that were in that room.

"You said, 'That other time.' Tell me about that other time.

Specific but Non-leading Questions

Specific but non-leading questions ask for details about topics that children have already mentioned. Use these questions only when the details are important,

because children often try to answer specific questions even when they do not know the relevant information.

Examples: "Do you remember what you were doing when he came over?"

"What was he wearing when that happened?"

Closed Questions

Closed questions provide only a limited number of options. Multiple-choice and yes-no questions are closed questions. Multiple-choice questions – particularly when they have more than two options – are preferable to yes – no questions because they permit a wider range of responses.

Example of a multiple-choice question:

"Did that happen in the kitchen, the bathroom, or some other place?"

Example of a yes-no question:

"Was your mom home when that happened?"

Explicitly Leading Questions

Explicitly leading questions suggest the desired answer or contain information that the child has not yet volunteered. Even yes-no questions are considered leading by many psychologists, particularly if the child is young or the interviewer does not reiterate the child's right to say "no." Leading questions should be avoided during forensic interviews.

Examples: "You told your mom you were scared of him, didn't you?"

"Did he have his pants on or off when he lay next to you?"

(when the child did not mention that he lay down).

X. ANATOMICALLY CORRECT DOLLS:

The use of anatomically correct dolls while having some usefulness, also adds serious risks & complications in interpretation. Even in routine clinical practice these dolls are overly-stimulating and provoke children's' responses which must be cautiously assessed. They should be presented in the latter part of an assessment at which time they may be helpful in confirming specifics. Unfortunately, many evaluators employ anatomically correct dolls early as a short-cut. Data based research studying the use of these dolls has yet to demonstrate their benefit (Bruck, et al 1995b). Non-abused children are stimulated by these dolls to react in a manner which may be suggestive of sexual abuse. This behavior is usual sexual curiosity and the child's interest in sexual play outside the interview may increase. However, non-abused, psychologically healthy children only rarely demonstrate fantasy play with dolls demonstrating intercourse unless they have been previously exposed.

I would suggest that in part the use of anatomically correct dolls was popularized by overzealous evaluators' attempts to confirm their predetermined conclusion as to the veracity of allegations. The dolls elicit conversations about genitals, what has occurred, and certainly almost always suggest to the child that there must be some kind of narrative they should provide about the naked human body. Ask yourself how you and your friends, having coffee after dinner, would react seeing nude dolls with genitals?

Research has demonstrated that young children have difficulty understanding symbolic representations of real objects (DeLoache & Marzolf, 1995). Three year olds

were confused by questions about their bodies and about the symbolic bodily representations of anatomic dolls. About 50% of the children who were touched in the genital region did not indicate that they were touched there when questioned either with or without dolls. Thus the dolls did not help with errors of omission. Also, a sizable number of children in both groups made false positive errors, i.e. reported false allegations when questioned with dolls. Nearly 60% of the sample indicated genital insertion, used dolls in a sexualized manner, or demonstrated in play other aggressive acts that were a cause for concern. Contrary to intuition, the experienced evaluator expects children, even those who have not been sexually abused to demonstrate some sexual interest or activity when presented with these dolls (Goodman & Aman, 1990).

When all the data and clinical experience are integrated, it is clear that young children have difficulty accurately reporting events involving their bodies, whether with or without anatomically correct dolls. There is a general consensus that anatomical dolls confuse the assessment of 3-4 year olds and must be used only late in the evaluation if at all. With children five and older the use of anatomical dolls is somewhat less problematic and results in fewer false reports, yet they must be used very cautiously and only after extensive nondirective inquiries have been exhausted. In general I believe these dolls in routine use are more problematic than helpful.

XI. FACTORS CORRELATED WITH INCREASED SUGGESTIBILITY:

Children who are young, who have low I.Q.'s and suffer psychiatric disorders are more suggestible. They are more likely to misperceive events and more likely to try to please an evaluator. There is significant evidence that a good memory is less likely to

be contaminated by suggestion. Thus older, brighter children who are less vulnerable to emotional distortion are capable of more accurate recall.

Suggestibility is also affected by temperament. Children who are highly reactive, easily irritable, socially shy or easily intimidated by adults are all more suggestible. The degree to which a child wishes to be compliant and please the interviewer has been demonstrated to be associated with suggestibility - even with a nonsensical question like “Is red heavier than yellow?” In contrast, self-confident children are less suggestible.

A number of studies indicate that suggestibility is an important determinant of errors in memory. For illustration, children who are repeatedly asked to “think really hard” about remembering an event that in reality never took place, eventually produce detailed accounts of these imaginary events (Ceci, Loftus, et al 1994).

XII. TRUE AND FALSE ALLEGATIONS OF CHILD SEXUAL ABUSE

(Green & Schetky, 1988):

Reports of child sexual abuse have dramatically increased, as has the use expert testimony. Psychiatry has become more focused on both the abuse and treatment, but on the need to study the evaluation process, what expertise we have, and how to discriminate true and false outcries. False allegations in the context of bitter divorces brought the issue to the forefront even more. In these cases, a divorcing spouse or ex-spouse uses these allegations to capture the court’s attention. The allegations seem to have credibility on face value alone, because they are so shocking and the stakes are incredibly high in family court. A father’s possession may be

restricted to supervised visits, be discontinued, or the mother may be awarded sole custody. In some jurisdictions it seems the District Attorney almost automatically files criminal charges with little data or evidence at the time. Prosecutors may rely heavily on the child's statement and the evaluator's interview of the child planning to obtain the rest of the evidence later. In the interim, considerable emotional damage can occur to the child and the family, and the legal context becomes more complex. This is why we have focused so much interest on the characteristics of the outcry and a competent evaluation.

Green and Schetky (1988) describe a continuum ranging from cases of obvious sexual molestation corroborated by the child, the testimony of witnesses, and physical evidence to cases in which the allegations are convincingly denied by the child and seem very unsubstantiated except for the allegations of parent, a family law attorney and the D.A. In these cases an irate mother may use audiotapes and telephone conversations as evidence. The father is indignant and furious. The prosecutor and defense counsel look for hypothesis-affirming data in the child's allegations, repeated interviews and the presentation of what they believe testimony will eventually show. Many cases which lack clarity, empathy, forensic assessments by child psychologists or psychiatrists offer opinions about the child's interview allegations. Experts are suggestible too and are encouraged to testify beyond the validity and weight of the child's allegations. A competent forensic evaluation includes the child, mother, father, and the child with each of the parents. Objectivity is all too easily lost by evaluators, parents, attorneys, prosecutors and juries. Parents of children in a day care setting in which many children were abused, can only be expected to be overly-reactive, to

interrogate their child, to leave the child with suggestions about what the parent wants to hear – whether positive or negative regarding abuse. Once the ball starts rolling, the story gains momentum not always attributable to the reality of the facts.

Multiple motivations and sources of error lead to false allegations of sexual abuse. These include a parents' genuine concern for the child's welfare, winning custody, gaining or restricting times of possession and the bitter vengeful desire to win. Allegations may be genuine – in other words actually believed by the parent – or may be completely contrived and dishonest for retribution. A 1986 study by Guyer and Ash noted a marked increased in the number of allegations of sexual abuse associated with contested custody cases, amounting to 33% of 400 court ordered custody evaluations in the previous five years. Guyer and Ash also noted that some of these cases may represent a Munchausen-by-Proxy syndrome in which a parent gets special gratification from imaginary illnesses in their children. Most parents should be relieved by the negative findings of a psychiatric evaluation regarding their child being abused. Yet, some parents become more upset and terribly angry when reassured that their child has not likely to have been abused, and if so seems resilient to it. These parents have a great deal invested in their crusade to save their damaged child. Only they know what is true and what needs to be done. They are their child's savior. We will return to this syndrome later as it is more common than most realize and terribly damaging.

The psychiatric expertise which bears on the reliability of the child's disclosure of sexual abuse is at times very pertinent and at others very limited in their court room. The child's verbalizations during a psychiatric evaluation should not be accepted at face value. They are subject to powerful distorting influences including shame, guilt, fear of

retaliation and abandonment, and loyalty conflicts. Internal pressures result in guilt and shame for participating in forbidden sexual acts accompanied by pleasurable sensations. There may also be enormous guilt about the prosecution of a father, scoutmaster or priest, and when possible the fear and guilt about the subsequent break-up of a family. The child's internal desire to tell the truth causes him terrible anxiety realizing he would be part of the incarceration of the perpetrator. He is even further disturbed as he almost always feels he cooperated in the acts.

When are allegations more likely to be incorrect or false?

False Disclosures:

1. A prime example is the child who is brainwashed by a vindictive parent, who fabricates the incest in order to punish the spouse, inserts it into the child's memory and thus prevents visitation. The allegations may be deceitfully implanted in the child's mind or may be implanted by a parent genuinely concerned. In either case, the child's reports may not be his actual memory of events. This is a "source" error. A mother, angry and bitter, may have observed what she believes to be inappropriate bathing or cleaning of the child's genital area or other inappropriate physical contact. She may have experienced, and even enjoyed a highly sexual relationship with her child's father. Now, in retrospect her anxiety and guilt may influence her perceptions. She may be genuine but not objectively correct.
2. The child may be influenced by a "quasi-delusional" mother, who projects her own unconscious sexual fantasies onto the spouse. In this case, the mother truly misperceives the relationship between the father and the child and is

diagnosed often as histrionic, paranoid or psychotic. This mother repeatedly and aggressively interrogates her child about the alleged sexual contact and pressures him to accept their misperceptions. She may coerce the child's compliance by withholding love, approval and closeness, if the child denies the events occurred or even demonstrates positive feelings toward his father. These family/clinical constellations fit the dynamics of parental alienation or the parental alienation syndrome as described by Gardner. Often this mother conveys to the child that it's not safe to see or have visits with the father, induces anxiety and then uses the child's anxiety to prove that something dangerous is happening to the child. As in the dynamics of Munchausen's-by-Proxy, mother claims she's the only one who really understands her child and she must be listened to and respected. She is her child's advocate and savior thus drawing attention to herself.

3. The child's allegations of sexual abuse may be based upon infantile fantasy rather than reality.

Freud spoke of young girls having a crush on their father and boys upon their mother in their oedipal fantasies. At the age of 3 to 7 these fantasies are indistinguishable from reality and in young adolescent girls their allegations may represent their projected longings for exclusive closeness which may be sexualized, with the parent.

This may most easily be understood as a girl longing for their father to pay them special and an inordinate abundance of interest and value which then takes on a sexual tone. Such allegations often lack any detail, yet the child falsely

accuses her father of incest for revenge. In this context the bitterness is derived from inside the child herself in response to either real or perceived abandonment, punishment or deprivation.

4. Some children knowingly make deceitful allegations to protect their mother and rid their home of a father who has been abusive with her mother. A teenager's claim may be manipulative in an effort to alter custody and possession, e.g. when one parent provides discipline and the other allows great freedom and indulgence. Some children are genuine and truly believe they are honest in their presentation. Here is where a carefully conducted forensic evaluation can be very helpful to everyone involved.
5. False allegations of sexual abuse are not unusually simply incorrect. They are initiated by parents or a third party, e.g. this occurs due to the hypervigilence of parents of young children after their parents have been sensitized by sensational news media coverage of sexual abuse scandals. Pediatricians and child mental health professionals by law also make reports to Child Protective Services of any "suspected" child abuse without having to confirm its veracity. They may be acting perfunctorily and simply reporting abuse based upon a small amount of information provided by the mother, the child, or exhibited by the child's physical or behavioral symptoms. I know clinicians who feel compelled to report even when they believe it's highly improbable that abuse has occurred. They are practicing defensive medicine. The report itself may then become overly weighted "evidence", as though there had been some real investigatory work

done or an expert professional opinion rendered about the abuse, though the report is simply conforming to the law to report any suspected child abuse.

Remember, very disturbed children, previously sexually abused children, bipolar children and others may exhibit eroticized behavior without being sexually abused. It is then easy to understand why a "third party" makes a report.

6. False allegations may be the result of contagion. Children in pre-school, school, daycare or church settings, and who are exposed to the allegations and testimony of their peers may come to believe their own abuse has occurred, especially if exposed to interviews involving suggestion that they too were abused.
7. Medical and physical findings partly because they are concrete, may give rise to concern of sexual abuse, e.g. vulvovaginitis, anal fissures and urinary tract infections, especially when combined with erotic play due to a childhood psychiatric disorder or the bitter accusations of a parent involved in family litigation, may result in a pediatrician or parent's report to C.P.S. and the belief in the child's being abused. Medical expertise notes that and fissures can be due to constipation, vaginitis is not usually related to abuse.

False allegations of abuse by children evidence certain characteristic features. The child seems all too certain of every detail and may be comfortably outspoken and nondefensive in his description of the sexual activity. Accounts given without mood or affect fluctuation, without a quivering voice averted eyes or halting in the account suggest a false allegation. Genuine disclosures especially if not a repeating

examination, are almost always accompanied by anxiety, a halting narrative, and retractions. A sexually abused child shows evidence of anxiety, ambivalence and shame when reporting it in an interview properly conducted, especially in the first interviews. If the child uses adult terminology to describe genitals and body parts it raises the question of the memories having been suggested by an adult. The adult could be a well-meaning C.P.S. worker, an investigator, an angry parent, a confused parent, or a well meaning mental health professional, who unwittingly is so struck by the story that he loses his professional objectivity (and thus expertise) and reinforces the story in the child's mind.

True victims of incest are almost always secretive about the molestation, and provide outcries resulting from some precipitating event. The allegations are made in an emotionally conflicted, shameful, anxiety ridden and halting manner. Small admissions are first made and retracted. Later admissions are often larger, more upsetting and startling. Guilt and shame are predominant affects, and it may take weeks or months to obtain and sort out the whole story. The Sexual Abuse Accommodation Syndrome helps us understand the progression of the story given in shame, humiliation and guilt. The story is changed and retracted. As their allegations are retracted and restated, their credibility is questioned. Abused children are fearful that the perpetrator may be incarcerated that he will harm them. When genuine incest victims are directly questioned about the molestation, very negative affects are almost always uncovered. The disclosure is accompanied by marked anxiety, fidgetiness and depression. The genuine victim uses age appropriate language to describe the activities. Very young children may enact sexual abuse using play, dolls and fantasy.

When the dolls are aggressive and display highly sexual activity, it's a powerful message about abuse. Severely traumatized children may also completely avoid any play with dolls or puppets. An important point for you is that while a child may have been sexually abused, present as an abused child in a properly conducted evaluation, the identity of the perpetrator may still be in question. Again this emphasizes the need for hypothesis testing. Sexually abused children are living in chaotic families, are very vulnerable and the perpetrator may be one of many in their life.

Evaluation should include sessions with the child alone and with each parent separately. A sexually abused child may expectedly exhibit signs of fearfulness upon entering the office. She often sits on the far end of a couch or across the room from her parents. An evaluator expects obvious signs of anxiety, depression, defensiveness and usually inhibition. When both parents are present, a victimized child is often clingy with her mother and fearful of the father, if he has been abusive. However, if the sexual contact was gradual, and it was experienced as gentle, nurturing and exciting, the child may display seductive behavior toward a molesting father. But this seductive child's behavior also raises the question of a psychiatric disorder which may lead to misinterpretation, e.g. bipolar children is a syndrome I have seen numerous times, present with inappropriate sexualized behavior. A child being controlled by a vindictive mother is often mindful of her mother's facial expression. The "brainwashed" child before responding will "check" with her mother, and this is an extremely telling clinical finding. It is an example of an expert's work rather than simply retelling of narrative information. The child may behave in a very hostile manner her toward father in the presence of her mother, yet when alone with her father (outside of mother's scrutiny),

may become friendly and cooperative. This is common in parental alienation and cases of false allegations.

In cases of alleged incest, separate psychiatric evaluations of each parent should be conducted. While comprehensive, certain issues such as substance abuse, personality disorder involving manipulation, severe narcissism, capacity for empathy and dishonesty are particularly important. Parents of incest victims are more likely to have experienced physical or sexual abuse in their own childhood, but this should be only one piece of data. Most sexually abused youth do not become abusers themselves. And there is no psychiatric evaluation of a parent that can prove he has abused a child or is a molester. History confirmed collaboratively is potent. Pedophilia is not always diagnosable nor part of molestation. On the other hand, an alleged perpetrator's past history of pedophilias and criminal convictions is relevant.

XIII. PEDOPHILIA AND SEXUAL MOLESTATION:

The National Center for Child Abuse and Neglect (1988) reports that in the United States156,000 children are sexually abused each year. Of these about 15% of all girls and 7% of all boys have been sexually molested before age 18. Sexual abuse involves all socioeconomic groups, educational levels and racial backgrounds. Most child molesters also experience sexual arousal for adults though some are exclusively sexually attracted to children under 14. Some molesters become involved with a child as a result of a major life stress, such as death or divorce of a spouse, the unavailability of an adult sexual partner or related to brain damage or substance abuse. Does your client fit this model? While women are known to sexually molest children, they do so at

a much far lower frequency. Some believe female molesters are more likely to have a serious mental illness though there is no convincing clinical or research data bearing on this. Mother-son incest is, however, very unusual.

Child molesters have been described as being in one of four distinct age groups. Molesters under age 18 become sexual perpetrators with a young child, often in an experimental fashion. Some studies report as many as 40-50% of sexually abused children have been abused by an adolescent. A second group of perpetrators, age 35 to 45, sexually abuse their own child or children of their friends. A third group, those over age 55, often have either central nervous system disease, lost their adult sexual partner by death or divorce, or are experiencing extraordinary stress. A fourth group is those pedophiles who have been aroused by children all of their lives. They work to put themselves into situations where they can easily access and groom children, and then sexually molest large numbers of children over time.

Child molestation all too commonly involves fondling of a child. More distinctively and less frequently it involves oral-genital contact and less commonly vaginal or anal penetration. A physical, sexual assault or rape with force is very infrequent. While the latter cases are likely to be covered by the media, they incorrectly leave the impression that child molesters commonly use physical assault or force. They don't; they employ the grooming process.

The child molester due to cognitive distortion views the experience as one of mutual consent. Molesters commonly believe they have established a caring, supportive role with the child, and that it has extended into greater physical intimacy. They report that the purpose of the sexual interaction is to teach the child about sex, to

bring the child sexual pleasure, and to demonstrate their love and mutual intimacy. Molesters use very pathologic cognitive distortions in order to justify their behavior. Nevertheless, at some level, the molester knows his behavior is deviant and illegal. This is reflected by his efforts to maintain secrecy. As the sexual interaction evolves the perpetrator tries to convince the child that he is also at fault for participating. The child feels shame, guilt and humiliation and is easily convinced that he will be held responsible by family, friends and society. He has no foundation of social experience from which to gain a better perspective. How could he? The child accepts responsibility, conceals the molestation and allows it to continue for fear of being caught. He feels suffocated in a vicious cycle of guilt, excitement, and cooperative behavior leading to increased guilty and shame.

A review of available procedures for identifying child molesters, pedophiles or even the risk of recidivism reveals no reliable instruments (Campbell, 2000, Murray, 2000). No psychological or psychiatric evaluation can reliably identify pedophilia. No MMPI profile or Rorschach can determine sexual orientation with certainty, and certainly no evaluation or testing can confirm molestation. These evaluations can assess the degree and type of personality pathology, capacity for empathy and attachment, impulse control and other such variables which may reflect on the person's capacity to abuse another. Even penile plethysmography is unreliable and can be fooled; perpetrators can inhibit responses to naked children. Innocent alleged criminals may not demonstrate sexual arousal to any stimulus. The procedure is so unnatural and results unreplicated that it is not very useful.

XIV. REFERENCE PRACTICE PARAMETERS

Forensic Psychiatric Evaluation Parameters: American Academy of Child and Adolescent Psychiatry

(J. Amer. Acad. of Ch. Adol. Psychiat., 36:3, March, 1997, 423-438)

A number of practice parameters have been established by the AACAP as guidelines in the practice of child psychiatry. While they are not rigid constraints or directives, to the extent from which they are deviated, a psychiatrist needs to explain the thought process, why the evaluation should have taken place differently, and why the evaluation was competent even while not conforming with the parameters. Recommendations for these guidelines are based on the available scientific research and current state of clinical practice. The parameters consider the clinical presentation of abused children, the normative sexual behavior of children, available interview techniques, the possibility of both true and false allegations, the assessment of credibility and the important forensic issues involved.

The "Parameters for the Forensic Evaluation of Children and Adolescents Who May Have Been Physically or Sexually Abused" identifies the distinct roles of the forensic evaluator, the clinician who conducts mental health assessments and provides treatment, and the consultant who provides expertise regarding public policy. The clinician who is working as a forensic evaluator often evaluates children in a private practice for forensic purposes in collaboration with professionals in a governmental agency, or a child protective services setting, and may assist the court in determining the child's needs. A forensic evaluation may involve evaluation of the child along with the credibility of allegations and evidence suggesting that the child has been abused. It

may also be employed to assess the evaluation and conclusions of other professionals most often those done by a protective services investigatory agency. Forensic evaluations are conducted in civil suits in which the plaintiff seeks remuneration. The evaluator may be employed by either the plaintiff or defense. Child psychiatry forensic evaluations are conducted for use in family court, juvenile court, civil litigation and criminal litigation.

The parameters outline the differences in a clinical and a forensic evaluation. The parameters emphasize the importance of the forensic assessment being very comprehensive, not simply accepting allegations (reported by an angry parent, a confused child or a plaintiff's attorney) without obtaining the appropriate comprehensive information for obtaining initial information from an adult, an angry parent with the child present sets up a situation in which the child is likely to repeat what his angry parent has reported. Significant background information should be gathered without the child present. The evaluator makes every effort to avoid false allegations being inserted into the child's memory, and the child's recanting of history from a secondary source which she has heard (without acknowledging this), and then being pressured or rewarded for its repetition. Those who believe the child has been abused should be interviewed in a setting without the child present. The AACAP emphasizes the need for several interviews, a posture of objectivity and a degree of skepticism. A competent forensic psychiatric evaluation requires the exploration and consideration of a variety of hypotheses, e.g. psychiatric illness in the child or memory insertion. Children who are repeatedly interviewed and can unfortunately be guided to a variety of allegations and even detailed "remembrances" by investigators and Child Protective Services agents,

who while well meaning, are misguided and accept their initial hypothesis rather than taking on a more objective posture and a truly “hypothesis-testing” mindset.

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

Historically, a landmark in the realization of the occurrence of child abuse was signaled by a radiologist in a hospital emergency room when Caffey (1946) reported a syndrome of children with multiple skeletal injuries and chronic subdural hematomas. It was not until the 1960s that it was realized that the physical abuse of children was not rare, and it was Kemp, et al 1962 in the Journal of the American Medical Association who described the “Battered Child Syndrome” in a landmark medical publication. It was not until 1974 that the federal government passed the Child Abuse Prevention and Treatment Act resulting in every state passing laws in which designated persons were required to report child abuse.

During the 1970’s our society as a whole began to realize the extent of sexual abuse and incest. The National Committee to Prevent Child Abuse (1995) estimated that in 1994 more than three million alleged victims were reported to child protective service agencies, of which one million were substantiated! Of these approximately 11 percent were sexual abuse, considered an underestimation.

The AACAP emphasized the importance of understanding normal sexual behaviors of children for two reasons. First, normal sexual play activities between children should not be confused with sexual abuse or reflecting a child's having been sexually abused. Second, it is important to recognize that sexually abused children more commonly manifest sexual behaviors than the normally developing child. What is a baseline for comparison? A non-clinical population study by Rosenfeld, et al (1986) found it is not uncommon for children ages 2 to 10 to occasionally touch a parent's genitals. Friedrich, et al (1991) studied normative sexual behavior of children by asking parents whether their children exhibited specific behaviors in the last six months. They report that at least 15% of the boys in the sample, age 2 to 6 demonstrated the exhibition of sexual parts to children or adults, masturbating with their hand, and the touching of sexual parts in public and at home. At least 15% of the girls in the sample, age 2 to 6, manifested flirtatious talk, masturbating with their hand, showing sexual parts to adults, touching sexual parts in public places and at home.

The guidelines for the forensic evaluation requires the evaluator to take the position of neither being a therapist or child advocate, but of one attempting to arrive at objective conclusions based on unbiased data. The AACAP guidelines as well emphasize the topics we've already noted in interviewing technique. Leading and suggestive questions are to be minimized though more specific questions may have to be asked later in the evaluation. The guidelines allow the use of anatomically correct dolls, but I believe they should only be introduced much later during the evaluation. It is a compromised technique. Once it has been employed, it can never be undone in terms of its power of suggestion and influence.

The guidelines note the usefulness of children's drawings in obtaining associative non-directive material. The child might be asked to draw self portraits, family drawings, or drawings of things that were upsetting to him. The greater usefulness of these drawings often lies in the affect and information they elicit. Whatever vehicle of communication is employed great care is used not to lead or coach the child to simply confirm the evaluator's predetermined hypothesis of what has occurred.

A number of reports have collected normative data regarding normal children's reactions to the presentation of traditional and anatomically correct dolls. Averson & Boat (1990) founded about 6% of 223 normal children age 2 to 5, manifested explicit sexualized play, and this was more likely to occur among poor African-American males. Sivan, et al (1988) observed 144 non-abused children in a playroom with anatomical dolls and reported that these children found the dolls no more interesting than other toys and that no explicit sexual activity was observed. Britton & O'Keefe (1991) demonstrated that children manifest sexually explicit behavior with non-anatomically correct dolls as frequently as when interviewed with anatomical dolls.

The AACAP guidelines also reference Benedek and Schetky (1987) who note the factors observed in the child which increase his 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 re-enacts 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 considerable recall of details, including sensory, motor and idiosyncratic detail; and the child has a history of telling the truth.

Dant and Flin (1992) discuss the application of statement validity analysis and criteria-based content analysis to the evaluation of children who alleged sexual molestation and found the following characteristics occur in unreliable or fictitious allegations: the child's statements become increasing 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. However, interpretation of this material is confounded by the issues described in the child sexual abuse accommodation syndrome.

For legal counsel, whether the prosecutor or defense, the AACAP Practice Parameters provide guidelines for evaluating children who may have been sexually abused and are useful in understanding the findings of evaluators and their reports. They may be used to measure the competence of the evaluation and either add weight to the findings or highlight areas of weakness in either the way the evaluation was conducted or the manner in which conclusions were derived.

XV. THREE IMPORTANT CLINICAL SYNDROMES:

A. MUNCHAUSEN'S BY PROXY

Munchausen's by Proxy involves a parent who induces or feigns an illness in the child in order to gain a sense of self worth and importance, become the savior of that child and give them a reason to live, and to obtain admiration for others as they rescue their child. Thus, in some situations in which sexual abuse is

alleged, an evaluator may find that a parent is either genuinely or manipulatively developing a story and/or situation in which they present their child to have been abused, use suggestion to cause the child to feel abused and behave in such a manner, and then seek repeated help from the medical profession as well as the police, authorities, District Attorney and family attorneys.

B. PARENTAL ALIENATION SYNDROME:

Parental alienation syndrome occurs in situations of divorcing parents or parents who are divorced in which one parent turns the child against the other parent who is usually the one not having primary possession. It is usually a mother who conveys to the child that their father is negligent of their needs, an evil person, has abandoned them, or is otherwise to be feared and avoided. This may occur at an unconscious and non-malicious way in a very anxious mother who finds the entire world threatening. This mother is genuinely, though possibly misguidedly, trying to protect her child and the father becomes the fearful target. On the other extreme is the mother who conspicuously deceives her child telling him that his/her father has been evil and destructive, possibly physically dangerous to her or to them, has had affairs or is sexually predatory toward them, and that they should be terrified of being alone with him. I have seen this even occur with teenage girls. The power of repeated suggestion is extraordinarily powerful, especially in a divorce in which the girl probably already is upset with her father.

C. THE CHILD SEXUAL ABUSE ACCOMMODATION SYNDROME:

The Sexual Abuse Accommodation Syndrome describes how a child may relate being sexually abused, later retract it, later recount it again with further

elaboration, and later retract it and so on. It helps one to understand how a child who has been attached and dependent upon someone may reveal inappropriate sexual behavior. After revealing it, the child then again feels guilty, ashamed and humiliated, possibly wishes to protect the perpetrator, and therefore in the next interview may retract it or be silent about the event. At a later time when feeling safe, the same child may again repeat the original history of molestation and may even provide more details. Therefore, the fact that a child tells one story on one day and another story on another day cannot in and of itself be taken to demonstrate that the child has not been molested. Understanding this internal psychodynamic constellation and its effect on the assessment process is further reason why initial evaluation interviews must be done carefully and appropriately if one is to obtain the important information required for a forensic evaluation and the court.

XI. CROSS-EXAMINATION

As parents we are all very aware of how young children, and even school age children can lost in their for something genuinely believe something was/is realistically not correct. Further, we know how easily children can be excited by silly humor about body parts. Studies have shown that if a young child is asked to pretend about an event, a person or a ghost, they blur reality and fantasy quite easily and if the interview (or parent) does not bolster the child's cognition, his poor fantasy-reality boundary may leave the child in the fantasy realm and he may even recall the event as factual.

Two concepts to consider in designing cross-examination of a child are reality monitoring and source monitoring. The first is related to the example just described. Open ended explanation to the example just described. Open ended explanation with the child that leads to bizarre, unrealistic or impossible stories suggests either he's reporting a fantasy or he's defensively expressing his terror. An obvious example here would be that the child beat up the predator and threw him out the window. Source monitoring is also a rich area for exploring validity. Reality monitoring refers to distinguishing if the event was real or imagined. Source monitoring looks to the origin of the information that the event actually occurred. Was the child told it occurred by his friends, by his parent, by C.P.S. or a detective? Often children have been told by a number of these people whether directly or by indirect positive reinforcement. And the story once told, children's accounts are often reinforced and shaped to fit the picture. Some children are repeatedly told not to change their story in any detail because they will no longer be believed "even in they recall something small and change their mind about what happened, they should stay with the exact same story." Another illustration of this in daily life is a child's recanting a story in a book or from a favorite movie as if it had actually occurred. These errors of "reality" and "source" fall under what we would classify as genuine. The child needs help in gradually working his way to distinguish reality for you. And this must be done patiently and using a non-threatening style what you refer to as disarming.

Source and reality monitoring can be explored through a series of questions, e.g.: Tell me about what you like to do? Who does that with you?

What do you do with your mom? Tell me all about it? What do you do with your dad? Tell me what you do at school. Tell me about your teacher. So when you are alone with dad, do you remember feeling his hand touch your privates? Did someone tell you he touched your privates? If you remember him touching your privates, can you remember where you were? Who else was there? What happened next? And then what? How many times did he touch your privates? Can you tell us whether you remembered it happening first or did you hear about it from someone first? Are you ever confused about whether your mother told you or whether you actually remember it? Do you ever think it was someone else? How do you know it was your dad (teacher, etc.)?

Now some of these are hypothesis challenging and suggestive, but after the child has made the allegation and testified to it, you need to look for another hypothesis or explanation to confirm the child's accurate recall and testimony or to impeach it.

Henderson in (Westcott, H., Davies, G., and Bull, H. (2002) in their handbook Children's Testimony outline the reasons children lie. Of particular interest, however, is the discussion of cross-examination. Studies reveal that lawyers tend to believe children were capable of remembering events accurately and being reliable witnesses and believed that false allegations of sexual abuse were rare (p. 280). Further, they had little idea of the possible causes of false allegations or the power of suggestion and therefore were not well equipped at mounting a defense. Attorneys were hesitant to use the age-appropriate language of the child. They also vastly underestimate the high proportion of

cross-examination questions the child misunderstands. Manuals suggest direct examination be in chronological and logical order to help the comprehension and retention of evidence and advise cross-examiners change subjects rapidly to confuse dishonest witnesses. Much of cross-examination theory she holds is in the effort of persuasion rather investigation and emphasizes controlling the witnesses disclosures. She reports that children are often cross-examined with the same goal.

Direct examination is used not as investigatory, but as simply an organizer for the witness to retell his story.

Cross-examination is not investigatory, it is intended to break down the story told, reshape it, or discredit the witness. Child witnesses are treated similarly and the power of suggestion is even greater with them. The attorney's attitude toward the child must be accepting warm and even calming. His attitude about the child's version of his testimony can be incredulous and conveyed in his tone of voice suggesting to the child he should search for another version more pleasing to the cross-examining attorney. Cross-examination breaks most of the rules of a forensic psychiatric evaluation. Indeed, I suspect you would use most of the errors of a forensic evaluation in order to manipulate the testimony on cross e.g. suggestion, leading, asking if the child would like to rethinks his answer or response about a certain piece of testimony, etc. But, remember the cross-examining defense attorney is speaking to the court as well as the child. The jury to some extent will respond to your examination and factor that into their evaluation of the child's credibility. Jurors remain generally sympathetic to child

witnesses and attorneys must be sympathetic as well. Remember, the child witness-whether confused, honest or purposefully deceitful – he is stressed, conflicted, frightened, and guilt ridden and needs your compassion.

X. SUMMARY

A criminal defense attorney needs to understand the issues and dynamics leading to false or incorrect allegations of sexual abuse of a child. This understanding of alternative hypotheses; of false allegations, of suggestibility, of influences on children's memory and reports are all critical in developing an understanding of your clients predicament and how to defend him against erroneous accusations.

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San Antonio, Texas

OUTLINE OF PRESENTATION

1. CHILD SEXUAL ABUSE OVERVIEW
2. CHILD DEVELOPMENT AND MEMORY
3. SEXUAL ABUSE – TYPES, PARAMETERS IN REGARDS TO SEQUALAE
4. CHILD PSYCHIATRIC EVALUATION – PARAMETERS
5. CREDIBILITY OF ALLEGATIONS AND OF EXPERT ASSESSMENT
6. FACTORS ASSOCIATED WITH "TRUE" AND "FALSE" ALLEGATIONS
7. CHILDREN'S MEMORY AND TESTIMONY
8. TESTIMONY OF THE CHILD AND EXPERT ASSESSORS
9. FAMILY COURT AND CRIMINAL COURT ACTIONS IN PARALLEL
10. THE ACCUSED MOLESTER – YOUR CLIENT
11. CROSS-EXAMINATION

CHILD DEVELOPMENTAL STAGES

A. INFANTS, TODDLERS, AND PRESCHOOLERS

B. EARLY SCHOOL AGE (6 – 10)

C. PRE-ADOLESCENCE AND EARLY ADOLESCENCE (11 – 14)

D. ADOLESCENCE (14 – 17)

LINES OF DEVELOPMENT

1. COGNITIVE
2. EMOTIONAL

FORENSIC AND NON-FORENSIC ASSESSMENTS
(Steller, et al, 1989)

» ISSUES OF TRUTH – DEFINITION

» SKEPTICAL NEUTRALITY

» ASSUMPTION OF HONESTY

» AVOID INTUITION

» SCIENTIFIC VALIDATION

» PHYSICAL SETTING AND MATERIALS

» INTERVIEWER DEMEANOR

» CONCERN ABOUT SUGGESTIBILITY

FORENSIC EVALUATION

1. CLIENT CENTERED
2. OPEN – ENDED
3. AVOID LEADING QUESTIONS
4. HYPOTHESIS TESTING
5. ALTERNATIVE HYPOTHESES
6. VIDEOTAPING

Interviewer Style and Demeanor:

1. Appears relaxed and does not react with surprise to disclosures of abuse or other material.
2. Avoids touching the child.
3. Does not ask the child to demonstrate events that require the child removing his/her clothing.
4. Does not make reinforcing comments such as “good girl”, which can interfere with obtaining objective facts by selectively reinforcing specific types of answers.
5. Avoids questions regarding why the perpetrator or child behaved in a particular way. These questions are difficult, often speculative to answer, and may convey to the child his/her own responsibility for what has occurred.
6. Refrains from using words like “pretend” or “imagine” that may suggest a fantasy or play mode, unless it is to question a reported event.

7. Asks the child to repeat inaudible comments by inquiring “What did you say?” or “I couldn’t hear that, could you please repeat it?” Does not assume what was meant.
8. Diffuses a child’s being overwhelmed by focusing on less stressful topics when necessary. Deeply empathic responses are avoided in order to avoid the child’s being so upset as to disrupt the interview, though reasonable and reflective empathy is appropriate.
9. Is cautious about using breaks, drinks, or candy as reinforcement for talking. When such rewards are employed, the child’s answers may be considered less credible because the child must have been more focused on receiving the reinforcement than on providing a correct answer.

FLAWED INTERVIEWING

» LEADING – EXPLICIT

» INDUCTION OF A STEREOTYPE

» SUPPORTIVE STATEMENTS

» ATMOSPHERE OF ACCUSATION

» REWARDS, BRIBES AND THREATS

» PEER OR OTHER PRESSURE

VIDEOTAPING

ADVANTAGES

1. Reduces questioning
2. Encourages proper technique
3. Strong evidence for prosecution
4. Discourages recantation
5. Used to refresh child's memory
6. Convince a perpetrator to confess

VIDEOTAPING

DISADVANTAGES

1. Shifts focus toward the interviewer
2. May have greater weight because taped
3. Highlights inconsistencies of immature child
4. May cause the child to be reticent
5. Poor quality tape translated to poor data
6. Why videotape only children?

THE FORENSIC INTERVIEW AND ASSESSMENT

PREPARATORY PHASE

» RAPPORT, NON THREATENING

» OPEN ENDED

» CONTEXT AND SETTING

INTERVIEWER STYLE AND DEMEANOR

- RELAXED
- AVOIDS GUIDING/REINFORCING COMMENTS
- REFRAIN FROM “PRETEND”
- CLARIFIES RESPONSES
- PROTECTS THE CHILD’S ANXIETY
- CAUTIOUS ABOUT REWARDS
- PRACTICE INTERVIEW/PREPATORY PHASE
- HYPOTHESIS TESTING
- INTRODUCING THE TOPIC
- INVITE A FREE NARRATIVE
- HIERARCHY OF QUESTIONS

PHASES OF THE INTERVIEW

The Introduction

Repeat identifying information in tape.
Introduce yourself to the child by name and occupation.
Explain the taping equipment and permit the child to glance about the room.
Answer spontaneous questions from the child.

The Truth/Lies Ceremony

Ask the child to label statements as “truths” or “lies.”
Get a verbal agreement from the child to tell the truth.

The Ground Rules

Explain the child’s rights to say “I don’t know.”

Explain the child’s responsibility to correct the interviewer when he or she is incorrect.

Allow the child to demonstrate an understanding of the rules with a practice question (e.g., I: “What is my dog’s name?” C: “I don’t know.”).

MEMORY

THREE COMPONENTS – INPUT, RETENTION, RECALL

AGE AND EMOTIONAL CHARGE

SUGGESTIBILITY – PLEASING INTERVIEWER

ANATOMICALLY CORRECT DOLLS

CAUTIONS

RISKS

ERRORS – FALSE POSITIVES AND NEGATIVES

TRUE AND FALSE ALLEGATIONS
(Green and Schetky, 1988)

QUALITY OF AN EXPERT'S EVALUATION AND CONCLUSIONS

FALSE DISCLOSURES

- VINDICTIVE PARENT, USUALLY MOTHER
- DELUSIONAL MOTHER
- NORMAL DEVELOPMENTAL RESPONSE EXAGGERATED
- HYPERVIGILENT THIRD PARTIES –
  - TEACHERS,
  - PEDIATRICIAN
- PSYCHIATRICALLY DISTURBED CHILDREN
- ALLEGATION DIRECTED TOWARD
  - INCORRECT PERSON (OTHER PERPETRATOR POSSIBLE)
- MEDICAL FINDINGS – FISSURES, VAGINITIS

TRUE DISCLOSURES

- THIRD PARTY WITNESS
- MEDICAL FINDINGS
- OUTCRY GIVEN HALTINGLY
- GOOD INITIAL ASSESSMENT,
  - VIDEOTAPED AND PROPERLY INTERPRETED USING EXPERTISE – NOT INTUITION OR CIRCULAR THINKING
- COLLATERAL CONTACTS

PEDOPHILIA AND CHILD MOLESTATION

National Center Child Abuse & Neglect reported

156,000 children sexually abused in 1988 – 15% of

all girls and 7% of all boys prior to age 18!

Pedophilia is arousal; Child molestation is behavior

AACAP PARAMETERS

American Academy of Child and Adolescent Psychiatry

"Psychiatric Evaluation of Children and Adolescents"

"Forensic Evaluation of Children and Adolescents Who May Have Been Physically or Sexually Abused"

RELEVANT SYNDROMES

MUNCHAUSEN'S BY PROXY
(FICTITIOUS DISORDER BY PROXY)

PARENTAL ALIENATION SYNDROME

SEXUAL ABUSE ACCOMMODATION SYNDROME