ADDITIONAL HANDOUTS FOR CSA


“As anxious parents outline the reasons for their anxiety, they cite one detail after another appearing to verify their assumption of sexual abuse. The “evidence” they present can progressively persuade themselves, and others, as to the legitimacy of the concerns. Related research, for example, demonstrates that attempting to explain why some event night have occurred progressively persuades people that the event did occur…These endorsements also encourage the development of loyal alliances between anxious parents and concerned others. Loyalty prevails within these alliances because any two people who endorse the same attitudes are more inclined to regard each other positively”. p.25

“The intense needs of people to obtain information under ambiguous circumstances motivates them to exchange imaginative speculations with each other. In turn, these speculative exchanges create fertile ground for a bountiful harvest of rumors”. p. 26

“The relevant research demonstrates that when confronted with ambiguous statements, anxious people interpret them in a biased manner”. p. 26

“The speculative exchanges of anxious parents and concerned others frequently converge into commonly shared theories. They rapidly reach a consensus via processes of “leveling” and “sharpening”. In their dialogues, they “sharpen” – or emphasize – impressions consistent with their preexisting expectations. Simultaneously, they “level” – or deemphasize” – any information inconsistent with their a priori thinking…In turn, the similarities of their thinking convince them they have discovered important facts – “We agree, therefore we must be right!” Thus, two or more people can verify for each other that some imaginary event actually occurred – and what originated as a worrisome rumor (sexual abuse) acquires the unwarranted status of an indisputable fact” p. 28

“Relying on behavioral indicators to conclude that a child has been sexually abused is ill-advised. Too many children who have never been sexually abused also exhibit behavioral
characteristics supposedly indicative of abuse. Various traumas in a child’s life such as family conflicts, acute illness, or enduring the harsh spotlight of a sexual abuse investigation can provoke the indicators.” pp. 18-19

“A fundamental principal regarding memory; namely, memory never improves with the passage of time. It either remains the same, or more often it fades and decays”. p. 127

“Unfortunately, child therapy can distort and confuse the recall of children by creating source-monitoring problems associated with memory…Therapists can profoundly distort the memory of children by suggesting interpretations of what they supposedly encountered or experienced. In response to the therapist’s influence, children accept these interpretations as legitimate. They then resort to their imaginations—though convinced they are searching their memories— inventing anecdotes of past events that appear to validate the therapist’s interpretations.” p. 129

“A therapist who responds sympathetically to a child’s plight, and offers hope of alleviating it, profoundly increases her influence with that child….Child therapists characteristically seek a warm and understanding relationship with their clients. Doing so allows them to assume a role of central significance in a child’s life.” p. 130

“Play therapy does not effectively aid children who have been abused”. p. 132.

“…the direction of play therapy responds to the theoretical convictions of its practitioners – and play therapists want children to dramatically express their feeling and emotions. Play therapists are particularly interested in the emotional experiences of children that seem to involve anger. Consequently, they attend selectively to their clients’ behavior, reserving their greatest interest for responses they interpret as corresponding to angry feelings and emotions. As a result of the therapist’s influence, children in play therapy learn when they are expressing “angry feelings” and how significant such expressions supposedly are…To the degree that children demonstrate imaginative improvisation in play therapy, they typically encounter lavish praise for the creativity with which they ventilate their feelings. Interestingly enough, related data have demonstrated that improvised, active behavior influences changes in attitudes and beliefs.” p. 132

“Children in play therapy respond to their treatment in an “as if” manner. In response to their therapist’s praise, they act as if they are angry, and this kind of pretending can influence children to conclude they actually are angry.” p. 132

“Children who act as if they are angry are also motivated to reconstruct past events in accordance with their apparent anger.” p. 133
“As a vehicle of therapist influence altering attitudes and beliefs, play therapy becomes progressively more persuasive over time. Though children appear to control the course of play therapy, therapists actually exercise ultimate control via their interpretive comments. Play therapists regularly attribute a child’s overt behavior to some underlying feelings. Simultaneously, they influence children to amplify and exaggerate the intensity with which they express those feelings. The therapist then labels the child’s feelings as anger or some other similar emotion, and attributes those feelings to an alleged history of sexual abuse.” p. 134

“Play therapy with children of divorce often excludes noncustodial parents, and these circumstances lure play therapists into sympathetic alliances with custodial parents…In turn, they interpret a child’s relationship with her noncustodial parent in a manner that corresponds to the custodian’s agenda….In their determination to create a “therapeutic alliance” with a custodial parent, play therapists may go beyond a genuine and understanding relationship to the extent of coalition formation.” p. 135

“Play therapists often isolate children from sources of information that might challenge their influence. For example, when they recommend limitations or suspensions of a noncustodian’s visitation rights, noncustodial parents obviously find it more difficult to defend their reputations.” p. 136

Poole & Lamb

Neurologically unable (prefrontal cortex not fully developed) to sustain and focus on adult instructions before age 6-7.

Young children tend to be interested in any particular conversation for only short periods of time.

Younger children have more difficulty than older children or adults in recognizing what event is under discussion

Preschool children sometimes remain off topic even when they are cued with specific prompts, therefore interviewers cannot assume that young children are “on board” even when their answers seem to make sense.

Young children are not adept at inferring adults’ intents, and they sometimes answer general questions in ways that can cause their responses to be misinterpreted.

Even when they begin talking about target events, they often shift focus as questioning continues.
Young children are more apt than older children and adults to have difficulty in determining whether they had obtained information from their own experiences or from other sources.

Researchers have documented that children are more likely to intrude information from the wrong source when the interviewer asked closed questions (e.g. Did he….?) as opposed to open-ended questions (e.g. “Tell me what happened…..”).

Children generally try to answer specific questions we know they cannot possibly answer.

Children frequently answer “yes” to yes-no questions.

**Therapists in a Forensic Case**

Greenberg and Gould (2001) indicate that a therapist may be particularly vulnerable to problems and ethical issues when they fail to realize the differences between traditional clinical treatment and treatment in the context of a court case. Particularly if information is coming from one source only. With that type of limited and biased input, Greenberg and Gould caution that a strong presentation of particular concerns to the therapist “may result in the therapist focusing more on that particular issue, altering the tone of the session, or subtly (or not so subtly) directing the session toward eliciting specific information and statements rather than exploring a variety of concerns significant to the child.” Or that may be other hypotheses for the observed behaviors.

“The therapist may come under pressure to express an opinion on a psycholegal issue more appropriate to the role of evaluator (e.g., the validity of an abuse allegation, a custody recommendation, or parental capacity)” (Greenberg and Gould, 2001). Greenberg and Shuman (1997) state, “Psychologists and psychiatrists who provide patient care can usually qualify to testify as treating experts, in that they have the specialized knowledge, not possessed by most individuals, to offer a clinical diagnosis and prognosis. However, a role conflict arises when a treating therapist also attempts to testify as a forensic expert addressing the psycholegal issues in the case”. The treating expert does not have the neutrality and depth or breadth of information that is required to make such declarations.

Greenberg and Gould (2001) state, “It is often appropriate for therapists to consult with children’s attorneys, the guardian ad litem, and CPS workers regarding the children’s needs. However, the therapist who strays beyond these boundaries to express opinions on psycholegal issues has an enormous potential to harm the child – not the least by missing emotional issues that may not be consistent with the therapist’s position or with information that the therapist has focused on in treatment.” They further state, “If the therapist has not seen the natural parent with the child, making statements about this parent-child relationship would likely be a violation of
APA ethical standards (APA, 1992, Standards 7.02-7.03).” These standards reflect that psychologists provide testimony, written or oral reports on the characteristics of an individual only when they have “conducted an examination of the individual adequate to support their statements or conclusions”; and they clarify any role conflicts they are faced with, i.e. treating therapist and forensic expert.

Mannarino and Cohen (2001) inform that because of the role differences between treating therapists and forensic psychologists it would difficult, if not impossible, for a therapist to offer unbiased opinions. They state, “It is the ethical responsibility of the therapist to not respond to questions pertaining to the ultimate issue before the court”. Despite pressure from attorneys who are not hesitant to ask these questions, judges who may not understand the differences in roles, and parents who want the therapist to opine when they feel it is their best interests, “it is up to the therapist to clarify his or her role and refrain from responding to these types of questions”.


Directs evaluator to define CSA as a life event rather than a clinical syndrome, rely on base rates for distinguishing and understanding differences between nonsexually abused children and sexually abused children, and consider issues of sensitivity and specificity when utilizing assessment tools.

Due to their cognitive limitations and inability to grasp the meaning of a sexual event, toddler and pre-school age children may be at less risk than older children to experience sexual victimization as traumatic when physical violence is absent.

Nightmares, fearfulness, over dependence, mood changes, and dissociation are behaviors sometimes exhibited by sexually abused children, which, at times, have been used inappropriately as “markers” that sexual abuse has occurred.

Asymptomatic children range from 21%-49%. Sexually abused children did not appear to be more symptomatic than other children receiving mental health treatment, with the exception of sexualized behaviors, which were exhibited at a higher frequency by sexually abused children.

Many normative behaviors of childhood appear as dissociative symptoms.

34% of 4-6 yr. old females were found to have nightmares and 45% were found to be “clingy” and “too dependent”. A high percentage of preschool children in the general population exhibit
nightmares, sudden changes in mood, poor concentration, fearfulness, disobedience, and temper tantrums.

Adult sexual behavior in children appeared more frequently in sexually abused children than normals. This was the only single behavior seen more often in sexually abused children. Range from 7%-90%. These behaviors are related to the frequency of abuse, use of force, and the number of perpetrators. Sexual behaviors may also be learned in contexts other than sexual abuse.

Research does not support a conclusion of sexual abuse based on the behavior of children with anatomically correct dolls. The use of dolls lacks psychometric properties required of test materials.

The majority of nonsexually abused toddlers and preschool children explored anatomical dolls genital areas, anuses, and breasts when presented with the dolls. 80% - 2 yr. old, 70% - 3 yr. old, 60% - 4 yr old, 40% - 5 yr old.

Behavioral Checklist may be useful in identifying the presence of emotional and behavior problems and for comparing responses of parents, teachers, and day care workers, but they lack the specificity and sensitivity for identifying whether a child has been sexually abused.

Drawings are one of the most misused tests in assessing sexual abuse.

When a child shows a significant change in sleeping, eating, and toilet patterns, as well as other signs of distress including emotional irritability and liability, one must consider alternative hypotheses regarding the source of the behaviors and draw conclusions only after collecting further factual information.

STRUCTURED FORENSIC INTERVIEW PROTOCOLS IMPROVE THE QUALITY AND INFORMATIVENESS OF INVESTIGATIVE INTERVIEWS WITH CHILDREN: A REVIEW OF RESEARCH USING THE NICHD INVESTIGATIVE INTERVIEW PROTOCOL

Michael E. Lamb, Yael Orbach, Irit Hershkowitz, Phillip W. Esplin, and Dvora Horowitz

Free author’s manuscript
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2180422/