

EVALUATING THE EVALUATION: RELIANCE UPON MENTAL HEALTH ASSESSMENTS IN CASES OF ALLEGED CHILD SEXUAL ABUSE

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INTRODUCTION

Performing comprehensive mental health assessments for forensic purposes requires a unique skillset apart from the clinical skills relied upon for therapeutic work. Assessment of children for forensic purposes requires an even more distinctive specialization, because of the complex cognitive, emotional, behavioral, and developmental factors that can vary greatly with chronological age and related abilities dramatically impacting a child's capacity to participate in the evaluation process.¹ Relying upon properly conducted forensic mental health assessment of children is not only important for meeting *Daubert* and *Frye* standards in court,² it also facilitates a less traumatic experience for the child via the utilization of child-friendly and child-effective techniques, often eliminating the need to conduct repeated evaluations.³

As it applies to the admissibility of behavioral science data and expert witness testimony offered by mental health professionals, the *Frye* standard requires that the methods used to reach the conclusions being offered as evidence in court be established enough to have gained general acceptance within their respective field.⁴ The *Frye* rule essentially exists, in part, to prevent “junk sci-

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¹ See generally STEPHEN J. CECI & MAGGIE BRUCK, *JEOPARDY IN THE COURTROOM: A SCIENTIFIC ANALYSIS OF CHILDREN'S TESTIMONY* (1995); SUSAN R. HALL & BRUCE D. SALES, *COURTROOM MODIFICATIONS FOR CHILD WITNESSES: LAW AND SCIENCE IN FORENSIC EVALUATIONS* (2008); CHILDREN'S TESTIMONY: A HANDBOOK OF PSYCHOLOGICAL RESEARCH AND FORENSIC PRACTICE (Helen L. Westcott et al. eds., 2002) (compiling research on issues pertaining to children's eyewitness testimony).

² *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993); *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

³ See HALL & SALES, *supra* note 1, at 233–34.

⁴ *Frye*, 293 F. at 1014.

ence” proffered by an expert witness acting as a “hired gun” from being relied upon by the finder of fact.⁵ The Federal Rules of Evidence adopt a more liberal interpretation for inclusion of such findings and testimony due to concerns that *Frye* may impede the admissibility of evidence that could be beneficial or even necessary in facilitating the goal of truth-seeking in legal process.⁶

The *Daubert* standard attempts to further clarify the admissibility of evidence by setting forth two requirements.⁷ First, it must be anticipated that the expert will testify based on scientific knowledge and, second, that the information being imparted is anticipated to aid the finder of fact in understanding the matter at hand.⁸ *Daubert* also requires that the individual testifying be qualified by education, training, skills, and experience to be declared an expert witness.⁹ Then, if all the aforementioned factors are determined to exist, the *Daubert* standard requires that the expert opinion testimony be considered both relevant and reliable.¹⁰ This is established through (1) its empirical testability; (2) whether the theory or study has been published or subjected to peer review; (3) whether the known or potential rate of error is acceptable; and (4) whether the method is generally accepted in the scientific community.¹¹ Initially, the *Daubert* criteria were only applicable to expert witness testimony about scientific evidence.¹² However, the *Kumho Tire Company v. Carmichael* verdict resulted in the application of *Daubert* to all expert witness testimony that stems from scientific as well as technical and specialized knowledge.¹³ The evolution of the *Frye* rule and the *Daubert* standard, particularly post-*Kumho*, have direct implications for mental health professionals who conduct interviews and evaluation of children who may have been sexually abused in terms of the appropriateness, utility, and value of their contributions in court. These implications apply to both the qualifications of the mental health professional and the quality of the evaluative methods employed.

The practice of forensic mental health assessment differs markedly from the practice of clinical work.¹⁴ This distinction is surprising to some attorneys and judges, and many clinical mental health professionals, who themselves fail to recognize the difference in forensic and clinical competence, methods, and implications. To illustrate the magnitude of difference in these fields, the American Psychological Association (“APA”) officially recognized forensic

⁵ *See id.*

⁶ *See* FED. R. EVID. 702.

⁷ *Daubert*, 509 U.S. at 591–92.

⁸ *Id.* at 592.

⁹ *Id.* at 588.

¹⁰ *Id.* at 597.

¹¹ *Id.* at 593–94.

¹² *Id.* at 597.

¹³ FED. R. EVID. 702 advisory committee’s note; *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 147 (1999).

¹⁴ *See* Am. Psychological Ass’n, *Specialty Guidelines for Forensic Psychology*, 68 AM. PSYCHOLOGIST 7, 7 (2013) [hereinafter APA, *Specialty Guidelines*].

psychology as a distinct specialization in 2001 and developed a seminal document entitled *Specialty Guidelines for Forensic Psychology* (which replaced the APA's earlier 1991 document entitled *Specialty Guidelines for Forensic Psychologists*) to guide psychologists and other mental health practitioners who routinely perform forensic work.¹⁵

This distinction between clinical and forensic work is not meant to promote a hierarchy of superiority within the field. Rather, it is designed to explicitly acknowledge the sometimes drastically different approaches, methodologies, and services that a forensic evaluator provides as opposed to a clinical therapist. Perhaps the domain of evaluating alleged child victims of sexual abuse is one area of practice in which these differences are most relevant.

So, what are these differences? Clinical therapists provide emotional support and validation to their clients' or patients' experience.¹⁶ In a clinical therapy setting and within therapeutic relationships, the self-report of the client is, to a large degree, accepted at face value with little attention paid to any internal or external motivation towards distortion.¹⁷ In other words, if someone presents in a therapeutic setting for treatment and reports symptoms of depression, the therapist's position is to formulate a treatment plan for that depression.¹⁸ However, if that same person presents in a forensic assessment setting and reports symptoms of depression, the forensic evaluator's position is to seek equally to prove and disprove that depression is present.¹⁹

Additionally, within the confines of the therapeutic relationship, the therapist is expected to provide emotional support and validation to the patient and to work towards the goal of alleviating the distress.²⁰ Because of the importance of the therapeutic relationship within the therapy process, the element of subjectivity is present, as the clinician forges a bond with the client.²¹ In contrast, the goal of forensic assessment is to objectively support or refute a hypothesis about the presenting issue and to answer relevant psycho-legal questions with the aim of assisting the legal process.²² In other words, in clinical work, the focus of the clinician is on aiding the client or patient. Whereas, in forensic practice, the focus of the evaluator is on aiding the legal system.²³ This is the case regardless of whether or not the forensic evaluator is appointed by

¹⁵ *Id.*

¹⁶ See Miguel M. Gonçalves et al., *Innovative Moments and Change in Client-Centered Therapy*, 22 *PSYCHOTHERAPY RES.* 389, 389 (2012).

¹⁷ Kenneth J. Gergen & John Kaye, *Beyond Narrative in the Negotiation of Therapeutic Meaning*, in *THERAPY AS SOCIAL CONSTRUCTION* 166, 167 (Sheila McNamee & Kenneth J. Gergen eds., 1992).

¹⁸ See Stuart A. Greenberg & Daniel W. Shuman, *Irreconcilable Conflict Between Therapeutic and Forensic Roles*, 28 *PROF. PSYCHOL. RES. & PRAC.* 50, 52 tbl.1 (1997).

¹⁹ *Id.*

²⁰ *Id.*

²¹ Cf. Gergen & Kaye, *supra* note 17.

²² APA, *Specialty Guidelines*, *supra* note 14, at 14–15.

²³ *Id.* at 7.

the court, mutually appointed by both sides in an agreed order, or privately retained by one side or the other, although it is conceivable why some may speculate otherwise in the latter situation. In reality, while there are certainly mental health professionals who may be tempted to fall into the role of “hired gun,” logic argues that qualified and competent forensic mental health evaluators are motivated to remain impartial regardless of who hires them and who is financing their services. Otherwise, their career could be short-lived, as a result of a dubious professional reputation.

In addition to differences between mental health providers providing clinical as opposed to forensic services in terms of methodology (therapy vs. assessment), approach (subjective vs. objective), and goals (relief of distress of the client/patient vs. guidance to the court), there are also significant differences in the training of clinical and forensic practitioners. Sometimes, competence is developed within the mental health professional’s formalized academic background. For example, some programs offer “tracks” in forensic work.²⁴ Many times, however, competence is developed with additional education, training, and experience after a generalist or even alternative specialization during the prerequisite training for licensure. This is because much of the knowledge and skill required for competence in clinical work is a prerequisite for establishing competence in forensic work. In the context of providing forensic assessment of children, one could easily argue that a greater than typical amount of education, training, and experience in child development factors is definitely beneficial and probably necessary.

There is an obvious exception to the ideal proposed for forensic mental health assessment of children alleging sexual abuse. Spontaneous disclosure (such as a child unexpectedly revealing an allegation of sexual abuse in the context of a non-forensic focus of treatment such as behavioral therapy for Attention Deficit Hyperactivity Disorder) may occur during the therapeutic relationship, in the course of therapeutic work, or in a therapeutic setting. Unfortunately, clinicians who do not possess competence in and who are not intending to perform a forensic mental health assessment, often find themselves in the situation of being an ad-hoc evaluator of sorts. The comments made in this article are not meant to apply to those types of situations in which any mental health clinician who works with children may find him or herself often times caught unaware.

So, what are these unique child factors that a quality forensic mental health assessment should consider and address? They can be divided into cognitive, emotional, behavioral, social, and developmental domains. Before this article

²⁴ For just a few examples of the educational programs currently available, see *Adult Forensic Track*, RUTGERS U. BEHAV. HEALTH CARE, http://ubhc.rutgers.edu/psyinnw/tracks/adult_forensic.html (last modified May 19, 2015); *Forensic Psychology*, GEO. WASH. U., <http://www.gwu.edu/graduate-programs/forensic-psychology> (last visited May 20, 2015); *Forensic Psychology Specialization*, N.Y.U. PSYCHOL., <http://psych.nyu.edu/programs/ma/forensics.html> (last updated Oct. 30, 2014).

explores examples of how and why these factors are relevant to appropriate forensic mental health assessment of alleged child victims of sexual abuse, the scope of this problem is delineated.

I. STATISTICS AND UNDERREPORTING OF CHILD SEX ABUSE IN AMERICA

The prevalence (total number of cases at a given time) of child sex abuse in America is largely derived from adult reports of past childhood sexual victimization.²⁵ As many as one in four girls and one in six boys will be the victim of child sex abuse.²⁶

The incidence (total number of new cases in a given period) of child sex abuse in America is generally derived from annual child abuse statistics collected and reported by child protective service agencies and represents those cases that were accepted, investigated, and ultimately substantiated.²⁷ The 2012 Annual Child Maltreatment Report based upon the National Child Abuse and Neglect Data System (“NCANDS”) reported the incidence rate as being 62,936 new confirmed cases of child sexual abuse in the United States in 2012 and represents the most recent published calculation.²⁸

The problem with incidence rates of child sex abuse is that they are believed to be an underestimation of the true phenomenon. The reason for this underestimation is multi-factorial. Considering the following trends sheds light on the inherent error in reported statistics of child sex abuse. To begin with, most cases of child sex abuse are never reported.²⁹ Most reported cases of child sex abuse are not substantiated by social service entities.³⁰ Most substantiated cases are not adjudicated in the legal system.³¹ Most prosecuted cases are pled down to lesser offenses that do not reflect child sex abuse.³² The cumulative result of these phenomena is that the true incidence rates of child sex abuse are unknown, but are very likely to be much higher than the NCANDS report suggests.

²⁵ See generally Shanta R. Dube et al., *Long-Term Consequences of Childhood Sexual Abuse by Gender of Victim*, 28 AM. J. PREVENTIVE MED. 430 (2005) (conducting a study of childhood sexual abuse with adults of the average age of fifty-six).

²⁶ *Id.* at 433.

²⁷ CHILDREN’S BUREAU, U.S. DEP’T OF HEALTH & HUMAN SERVS., CHILD MALTREATMENT 2012, at x (2013).

²⁸ *Id.* at 21.

²⁹ See generally Steven M. Kogan, *Disclosing Unwanted Sexual Experiences: Results from a National Sample of Adolescent Women*, 28 CHILD ABUSE & NEGLECT 147 (2004) (studying factors that influence whether female victims of unwanted sexual experiences disclose the abuse).

³⁰ See Johan Melander Hagborg et al., *Prosecution Rate and Quality of the Investigative Interview in Child Sexual Abuse Cases*, 9 J. INVESTIGATIVE PSYCHOL. & OFFENDER PROFILING 161, 162 (2012).

³¹ *Id.* (“The prosecution rate in Sweden for [child sexual abuse] cases is between 10 [percent] and 15 [percent] of cases reported to the police officer.”).

³² See Sara Harris, *Toward a Better Way to Interview Child Victims of Sexual Abuse*, NAT’L INST. JUST. J., Winter 2010, at 12, 15 tbl.1.

II. CONSIDERATIONS FOR CHILDREN WHO ALLEGE SEXUAL ABUSE

Issues specific to the alleged child victims include cognitive, emotional, behavioral, and social factors that are developmentally dependent in relation to chronological age.³³ Each domain is considered separate yet interrelated to the others.³⁴ For instance, development influences cognition, which influences emotion, which influences behaviors, which influences social interaction.³⁵ The trauma of abuse further complicates this interplay. For these reasons, it is important that the evaluator possesses not only expertise in the domain of forensic mental health practice but is also highly knowledgeable and skilled when it comes to child development factors. The younger the alleged child victim, the more important such developmental expertise becomes.

A. Cognitive Considerations

A child's disclosure of alleged abuse is most certainly going to involve memory because he or she will be reporting about events that occurred in the past. It is important to understand that memories are constructed not reproductive. In other words, people must assemble memories rather than simply recall the equivalent of a mental photograph or video that accurately portrays the reality of a historical moment.³⁶ Because the process of encoding, storing, and retrieving a memory are separate tasks, each step represents an opportunity for error to intrude. Ceci and Bruck analyze and summarize the large body of research about memory with an aim of identifying relevant issues in children's narratives of alleged abuse.³⁷

Memory is selective about what is encoded. Things are more likely to be encoded if the event is either highly novel or highly familiar, of long duration, of high interest or intrigue, or of a repetitive nature.³⁸ With regard to context, the brain may assume certain things at the time of encoding that represent expectations rather than fact.³⁹ For example, one may encode a memory of having dessert at a café with a friend and assign blueberry pie to the other party, if the friend typically orders blueberry pie. This detail can exist as quite real in memory, even if the friend happened to order cherry pie on that specific occasion. This is called script-based knowledge.⁴⁰

³³ KENNETH W. MERRELL, BEHAVIORAL, SOCIAL, AND EMOTIONAL ASSESSMENT OF CHILDREN AND ADOLESCENTS 312 (2d ed. 2003).

³⁴ *Id.* at 6.

³⁵ *Id.*

³⁶ Daniel L. Schacter, *Constructive Memory: Past and Future*, 14 *DIALOGUES CLINICAL NEUROSCIENCE* 7, 11 (2012).

³⁷ CECI & BRUCK, *supra* note 1.

³⁸ See J. Poppenk et al., *Revisiting the Novelty Effect: When Familiarity, Not Novelty, Enhances Memory*, 36 *J. EXPERIMENTAL PSYCHOL.* 1321, 1326 (2010).

³⁹ Sharda Umanath & Elizabeth J. Marsh, *Understanding How Prior Knowledge Influences Memory in Older Adults*, 9 *PERSP. ON PSYCHOL. SCI.* 408, 415 (2014).

⁴⁰ CECI & BRUCK, *supra* note 1, at 43.

Emotional state at the time of the event also influences encoding. During a traumatic event, limited encoding of details may occur.⁴¹ This is because the focus is on the more salient elements of the situation. This is particularly true in the case of survival situations.⁴²

Encoded memories are next stored in short-term memory and may be forwarded on to long-term memory.⁴³ Memory storage is impacted by the passage of time, the number of times the event has been recalled or re-experienced, and intervening experiences.⁴⁴ The shorter span of time a memory is stored, the more accurate the recall of that memory.⁴⁵ Stored memories that lay dormant (not recalled or re-experienced) decay in integrity with time.⁴⁶ The number of times the original memory has been recalled or re-experienced can strengthen its accuracy, if the recall and re-experiencing is an accurate replication without interference (conflicting or contrary data).⁴⁷ If interference exists during recall and re-experiencing, the accuracy of the original memory is weakened.⁴⁸ Just as is true with encoding, knowledge about context and related expectations may influence storage by filling in the gaps of missing information with what is assumed to be true.⁴⁹ What we know in generalities may become part of specific memories while the memory is in storage.⁵⁰

Recall of memory is better when the circumstances of recall are similar to the circumstances of encoding.⁵¹ Interviewing people at the location where an event occurred typically produces better recall.⁵² Similarly, if the individual's emotional state at the time of recall is congruent with his or her emotional state

⁴¹ Katherine R. Mickley Steinmetz et al., *The Effects of Trauma Exposure and Posttraumatic Stress Disorder (PTSD) on the Emotion-Induced Memory Trade-Off*, 6 FRONTIERS INTEGRATIVE NEUROSCIENCE, June 2012, art. 34, at 10.

⁴² Valerie J. Edwards et al., *Autobiographical Memory Disturbances in Childhood Abuse Survivors*, 4 J. AGGRESSION, MALTREATMENT & TRAUMA 247, 248 (2001).

⁴³ CECI & BRUCK, *supra* note 1, at 42; Lynne Baker-Ward & Peter A. Ornstein, *Cognitive Underpinnings of Children's Testimony*, in CHILDREN'S TESTIMONY, *supra* note 1, at 21, 23–27.

⁴⁴ Maria Carmen Inda et al., *Memory Retrieval and the Passage of Time: From Reconsolidation and Strengthening to Extinction*, 31 J. NEUROSCIENCE 1635, 1640 (2011).

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ CECI & BRUCK, *supra* note 1, at 43; Martine Powell & Don Thomson, *Children's Memories for Repeated Events*, in CHILDREN'S TESTIMONY, *supra* note 1, at 69, 72–73.

⁴⁸ Inda et al., *supra* note 44, at 1635.

⁴⁹ *See id.*

⁵⁰ Umanath & Marsh, *supra* note 39, at 408.

⁵¹ NORMAN E. SPEAR, *THE PROCESSING OF MEMORIES: FORGETTING AND RETENTION* 406–07 (Psychology Press 2014) (1978).

⁵² *See id.*

at the time of encoding, recall is more accurate.⁵³ Providing cues, such as referencing one part of an event, improves recall.⁵⁴

One difficulty is that memory enhancing techniques have been shown in research to both improve and impair recall of memories.⁵⁵ For example, repeated questioning will likely result in additional information, but the accuracy of the additional information will depend on how much alteration the original memory has been subjected to through interference.⁵⁶ The longer the passage of time between questioning, the more opportunity for intrusions to weaken the integrity of the original memory by adding, deleting, or changing elements. Memories for which the context is highly familiar to us or bizarre in nature will be more readily recalled.⁵⁷

Script-based knowledge can influence recall just as it influences encoding and storage. The brain will fill in missing information with what we assume to be true.⁵⁸ This is particularly true for things like sequence.⁵⁹ For example, one may remember a server taking the drink order prior to the food order not because this actually occurred this way, but because events in this context typically occur in that order. If the evaluator checks credibility of a child disclosure by examining extraneous details surrounding an event (whether or not he or she had homework that night), the child may rely on script-based knowledge (the child has homework most nights) that is inaccurate (in reality, no homework was assigned that night), while still being accurate about the germane issue at hand (whether or not abuse occurred). While this phenomenon may appear on the surface to discredit the credibility of a child's allegation, a true understanding of the cognitive processes reveals that discrediting the report based solely on this type of error would be inappropriate.

Motivation also plays a role in recall. This applies to the individual's direct motivation to remember as well as to the individual's motivation to cooperate with the interviewer, please the interviewer, refute the interviewer, and damage or protect another party.⁶⁰ Ascertaining what a child's motivations are in this

⁵³ *Id.*

⁵⁴ See Jared B. Jobe & David J. Mingay, *Cognitive Research Improves Questionnaires*, 79 AM. J. PUB. HEALTH 1053, 1054 (1989) (“[M]emory is improved by providing additional cues for the recall of difficult to remember information.”).

⁵⁵ Coral J. Dando et al., *When Help Becomes Hindrance: Unexpected Errors of Omission and Commission in Eyewitness Memory Resulting from Change Temporal Order at Retrieval?*, 121 COGNITION 416, 416–17 (2011).

⁵⁶ CECI & BRUCK, *supra* note 1, at 43; Powell & Thomson, *supra* note 47, at 72–75.

⁵⁷ Poppenk et al., *supra* note 38.

⁵⁸ See Armin Schneider et al., *The Mechanisms of Spontaneous and Provoked Confabulations*, 119 BRAIN 1365, 1368 (1996).

⁵⁹ See generally Petko Kusev et al., *Judgments Relative to Patterns: How Temporal Sequence Patterns Affect Judgments and Memory*, 37 J. EXPERIMENTAL PSYCHOL. 1874 (2011) (studying relative frequency judgment and recall of sequentially presented items).

⁶⁰ CECI & BRUCK, *supra* note 1, at 43–44; Stephen J. Ceci et al., *Children's Suggestibility Research: Implications for the Courtroom and the Forensic Interview*, in CHILDREN'S TESTIMONY, *supra* note 1, at 117, 127.

regard may shed an interesting light on a child's recall during prior disclosures in terms of both the availability of the memory and content of the memory. Motivation of the child that subconsciously influences memory is an issue distinct from fabrication or false testimony, which will be discussed later.

In sum, by the time a memory is actually encoded, stored, and retrieved and subject to a variety of internal and external influences, what is recalled is hardly a mirror image of reality, even under optimal circumstances. Therefore, the evaluation should take into account what would be considered possibly inherent errors in memory and interpret them as such, as opposed to interpreting such errors as directly implying a lack of credibility on the part of the child.

Perhaps most legally relevant to the issue of memory in child witnesses is the concept of suggestibility. Cognitive and emotional expectations can influence memory at the encoding, storage, and retrieval phase.⁶¹ For example, a child who believes a man to be evil and experiences the emotion of fear upon encountering him may perceive a red stain on the man's shirt as blood. On the other hand, a child who believes a man to be good and experiences a positive emotion upon encountering him may perceive the same red stain as paint. This type of suggestibility can occur at the point of encoding, while the memory is in storage, or at the point of retrieval, depending on when these emotions and cognitions form.⁶² An evaluation should take into account the child's cognitive perceptions and emotions in an attempt to establish whether the possibility of this phenomenon exists in a child's narrative.

Research has examined the concern of suggestibility of abuse when no abuse has occurred.⁶³ Older children tend to be more accurate in their reports than younger children in general when questioned about past events.⁶⁴ An exception exists, however, for suggested abuse that did not occur. Children are generally suggestible, and younger children are usually more suggestible than older children when it comes to a variety of issues.⁶⁵ However, this general tenet of suggestibility does not appear to apply to suggestions of abuse in the absence of abuse.⁶⁶ The implication is that, while many elements of a child's disclosure are prone to the influence of suggestibility, the gist of a child's

⁶¹ Betsy A. Tobias et al., *Emotion and Implicit Memory*, in THE HANDBOOK OF EMOTION AND MEMORY: RESEARCH AND THEORY 67, 78–81 (Sven-Åke Christianson ed., 1992).

⁶² See *id.* at 79–80.

⁶³ Yoojin Chae et al., *Event Memory and Suggestibility in Abused and Neglected Children: Trauma-Related Psychopathology and Cognitive Functioning*, 110 J. EXPERIMENTAL CHILD PSYCHOL. 520, 521 (2011).

⁶⁴ Maggie Bruck & Laura Melnyk, *Individual Differences in Children's Suggestibility: A Review and Synthesis*, 18 APPLIED COGNITIVE PSYCHOL. 947, 989 (2004).

⁶⁵ Chae et al., *supra* note 63, at 533.

⁶⁶ Iris Blandón-Gitlin & Kathy Pezdek, *Children's Memory in Forensic Contexts: Suggestibility, False Memory, and Individual Differences*, in CHILDREN AS VICTIMS, WITNESSES, AND OFFENDERS 57, 65 (Bette L. Bottoms et al. eds., 2009).

disclosure (whether or not abuse occurred) is fairly resistant to third-party suggestion.⁶⁷

Another issue pertaining to memory is the controversy surrounding repressed memory. That is beyond the scope of this article and less relevant to child witnesses, since this phenomenon tends to apply to adult witnesses alleging prior abuse during childhood. Of relevance to child witnesses, however, is the phenomenon of infantile amnesia that precedes a child's cognitive ability to form an autobiographical narrative.

Infantile amnesia refers to the inability to recall experiences that happened during the first few years of life.⁶⁸ The implication is that a child witness who asserts a memory of sexual abuse at an earlier age, say at twelve months old, could not possibly be referencing a literal memory. A child's cognitive ability to form autobiographical memories begins at the end of infantile amnesia, when the child acquires the ability to have cognitive representations of themselves and their experiences.⁶⁹ This occurs sometime between the age of two and four years of age, according to most theorists and researchers.⁷⁰

Language abilities are another cognitive variable that can greatly impact a child's allegation of abuse. This factor is addressed later in Part II.E, devoted to developmental considerations. For now, consider this hypothetical example: a young child witness was asked by the examining attorney at trial the following question, "Are you in school?" to which the child replied, "No." A dilemma arose because the child was known to be in the first grade, and the child's disclosure involved a school employee's alleged behavior at school. The child's response was immediately seized upon as evidence of lack of reliability and credibility. However, when the opposing attorney clarified the question by asking, "What grade are you in?" the child replied with equal frankness, "First." Perplexed, the questioning attorney continued, "Then, why did you tell the other attorney that you are not in school?" The little girl looked at the attorney incredulously and retorted simply, "Because I cannot be both here and there."

The child above interpreted the question literally. The implication is that the questions posed by the evaluator must be formulated to avoid such developmental language mishaps. If an evaluator relies upon video or audio recording of his or her assessments, reviewing the phrasing of questions as well as the evaluator's interpretation of child responses through a developmental lens can sometimes reveal problematic instances of developmental miscommunications.

Comprehension involves an interplay between a child's pre-existing level of knowledge and language skills. This is discussed more in Part II.E, entitled Developmental Considerations. Also, attention spans of child witnesses vary

⁶⁷ See *id.*

⁶⁸ Sheena A. Josselyn & Paul W. Frankland, *Infantile Amnesia: A Neurogenic Hypothesis*, 19 LEARNING & MEMORY 423, 423 (2012).

⁶⁹ Pascale Piolino et al., *Episodic and Semantic Remote Autobiographical Memory in Ageing*, 10 MEMORY 239, 254 (2002).

⁷⁰ See, e.g., *id.*

considerably with age and across children, particularly those with Attention Deficit Hyperactivity Disorder.

B. Emotional Considerations for Child Witnesses

Child witnesses may find the process of evaluation stressful or even frightening. This is discussed more in Part II.D, entitled Social Considerations. In general, reducing a child's distress promotes more cooperative, complete, and accurate reports.

In cases of sexual abuse, children are reluctant to discuss things that make them feel embarrassed or ashamed.⁷¹ Fear of retribution or getting themselves or another person in trouble may also influence children's willingness to discuss events.⁷²

The evaluator sometimes utilizes visual aids to help children reduce shame-based distress as an alternative to verbalizing in certain situations.⁷³ However, one must acknowledge the risks and the appropriateness of these tools as part of an evaluation and their limitations to certain conditions. These considerations are discussed further in Part II.E, entitled Developmental Considerations.

The majority of children who are sexually abused know their perpetrator.⁷⁴ The perpetrator could be a friend, teacher, coach, family member, or even parent. It is important to understand that many victims of child sexual abuse love their perpetrator and are highly conflicted about their own distress and concern for the offending adult.⁷⁵ Many children who are sexually abused will not show fear of their perpetrator, which is often mistaken as an indication that abuse did not really occur.⁷⁶

Children alleging abuse often experience irrational guilt about breaking a "secret" that the perpetrator and victim have shared or guilt for getting the other person in trouble, particularly if the adult is someone the child loves or has attachment towards.⁷⁷ The fear may also be caused by dread of talking about embarrassing acts in front of others and the perpetrator specifically, if the child associates the presence of the perpetrator with the emotional experience of shame or degradation.⁷⁸

⁷¹ See Irit Hershkowitz et al., *Suspected Victims of Abuse Who Do Not Make Allegations: An Analysis of Their Interactions with Forensic Interviewers*, in CHILD SEXUAL ABUSE: DISCLOSURE, DELAY, AND DENIAL 97, 99 (Margaret-Ellen Pipe et al. eds., 2007).

⁷² See *id.*

⁷³ Debra Ann Poole et al., *Forensic Interviewing Aids: Do Props Help Children Answer Questions About Touching?*, 20 CURRENT DIRECTIONS PSYCHOL. SCI. 11, 11 (2011).

⁷⁴ CHILDREN'S BUREAU, *supra* note 27, at 21–22 (“[Only] [12] percent . . . of victims were maltreated by a perpetrator who was not the child's parent.”).

⁷⁵ See, e.g., Poole et al., *supra* note 73.

⁷⁶ Jennifer M. Foster & David K. Carson, *Child Sexual Abuse in the United States: Perspectives on Assessment and Intervention*, 1 AM. J. HUMAN. & SOC. SCI. 97, 102 (2013).

⁷⁷ *Id.* at 98.

⁷⁸ *Id.* at 100.

Mental health evaluators typically cannot guarantee to the child, at the point of assessment, that he or she will not have to face the accused perpetrator. This is often a concern that children have surrounding disclosure.⁷⁹ Evaluators may mistake the child's expressed concerns about this as an indication that the child is being dishonest. Given that this is a common concern among child victims of sexual abuse, drawing that conclusion based solely on the child's concern in that regard would be inappropriate.

The court system allows for modifications in cases where children are required to testify against the accused perpetrator.⁸⁰ This is because, while a child may or may not fear the perpetrator directly, the most common fear children have of testifying in court in sexual abuse cases is facing the perpetrator.⁸¹ Sometimes, this fear is because the child has safety concerns about the perpetrator, particularly if the abuse involved elements of threats, physical abuse, helplessness, pain, or terror. In fact, the need for modifications in the legal process for child witnesses is well established in the research based upon the unique needs of this population.⁸² Modifications exist that are either theoretically or empirically supported. Yet, their utilization remains uncommon in many jurisdictions perhaps due to lack of awareness of the available modifications or lack of appreciation of their relevance or importance.⁸³

These modifications must be employed carefully in criminal trials, however, in order to avoid violating the defendant's rights according to the Sixth Amendment (right to confront witnesses against him or her) and Fourteenth Amendment (right to due process). This issue was addressed in *Maryland v. Craig*.⁸⁴ Modifications include placing the child behind a screen, instructing the child to make eye contact only with the attorney, judge, or a support person such as a parent during their testimony (provided that no cues are relayed to the child influencing their answers to the questions).⁸⁵ Hearsay exceptions may also be employed to allow someone such as a forensic evaluator to speak on the child's behalf, although *Crawford v. Washington* has had a restrictive effect on this practice.⁸⁶ Increased availability and utilization of technology allows for

⁷⁹ Bradley D. McAuliff et al., *Supporting Children in U.S. Legal Proceedings: Descriptive and Attitudinal Data from a National Survey of Victim/Witness Assistants*, 19 PSYCHOL. PUB. POL'Y & L. 98, 99 (2013).

⁸⁰ *Id.*

⁸¹ Christina Back et al., *Managing the Legal Proceedings: An Interpretative Phenomenological Analysis of Sexually Abused Children's Experience with the Legal Process*, 35 CHILD ABUSE & NEGLECT 50, 54 (2011).

⁸² HALL & SALES, *supra* note 1, at 13.

⁸³ *Id.* at 13–15.

⁸⁴ *Maryland v. Craig*, 497 U.S. 836 (1990) (upholding Maryland's procedure allowing child witnesses in a child abuse case to testify via one-way closed circuit television).

⁸⁵ Dawn Hathaway Thoman, *Testifying Minors: Pre-Trial Strategies to Reduce Anxiety in Child Witnesses*, 14 NEV. L.J. 236, 266 (2013).

⁸⁶ *See Crawford v. Washington*, 541 U.S. 36, 68–69 (2004) (“Where testimonial statements are at issue, the only indicium of reliability sufficient to satisfy constitutional demands is the one the Constitution actually prescribes: confrontation.”).

children to testify via one-way or two-way closed circuit television from another location either within or outside of the courthouse, which can distance them from the accused perpetrator.⁸⁷ This modification can also be helpful in reducing the inherent mismatch between a child and the traditional courtroom in general.

One hallmark of credibility that evaluators commonly look for in children alleging abuse is the congruence between their narrative and their affect.⁸⁸ A high degree of congruence between display of emotion and verbal reporting is typically associated with credibility of reporting.⁸⁹ A lack of congruence between display of emotion and verbal reporting is often interpreted as a sign of a credibility concern.⁹⁰ However, research examining child affect while discussing sexual abuse reveals that the majority of children display a neutral affect as opposed to a distressed affect.⁹¹

This may be a product of the number of times a child has shared his or her narrative, thus becoming perhaps somewhat desensitized to telling the story.⁹² Sometimes, a mental health evaluator is the first person to whom the child discloses alleged abuse. Other times, a child may have shared his or her story numerous times with police officers, child protective services workers, parents, teachers, therapists, other evaluators, or even attorneys prior to the forensic assessment. It is reasonable to expect then, that a child's affect may appear quite different at one point in time relative to another, depending upon when the forensic mental health evaluation occurs and how many times and to how many people the child has previously relayed the accusation. The evaluator should consider the timing and context in which he or she is receiving the child's narrative of abuse when making clinical judgments about the credibility of those allegations based in part upon the child's affect.

Judgments about affect made as part of the mental health evaluation pose even greater challenges if the child has a comorbid mental health diagnosis, common among abused populations, such as clinical depression, anxiety, acute stress disorder, post-traumatic stress disorder, or dissociative disorder.⁹³ Also, children with developmental and cognitive disabilities are at increased risk of

⁸⁷ Thoman, *supra* note 85, at 267.

⁸⁸ Ellen Wessel et al., *Expressed Emotions and Perceived Credibility of Child Mock Victims Disclosing Physical Abuse*, 27 *APPLIED COGNITIVE PSYCHOL.* 611, 614 (2013).

⁸⁹ Paola Castelli & Gail S. Goodman, *Children's Perceived Emotional Behavior at Disclosure and Prosecutors' Evaluations*, 38 *CHILD ABUSE & NEGLECT* 1521, 1521 (2014).

⁹⁰ *Id.*

⁹¹ Daniel Bederian-Gardner & Deborah Goldfarb, *Do Jury Instructions on Witness Emotions Prime or Educate the Jury?*, Presentation at the Conference on Psychology and Lawyering: Coalescing the Field (Feb. 22, 2014), available at <http://vimeo.com/album/2771068/video/88935526> (starting at 20:15).

⁹² *Id.*

⁹³ Tanja Hillberg et al., *Review of Meta-analyses on the Association Between Child Sexual Abuse and Adult Mental Health Difficulties: A Systematic Approach*, 12 *TRAUMA VIOLENCE & ABUSE* 38, 44 tbl.3 (2011).

abuse of all types⁹⁴ and may have impaired affect as a result of their cognitive functioning.⁹⁵ The mental health evaluator must consider that affect may present variably among children alleging abuse due to any of these aforementioned factors.

C. Behavioral Considerations

Common behavioral issues associated with the child witness include denial followed by disclosure of abuse, recantation of prior allegations, false accusations, and cooperation during testimony.⁹⁶ Some studies suggest that the majority (approximately 75 percent) of children who eventually disclose sexual abuse previously denied that the abuse occurred.⁹⁷ Some studies also suggest that nearly 25 percent of children who disclose sexual abuse will later recant their allegation.⁹⁸ One possible interpretation of this finding is that it reflects defense mechanisms like denial or suppression, a theoretical coping strategy which may help children avoid the negative emotions associated with a negative event by cognitively not recalling it. Another possibility is that recantation could reflect a child's desire to correct an untruthful narrative. However, more recent studies have not found denials and recantations to be common among children alleging sexual abuse producing conflicting findings thus conclusions on this matter.⁹⁹

Research shows that even very young children can and do lie.¹⁰⁰ However, false allegations of sexual abuse are rare, if defining "false" as deliberate lies.¹⁰¹ False allegations are slightly more common but still rare, if defining "false" as also including honest errors made by the children in their allegations as opposed to intentional lies.¹⁰² Some studies show that false allegations of

⁹⁴ See, e.g., Roberta A. Hibbard et al., *Maltreatment of Children with Disabilities*, 119 PEDIATRICS 1018, 1018 (2007).

⁹⁵ Ruth B. Grossman et al., *Emotional Facial and Vocal Expressions During Story Retelling by Children and Adolescents with High-Functioning Autism*, 56 J. SPEECH LANGUAGE & HEARING RES. 1035, 1036 (2013).

⁹⁶ See generally CECI & BRUCK, *supra* note 1.

⁹⁷ Teena Sorensen & Barbara Snow, *How Children Tell: The Process of Disclosure in Child Sexual Abuse*, 70 CHILD WELFARE 3, 9 (1991).

⁹⁸ *Id.* at 11.

⁹⁹ See April R. Bradley & James M. Wood, *How Do Children Tell? The Disclosure Process in Child Sexual Abuse*, 20 CHILD ABUSE & NEGLECT 881, 887–88 (1996); Kamala London et al., *Disclosure of Child Sexual Abuse: What Does the Research Tell Us About the Ways That Children Tell?*, 11 PSYCHOL. PUB. POL'Y & L. 194, 217 (2005).

¹⁰⁰ Victoria Talwar & Angela M. Crossman, *Children's Lies and Their Detection: Implications for Child Witness Testimony*, 32 DEVELOPMENTAL REV. 337, 342 (2012); Aldert Vrij, *Deception in Children: A Literature Review and Implications for Children's Testimony*, in CHILDREN'S TESTIMONY, *supra* note 1, at 175, 177.

¹⁰¹ Kathleen Coulborn Faller, *Coaching Children About Sexual Abuse: A Pilot Study of Professionals' Perceptions*, 31 CHILD ABUSE & NEGLECT 947, 948 (2007) (finding a 4 percent rate of false allegations when considering only deliberate lies).

¹⁰² See *id.*

child sex abuse are more likely to occur within the context of a custody dispute.¹⁰³ While false allegations made by children of sexual abuse tend to be rare in general, the vast majority of allegations involving claims of ritualistic abuse are false.¹⁰⁴ The latter may be a product of reliance upon urban legend and portrayals of sensationalized child sex abuse in the media that do not correspond with reality in cases of fabrication.

Eliciting the cooperation of a child, especially very young children, in a mental health evaluation can be challenging. A variety of factors may account for a child's unwillingness to participate upon demand. The child may be being directly oppositional or overwhelmed and lack the coping skills to self-soothe in order to participate. The child may be unable to meet the demands of the situation due to limited attention span, an inability to sit still, or inability to engage in prolonged dialogue. Young children lack an appreciation for the importance of the evaluation and its relation to the overarching legal processes and their potential role in it. They may also be unable to appreciate the high stakes outcomes of the situation or to link immediate behavior to long-term consequence. A balance of efficiency, effectiveness, and patience is critical in managing behavioral issues when evaluating children alleging abuse. Again, the mental health evaluator must possess not only strong forensic skills when conducting assessments of alleged child sex abuse but also be knowledgeable and skilled enough in the domain of child development to be able to establish adequate rapport and offer a child-friendly assessment process. This is necessary not only to reduce the level of stress and distress placed on the child as part of the evaluation process, but also to attain the most accurate and reliable results, which are heavily dependent upon the child's participation.

For example, the evaluator should offer the child frequent breaks to use the restroom, have a snack, expend energy, and play before returning to be assessed further. Scheduling the child's assessment to occur at a time that is least intrusive to their routine may also help to facilitate a child's cooperation and decrease resistance. For example, pre-school children should not be scheduled during what is typically their naptime. School-age children should ideally be evaluated during or closely following school hours, so that they are not already tired from the events of the day. Having a child present for a mental health evaluation on the day and time he or she is supposed to be on a long-awaited field trip to the zoo will likely be met with catastrophic cooperation results. While pragmatic limitations in reality do exist, the evaluator should, at minimum, be aware of how these circumstances may influence the child's ability and willingness to participate in the evaluation process.

Evaluators may use rewards to elicit a young child's cooperation with the evaluation. While this can be a useful behavioral tool, rewards should be ex-

¹⁰³ Nico Trocmé & Nicholas Bala, *False Allegations of Abuse and Neglect When Parents Separate*, 29 CHILD ABUSE & NEGLECT 1333, 1342 (2005).

¹⁰⁴ Bette L. Bottoms et al., *An Analysis of Ritualistic and Religion-Related Child Abuse Allegations*, 20 L. & HUM. BEHAV. 1, 29 (1996).

plicitly linked to something like the duration of the child's participation versus rewards for any particular questions and answers that may inadvertently shape a child's responding pattern.

D. Social Considerations

Children tend to see adults as honest and assume that adults asking them questions are doing so for benign and legitimate reasons.¹⁰⁵ Therefore, children do not tend to evaluate the motivation or strategic implications of questions posed to them by adults.¹⁰⁶ This is especially true for younger children who are more naïve than adolescents.¹⁰⁷ So, if an adult asks a child a question, the child assumes the question must have an answer.¹⁰⁸ This is a phenomenon sometimes referred to as adult or authority legitimacy.¹⁰⁹ The implication is that if an authority figure asks, "What color of hat was the man wearing when he approached you?" the child will likely say "red" or some other color rather than respond that the man was not wearing a hat. The child will assume, based upon the adult's question, that the man must have been wearing one. Even if the child finds the adult interviewer's question suspect, it may not be socially acceptable for some children to challenge adults or to accuse them of deceitfulness. A child may believe an answer such as "there was no hat" will be perceived as rude or disrespectful. So, the proverbial path of least resistance is to provide an answer of some sort. A skilled evaluator will be aware of such phenomenon and will phrase questions and interpret responses accordingly.

Repetitive questioning often results in a child changing the response each time the question is re-asked or re-phrased. This is because the child interprets the repetition as a clue that the original response is incorrect.¹¹⁰ This is reinforced in the school environment, where children are often given multiple attempts or prompts to answer a question correctly. Children are also prone to guess answers to questions that they do not know, which is also reinforced in the school environment. Again, a competent evaluator will be familiar with this dynamic and will take care to avoid its presence in the assessment process.

Children may also be sensitive to intentional and unintentional reinforcement from the adult questioning them. This reinforcement could come in the form of tangible rewards for what the interviewer sees as cooperation (stickers for every question answered) or praise ("You are such a smart boy!"). Reinforcement could also come in intangible forms not intended by the interviewer

¹⁰⁵ L. Dennison Reed, *Findings from Research on Children's Suggestibility and Implications for Conducting Child Interviews*, 1 CHILD MALTREATMENT 105, 113 (1996).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 112–13.

¹¹⁰ Pauline Howie et al., *Children's Event Reports: Factors Affecting Responses to Repeated Questions in Vignette Scenarios and Event Recall Interviews*, 30 BRIT. J. DEVELOPMENTAL PSYCHOL. 550, 550–51 (2012).

in the form of facial expressions or changes in tone of voice. Given that children are generally inherently motivated to be liked by adults and to cooperate with or please adults, reinforcement can be a powerful shaper of child responses. This may partially account for differences in a child's narrative between evaluators when comparing conflicting statements or evaluative conclusions made by professionals.

Children also tend not to be therapeutically sophisticated. While it is standard routine for mental health evaluators to sit directly opposing the examinee, make direct eye contact, and ask poignant questions, this approach often suggests a negative dynamic to the child.¹¹¹ Most children are not accustomed to talking to adults in this manner unless they are being confronted or are "in trouble." Since many child victims of abuse carry irrational guilt about their experiences, this misinterpretation of context has the potential to influence the narrative.¹¹² For example, it is possible that a child may equate being questioned by an authority figure in a formal manner to some type of disciplinary interaction similar to what might be encountered in the school setting. Because the approach and methodology used during a forensic mental health evaluation can seem rather sterile in contrast to the therapeutic approach relied upon in psychotherapy or counseling, the evaluator may need to adapt his or her style to convey to, and even explicitly reassure the child that he or she is not being evaluated as a result of any wrongdoing.

E. Developmental Considerations

Younger children forget information faster than older children, and their recall of memory also tends to have more errors of both omission and commission.¹¹³ Also, because younger children have a smaller pool of contextual knowledge, encoding of memory is assumed to be inferior to that of older children who have a larger pool of contextual knowledge (which increases the likelihood that a memory will be encoded).¹¹⁴ However, because younger children do not have contextual knowledge, they may be less prone to errors in memory stemming from script-based knowledge.¹¹⁵ Thus, it is possible that younger children assume less about the events that they remember compared to older children who may have cognitive resources to fill in the gaps. Younger children are typically more suggestible than older than children, but this does not appear to be true for suggested abuse that did not occur.¹¹⁶

¹¹¹ CECI & BRUCK, *supra* note 1, at 152–53; HALL & SALES, *supra* note 1, at 121.

¹¹² See ELIANA GIL, THE HEALING POWER OF PLAY: WORKING WITH ABUSED CHILDREN 6 (1991).

¹¹³ See generally WOLFGANG SCHNEIDER & MICHAEL PRESSLEY, MEMORY DEVELOPMENT BETWEEN TWO AND TWENTY 130–91 (2d ed. 1997) (discussing development of encoding and retrieval strategies).

¹¹⁴ *Id.* at 145.

¹¹⁵ See generally *id.* at 79–129 (discussing knowledge base).

¹¹⁶ Blandón-Gitlin & Pezdek, *supra* note 66.

Receptive and expressive language abilities of children vary as a function of age and related development capacities.¹¹⁷ Young children may misunderstand the question being asked of them but be unaware of their own misunderstanding and, therefore, fail to ask for clarification or state their confusion. In these cases, the child will likely answer the question with confidence but do so inaccurately. Even when children are aware of their confusion, they are more likely to guess an answer than to state that they do not know or to ask for help answering the question, particularly if the question is posed as forced-choice versus open-ended.¹¹⁸ This behavior is reinforced in the school setting, where a guess may be right but a lack of response is always wrong.

The limited vocabulary of younger children can pose problems with their interpretation of questions as well as their responses. This may especially pertain to elements of sex acts and anatomy. Sometimes, children do not possess terminology or may have slang terminology for certain body parts, like genitalia. Because of their limited vocabulary and the shame or embarrassment children feel discussing things like sex acts and private body parts, the use of diagrams, drawings, and anatomically correct dolls or models is sometimes employed.

The dilemma with using visual aids as part of the mental health evaluation is that it can expose children to content to which they have not previously been exposed. Ethically, this is concerning with regard to content of a sexual nature but it also poses the potential to taint their narrative. This may be particularly true of anatomically correct dolls. Children have a context for playing with dolls, and it is one of fantasy role play. If a child is provided a doll and asked to tell or act out a “story,” the narrative relayed may be based in fantasy either in part or whole, because they misunderstand the goal of the task.

While it is not uncommon for evaluators to incorporate such tools as part of an assessment process, care must be taken to do so appropriately and to consider the risks of introducing this method into the evaluation process. For example, such tools may be helpful in allowing a child to show as opposed to speak, when speaking produces shame and embarrassment for that particular child. Or, visual aids can be used when the child has already given a verbal narrative that needs clarification, such as the location of a unique slang term for a body part that the evaluator may not recognize.

Another cautionary note about vocabulary is that young children use cognitive processes that are literal and concrete in nature.¹¹⁹ Shaping questions to fit

¹¹⁷ See generally Caroline K.P. Roben et al., *Longitudinal Relations Among Language Skills, Anger Expression, and Regulatory Strategies in Early Childhood*, 84 CHILD DEV. 891 (2013) (studying developmental changes in language skills and anger expression as children age).

¹¹⁸ Ruth Marchant, *How Young Is Too Young? The Evidence of Children Under Five in the English Criminal Justice System*, 22 CHILD ABUSE REV. 432, 434 (2013).

¹¹⁹ See generally D.V.M. BISHOP, UNCOMMON UNDERSTANDING: DEVELOPMENT AND DISORDERS OF LANGUAGE COMPREHENSION IN CHILDREN (Classic ed. 2014).

this literal way of thinking will help elicit the most accurate answers.¹²⁰ Understanding a young child's tendency to interpret things literally can also help make sense of responses that seem surprisingly contrary to established fact. Recall the previously provided example of the little girl in school in Part II.A, entitled Cognitive Considerations.

Attention spans of children also vary as a function of age.¹²¹ Though accommodating children's attention limitations may seem disruptive to the evaluation process at the time, it should serve to make their assessment more productive and reliable. While forensic mental health evaluations are often single appointment procedures, very young children may need multiple shorter appointments to gain trust, build rapport, and accommodate their limited ability to focus for prolonged periods.

CONCLUSION, DISCUSSION, & DIRECTIONS

Even very young children can be effective and accurate reporters of sexual abuse, when they have been questioned using neutral, empirically-informed interviewing techniques, when emotional distress is reduced, when the social environment is child-friendly, when they have been adequately prepared for their role in the forensic evaluation process, and when their unique developmental needs are acknowledged and effectively addressed.¹²²

Children's testimonies are likely to have numerous inaccuracies but the gist of their narrative (abuse versus no abuse) can maintain integrity in spite of inaccuracies about extraneous things (whether or not homework was assigned by the teacher on the night in question).

Care should be taken from the point of initial disclosure to the point of trial to protect the child's testimony from unnecessary or repeated interviews. Interviews that occur in close proximity to the time of the event are more likely to be accurate due to the decreased likelihood of memory taint by cognitive intrusions across time. Ensuring the competency of early interviewers is imperative. This is in order to protect the child's testimony from biased interviewing, suggestive techniques (whether intentional or not), and to ensure that questions are designed to be developmentally appropriate and that the child's responses are accurately interpreted from a developmental perspective.

Many times, courts and attorneys use mental health therapists as evaluators in cases of child sexual abuse. Clinical implications highlight the importance that the mental health professional selected for this evaluation role is not the child's therapist and holds specific training, education, experience, and exper-

¹²⁰ See JOAN TOUGH, *THE DEVELOPMENT OF MEANING: A STUDY OF CHILDREN'S USE OF LANGUAGE* 166 (2012).

¹²¹ Timothy A. Salthouse et al., *Division of Attention: Age Differences on a Visually Presented Memory Task*, 12 *MEMORY & COGNITION* 613, 613 (1984).

¹²² See generally CECI & BRUCK, *supra* note 1; HALL & SALES, *supra* note 1; CHILDREN'S TESTIMONY, *supra* note 1.

tise in forensic assessment of child sexual abuse. Forensic assessment is not a general clinical competency. It is a highly specialized area practiced appropriately by very few adequately qualified professionals, although many generalist practitioners routinely agree to provide such services.

The importance of this distinction cannot be overemphasized for several reasons. In addition to concerns about training and skill level for forensic evaluation, which is qualitatively different from therapeutic evaluation, care must be taken to protect the child's report from sources of interference or taint in an effort to preserve and protect the child's memory in an unaltered form and to document the child's report effectively and accurately. Conducting an appropriate forensic evaluation early on may minimize the need for repeated interviews, which can be stressful for the child in addition to the risk of introducing error.

Also, the therapeutic alliance is one that inherently involves support and advocacy. For someone in the therapist role, to disbelieve a child's report of abuse damages the therapeutic relationship. Also, therapists in clinical settings are accustomed to accepting their patients' reports at face value. When a patient presents and says, "I am depressed," there is little reason for the professional functioning in the role of therapist to disbelieve that statement. This is in contrast to forensically trained evaluators who actively seek to prove and disprove competing theories of what happened at every step of the assessment process.

Forensic evaluators are trained to use evaluation techniques that are developmentally appropriate, unbiased, neutral, non-leading, and non-suggestive, rendering their determinations inherently more objective than those obtained by the therapeutic techniques that characterize generalist clinicians' work. This will ensure that the evaluation being relied upon in the legal case meets both the *Daubert* or *Frye* standards.

Forensic mental health evaluators also may serve as a non-evaluator expert witness to discuss some of the concerns delineated in this article. In cases where children have already been interviewed, retaining the services of a forensic mental health evaluator to review and opine on the appropriateness or effectiveness of the prior interview techniques and interpretation of the child's responses may prove helpful in preparing to challenge earlier reports of child sex abuse using *Daubert* or *Frye* criteria and/or to prepare depositions or examinations of prior interviewers or evaluators.

Implications are that legal professionals should educate themselves and their colleagues about the need for and availability of appropriate forensic assessment in allegations of child sex abuse, the strengths and weaknesses of child testimony regarding sex abuse allegations, and the modifications within the legal process that will render the child witness's participation less stressful, more effective, and more meaningful in the search for truth and the pursuit of justice.