



PRACTICE GUIDELINES

Psychosocial Evaluation of Suspected Sexual Abuse in Children. Second Edition.

STATEMENT OF PURPOSE

These Guidelines for mental health professionals reflect current knowledge and an emerging consensus about the psychosocial evaluation of suspected sexual abuse in children. They are not intended as a standard of practice to which practitioners are expected to adhere in all cases. Evaluators must have the flexibility to exercise clinical judgment in individual cases. Laws and local customs may also influence the accepted method in a given community. Practitioners must be prepared to justify their decisions about particular practices in specific cases. As experience and scientific knowledge expand, further refinement and revision of these Guidelines are expected.

These Guidelines are specific to psychosocial evaluations. Psychosocial evaluations are a systematic process of gathering information and forming professional opinions about the source and meaning of statements, behavior, and other evidence that are the basis of concern about possible sexual abuse. The results of such evaluations may be used to direct treatment planning and to assist in legal decision making.

Psychosocial evaluators should first establish the purpose of the evaluation and their role in the evaluation process. Psychosocial evaluations may be conducted for purely clinical reasons or be forensic in nature. These guidelines pertain to both situations.

Clinical evaluations may be requested by parents, guardians or other professionals to determine whether there is reason to be concerned about possible abuse. It is also customary for clinicians to precede treatment for the effects of sexual abuse with an assessment of the sexual abuse history. Forensic evaluations have the explicit purpose of contributing to legal decision making or legal proceedings. Such evaluations may be requested by parents or guardians, public child protective services (CPS) agencies, attorneys, guardians ad litem (or court appointed special advocates), or other professionals. The results may be used in civil or criminal proceedings. As noted in these guidelines, forensic evaluations are different from clinical evaluations in generally requiring a different professional stance and additional components.

In all cases, evaluators should be aware that any interview with a child regarding possible sexual abuse may be subject to scrutiny and have significant implications for legal decision making and the child's safety and well-being.

GUIDELINES

I. THE EVALUATOR

A. CHARACTERISTICS

1. The evaluator should possess a graduate level mental health degree in a recognized discipline (e.g. psychiatry, psychology, social work, nursing, child development) or be supervised by a professional with a graduate level degree.
2. The evaluator should have professional experience assessing and treating children and families, and professional experience with sexually abused children. A minimum of two years of professional experience with sexually abused children is expected; three to five years is preferred for forensic evaluators. If the evaluator does not possess such experience, supervision is essential.
3. The evaluator must have had specialized training in child development and child sexual abuse. This training should be documented in terms of formal course work, supervision, or attendance at conferences, seminars, and workshops.
4. The evaluator should be knowledgeable about the dynamics and the emotional and behavioral consequences of sexual abuse experiences. The evaluator should be familiar with the professional literature and with current issues relevant to understanding and evaluating sexual abuse experiences.
5. The evaluator should be familiar with different cultural values and practices that may affect definitions of sexual abuse, child and/or family comfort with the evaluation process, child and/or family willingness to provide complete and accurate information, and the evaluator's own interpretation of responses.
6. If the purpose of the evaluation is forensic, the evaluator should have experience in conducting forensic evaluations and providing expert testimony. If the evaluator does not possess such experience, supervision is essential.
7. The evaluator should approach the evaluation with an open mind to all possible responses from the child and all possible explanations for the concern about sexual abuse. The evaluator should recognize that all sources of information have limitations and may contain inaccuracies. In forming an opinion, the evaluator should consider plausible alternative hypotheses.

II. COMPONENTS OF THE EVALUATION

A. PROTOCOL

1. A written protocol is not necessary; however, evaluations should ordinarily involve reviewing those materials considered relevant for the type of evaluation; conducting collateral interviews when necessary; establishing rapport; assessing the child's developmental status, cognitive capacity, level of functioning and level of distress; and

specifically evaluating the possibility of abuse. The evaluator may use discretion in the order and method of assessment. Forensic evaluations differ from evaluations conducted for purely clinical reasons in that they generally involve reviewing relevant materials and conducting collateral interviews.

2. If information is available prior to the evaluation that meets the respective state's definition of reasonable suspicion for a CPS report, but no CPS report has yet been made, the evaluator should make the report and may choose to defer the evaluation until the CPS investigation has been conducted.
3. When possible, unsupervised contact between the child and the suspected offender should be strongly discouraged during the evaluation process.

B. EMPLOYER OF THE EVALUATOR

1. Evaluation of the child may be conducted at the request of a legal guardian prior to court involvement. When only one parent has requested the evaluation, evaluators should give careful consideration to informing the other parent about the evaluation whether or not that parent is the focus of concern. When the other parent is the focus of concern, that parent is likely to request another evaluation; evaluators should consider whether it would be in the child's best interest to have a mutually agreed upon or court appointed evaluator to avoid unnecessary evaluations.
2. If the evaluation is specifically requested or intended for use in a legal proceeding or a court is already involved, the preferred practice is a court-appointed or mutually agreed upon evaluator of the child. In some circumstances exceptions to this practice are acceptable or are customary practice (e.g., contractual arrangements with child protective services, civil damage suits, when one party refuses to cooperate).
3. Discretion should be used in agreeing to conduct an evaluation of a child when the child has already been evaluated. Additional evaluations should be conducted only if they clearly further the best interests of the child. When a second opinion is required, a review of the records may eliminate the need for re-interviewing the child.

C. NUMBER OF EVALUATORS

1. The evaluation may be conducted by a single evaluator or by a team of professionals.

D. COLLATERAL INFORMATION GATHERED AS PART OF THE EVALUATION

1. Evaluators may seek and review background materials or conduct interviews as part of the evaluation process. The amount and nature of information reviewed depends on the purpose of the evaluation and the extent to which such information will be helpful in addressing the referral question and understanding the child's presenting problems or concerns. For clinical evaluations, clinical judgment should determine the necessity for additional records, materials, or interviews. Evaluators should request that background material be made available and collateral interviews be permitted for forensic evaluations.

2. The evaluation report should reflect an objective review of collateral information relied upon in the evaluation or opinion forming process.

E. INTERVIEWING THE ACCUSED OR SUSPECTED INDIVIDUAL

1. It is not necessary to interview the accused or suspected individual in order to form an opinion about possible sexual abuse of the child.
2. An interview with or review of the statements from a suspected or accused individual may provide additional relevant information (e.g., alternative explanations, admissions, insight into relationship between child and accused individual).
3. If the accused or suspected individual is a parent who seeks to participate in the evaluation and there are no contraindications (e.g., criminal investigation or charges pending, civil suit), interviewing of the accused or suspected parent should be given strong consideration.

F. RELEASING INFORMATION

1. Suspected abuse should always be reported to authorities as dictated by state law. Except as specified by law, clinical evaluators have no affirmative duty to disclose confidential clinical information.
2. Permission should be obtained from legal guardian(s) to request collateral materials and for release of information about the evaluation to relevant medical or mental health professionals, other professionals (e.g., schoolteachers), and involved legal systems (e.g., CPS, law enforcement, lawyers, courts). Discretion should be used in releasing sensitive individual and family history that does not directly relate to the purpose of the assessment.
3. Feedback about the results of the evaluation should usually be offered to parent(s) or legal guardian(s) and may be offered to the child, except where doing so would not be in the best interests of the child.

III. INTERVIEWING

A. RECORDING OF INTERVIEWS

1. Written documentation is the minimum requirement. Verbatim quotation of significant questions and answers is desirable. Forensic evaluations should contain specific documentation of questions and responses (verbal and nonverbal) regarding possible sexual abuse.
2. Audio or video recording may be preferred practice in some communities. Professional preference, logistics, or clinical considerations may contraindicate recording of interviews. Professional discretion is permitted in recording policies and practices.
3. When audio and video recording are used, the child and legal guardian should be informed. It is desirable to obtain assent from the child (when age appropriate) and consent from legal guardian(s).

B. OBSERVATION OF THE INTERVIEW

1. Professional discretion is permitted in observation policies and practices. Observation of interviews by involved professionals (CPS, law enforcement, etc.) may be indicated if it reduces the need for additional interviews and will not compromise the evaluation process.
2. Observation by non-accused and non-suspected primary caregiver(s) may be indicated for particular clinical reasons; however, great care should be taken that the observation is clinically appropriate, does not unduly distress the child, and does not affect the validity of the evaluation process.
3. If interviews are observed, the child must be informed. It is desirable to obtain assent from the child(when age appropriate) and consent from legal guardian(s).

C. NUMBER OF INTERVIEWS

1. The evaluator determines the number of interviews necessary to address the referral question and assess the child's presenting problems or concerns. This does not imply that all sessions must include specific questioning possible sexual abuse. The evaluator may decide, based on the individual case circumstances, to adopt a less direct approach and reserve questioning about possible sexual abuse for subsequent interviews. Repeated direct questioning of the child regarding sexual abuse when the child is not reporting or is denying abuse is usually contraindicated.
2. If the child does not report abuse and further direct questioning is judged to be counterproductive, but the evaluator has continuing concerns about the possibility of abuse, the child may be referred for an extended evaluation or therapy that is less directive, but diagnostically focused. Recommendations regarding conditions necessary to insure the child's protection from possible abuse should be made.

D. FORMAT OF INTERVIEW

1. When possible, interviewing the primary caregiver and reviewing other collateral data first to gather background information may facilitate the evaluation process.
2. The child should be seen individually, except when the child refuses to separate from a parent/guardian. Discussion of possible abuse with the child in the presence of the caregiver during evaluation interviews should be avoided except when necessary to elicit information from the child. In such cases, the interview setting should be structured to reduce the possibility of improper influence by the caregiver on the child's behavior or statements.
3. In some cases, joint sessions with the child and the non-accused caregiver or accused or suspected individual might be helpful to obtain information regarding the overall quality of the relationships. Such joint sessions should not be conducted for the purpose of determining whether abuse occurred based on the child's reactions to the participating adult. Joint sessions should not be conducted if they will cause significant distress for the child.
4. Joint sessions with a child and an accused or suspected individual should only be considered when the individual is a parent or primary caregiver. In making a decision about conducting a joint session with a child and the accused or suspected parent,

the evaluator should carefully weigh the possibility of gaining valuable information against the significant potential for negative consequences for an abused child and for the evaluation process. A child should never be asked to discuss the possible abuse in front of an accused or suspected parent.

IV. CHILD INTERVIEW

A. GENERAL PRINCIPLES

1. The evaluator should create an atmosphere that enables the child to talk freely, including providing physical surroundings and a climate that facilitates the child's comfort and communication.
2. The evaluator should convey to all parties that no assumptions have been made about whether abuse has occurred.
3. Language and interviewing approach should be developmentally and culturally appropriate.
4. The evaluator should take the time necessary to perform a complete evaluation and should avoid any coercive quality to the interview.
5. Interview procedures may be modified in cases involving very young, minimally verbal children or children with special problems (e.g., developmentally delayed, electively mute, non-native speakers).
6. The difference between the evaluation phase and a treatment phase should be articulated. Under certain circumstances, (e.g., disputed custody cases) it may be preferable to obtain agreement from the parties before proceeding with treatment following evaluation.

B. QUESTIONING

1. It may be helpful to preface questioning with specific statements designed to reduce misunderstandings during the interview(s), and promote accuracy and completeness.
2. It may be helpful to begin the interview with open-ended questions about neutral topics (e.g. family, school, recent events) so that the child has an opportunity to practice providing free recall responses.
3. Initial substantive questioning should be open-ended and as non-directive as possible to elicit free recall responses. More focused or specific questioning should follow. Once information is provided in response to a specific question, open-ended prompts should again be used.
4. The child should be questioned directly about possible sexual abuse at some point in the evaluation if less directive approaches have not yielded adequate information to answer the referral question.
5. The evaluator may use the form of questioning deemed necessary and justified to elicit information on which to base an opinion. Highly specific questioning should only be used when other methods of questioning have failed, when previous information warrants substantial concern, or when the child's developmental level precludes

more non-directive approaches. However, responses to these questions should be carefully evaluated and weighed accordingly. Coercive or intimidating questioning is never justified.

C. USE OF DOLLS AND OTHER DEVICES

1. A variety of non-verbal tools may be used to assist young children in communication, including drawings, toys, doll-houses, dolls, puppets, etc. Since such materials have the potential to be distracting or misleading they should be used with care. They are discretionary for older children.
2. Anatomical dolls are accepted interview aids. Evaluators using anatomical dolls should be knowledgeable about the functions they may serve and should conform to accepted practice. (Refer to the APSAC Guidelines on the Use of Anatomical Dolls in Child Sexual Abuse Assessments).
3. Anatomical dolls should not be used as a diagnostic test for sexual abuse. Definitive conclusions about a history of sexual abuse should not be based solely on interpretation of behavior with the dolls. Unusual behavior with the dolls may suggest further lines of inquiry that should be pursued. The unusual behavior and the responses to further questioning should be noted in the evaluation report.
4. Story books, coloring books or videos that contain explicit descriptions of abuse situations are potentially suggestive and are primarily teaching tools. They are typically not appropriate for evaluation purposes.

D. PSYCHOLOGICAL TESTING

1. Formal psychological testing of the child is not necessary for the purpose of proving or disproving a history of sexual abuse.
2. Psychological testing may be useful when the clinician has questions about the child's intellectual or developmental level. Psychological tests can also provide helpful information regarding a child's emotional status and general functioning.
3. Psychological testing of parents is not a routine component of child evaluations. An evaluation that includes assessment of parents may involve psychological tests.

V. CONCLUSIONS/REPORT

A. GENERAL PRINCIPLES

1. The evaluation report should document the sources of information and/or data relied on in forming an opinion and making recommendations.
2. The evaluator may state an opinion that abuse did or did not occur, an opinion about the likelihood of the occurrence of abuse or simply provide a description and analysis of the gathered information.
3. Opinions should include supporting information (e.g., the child, parent(s)/guardian(s) and/or the accused individual's statements, behavior, psychological symptoms). Possible alternative explanations should have been considered. The evaluator should not suggest that mental health professionals have any special ability to detect whether an individual is telling the truth.

4. The evaluation may be inconclusive. If so, the evaluator should cite the information that causes continuing concern but does not enable confirmation or disconfirmation of abuse. If inconclusiveness is due to such problems as missing information or an untimely or poorly-conducted investigation, these obstacles should be clearly noted in the report.
5. Recommendations should be made regarding therapeutic or environmental interventions to address the child's emotional and behavioral functioning and to ensure the child's safety.

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These Guidelines are the product of APSAC's Task Force on the Psychosocial Evaluation of suspected Sexual Abuse in Children, chaired by Lucy Berliner, MSW. The initial version was the result of a lengthy, iterative process. These revisions are the result of a similar process conducted in 1996. Appreciation goes to the many APSAC members who contributed their time and expertise to produce these Guidelines. The Guidelines will be updated periodically. Any comments or suggestions about them should be directed to Lucy Berliner through APSAC, 332 South Michigan Avenue, Suite 1600, Chicago, Illinois, 60604.