

Behavioral and Psychological Assessment of Child Sexual Abuse in Clinical Practice

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ABSTRACT

This paper discusses the behavioral and psychological assessment of Child Sexual Abuse (CSA) in clinical practice. Following a brief introduction regarding definition and etiology of CSA and discussion on issues of behavioral/ psychological consequences of CSA, the paper reviews the various approaches towards behavioral/psychological assessment in establishing validity of alleged CSA. The shortcomings of the various behavioral/psychological assessment procedures and the issues of general consensus on behavioral assessment in CSA have been reviewed. The role of behavioral/psychological assessment in child protection issues is also discussed.

Keywords: Child Sexual Abuse, psychological/behavioral consequences, psychological/behavioral assessment, child protection issues, mental health professionals, post-traumatic stress disorder

INTRODUCTION

In the last two decades there has been an explosion in the number of studies that have concentrated specifically on sexually abused children. Behavioral and psychological assessment of child sexual abuse (CSA) that includes identification, diagnosis, etiology, and social, physical and psychological consequences has been the focus of research. It is important to know about the social, environmental climate in which CSA occurs; indices of behavior and emotions which point towards it and the factors that preclude identification etc.

Definition of what act constitutes CSA has implications in behavioral assessment. The most comprehensive definition has been given by the Standing Committee on Sexually Abused Children (SCOSAC, 1984) which states that “any child below the age of consent may be deemed to have been sexually abused when a sexually matured person has engaged or permitted the engagement of that child in any activity of a sexual nature which is intended to lead to sexual gratification of the sexually mature person”.

Another factor which should be kept in mind while doing behavioral and psychological assessment is the etiology of CSA. It has been suggested that four factors influence the occurrence of CSA (Finkelhor, 1984). First, it is the motivation of the abuser that includes the abuser’s sexuality. Second factor is the absence of internal inhibitions (moral values of the adult). Third factor is the absence of external inhibitors (supervision of child by others) like protective family, secure attachment to the primary care giver, good monitoring of the child’s whereabouts and confiding relationship for the child’s increased chances of abuse (Budin & Johnson, 1989; Conte et al 1989). Last it is the lack of child’s own resistance towards the adult also increases the chances of abuse.

BEHAVIORAL AND PSYCHOLOGICAL CONSEQUENCES OF CSA

The consequences of CSA are both psychological as well as physical. The behavioral and psychological assessment in child sexual abuse should focus on psychological consequences of CSA. Also, the wide range of serious long and short-term consequences of CSA including the need to prevent reactive abuse (abuse of other children by a victim) is one reason why all children suspected to be sexually abused need to be referred for psychological testing and treatment (Glasser et al 2001; Johnson

2004). Children can exhibit a myriad of immediate psychological consequences like emotional disturbances in form of fear, anxiety, depression, anger, hostility and low self-esteem (Browne & Finkelhor 1986; Bentovim et al 1988; Kendall-Tackett et al 1993). These children can also present with various anxiety disorder (fearfulness, nightmares, phobias etc), posttraumatic stress disorder (PTSD), hysterical reactions, depression, suicidal behavior, substance abuse etc. Research reports have shown that 20-70% of children with CSA suffer from posttraumatic stress disorder (Wolfe et al 1991; McLeer et al 1992). However, it has also been estimated that 1/3rd of the abused children show no psychological symptoms or only non-specific symptoms. This allows the abuse to go undetected over prolonged periods (Kendall-Tackett et al 1993).

Browne & Finkelhor (1986) did an extensive review of earlier research on the impact of sexual abuse. Initial effects of abuse that were noted included fear, anger, hostility, guilt, shame, sleep disturbances, eating disorders and an array of sexualized behavior from genital manipulation to pregnancy, 'mummy/daddy' and nurses/doctors' related themes in their play. Sexually inappropriate behaviors are related to early onset of sexual abuse (McClellan et al, 1996). Later effects included depression, anxiety, negative self-concepts, interpersonal problems, a tendency towards re-victimization and self-destructive behaviors.

In a study comparing the parent reports of definitely abused, alleged abuse, and non-abused pre-pubescent females using Structured Interview for Signs Associated with Sexual Abuse, researchers found significant differences between the three groups (Wells et al 1995). The symptoms that did not seem to be related to abuse included nightmares, crying easily, fears of being left alone, bedwetting, headaches, and stomach aches. The symptoms that were significantly different between the girls who were definitely sexually abused and those who were allegedly abused were difficulty getting to sleep, noticeable changes in behavior, fear of being left with a particular person, fear of males, becoming withdrawn, unusual interest or curiosity about sexual matters. It was concluded by the researchers that a parent report can be useful as part of the assessment, regarding the likelihood of sexual abuse.

The effects of CSA can have their ramifications into adulthood as well. Even in adults, varied emotional and psychological reactions occur. Low self esteem, sense of helplessness and self-hatred and disturbed interpersonal relationship in form of marital discord and divorce are seen. Psychiatric illnesses like depression, anxiety, suicidal tendencies, hysterical reactions, sexual problems and borderline personality disorder have been reported in adults with sexual abuse in their childhood (Cotgrove & Kolvin, 1996). The behavioral consequences of sexual abuse are affected by the child's age, development, physical acts performed, threats and bribes, fear of retribution, fear of culpability, chronicity of acts, child's resilience and relationship to the perpetrator (Haj-Yahi & Tamish, 2001; Macfie et al 2001; Molnar et al 2001; Hanson et al 2001) and effective treatment.

PHYSICAL CONSEQUENCES OF CSA

HIV and other sexually transmitted diseases are seen in children CSA that can have its own ramifications in adulthood. CSA may lead to unwanted pregnancies and rarely genital injuries (Willis & Levy, 2002). However, even in documented cases of CSA, only 50% of cases show physical findings (Muram, 1989). A careful or experienced perpetrator is unlikely to perform an act that will result in his or her detection. Intense and persistent pain, obvious tissue injury, or bleeding can lead to immediate suspicion or detection unless the perpetrator is able to keep the trauma from being discovered. A child who is injured may be kept away from pre-school or school or other adult caretakers until healing occurs. Some types of abuse, such as exhibitionism, voyeurism, viewing or creating pornography, touching and licking may not result in physical findings. Reddening of the skin caused by rubbing will resolve in minutes to hours unless the skin is excoriated. Minor scratches may not be detectable (Johnson, 2004).

Persistent lack of knowledge that physicians have shown about normal and abnormal female genitalia is of great concern.

Emergency room physicians should not misinterpret findings that can lead to a mistaken report of physical trauma, or to failure to recognize trauma (Johnson, 2004). Detailed physical examination including genital and rectal examination is also mandatory in such cases. As far as possible an examiner who is familiar to the child should do the genital examination, as it would help in better cooperation from the abused child. Additionally, a child may be entertained or distracted by the television or any other means. Colposcopy, Foley catheter Technique, Wood Lamp Examination can be useful to get forensic evidences (Atabaki & Paradise, 1999). Most children, even those who have been sexually abused will have a normal genital examination. Although the diagnosis of sexual abuse can never rely solely on physical findings, abnormal findings can make oneself suspicious of sexual abuse especially if there have been previous normal findings (Botash 1997). A practitioner must be aware of specific genital findings, which are normal, abnormal, and suspicious.

RECOGNIZING OCCURRENCE OF CSA

How does one know if a child has been sexually abused?

Unfortunately, there are often no obvious signs that a child has been sexually abused. Due to the fact that sexual abuse occurs in private and often does not result in physical evidence, sexual abuse can be difficult to detect. Moreover, neither there is a characteristic syndrome of CSA nor any particular symptom that majority of sexually abused children exhibit. Mental health professionals are often unable to decide as to how to proceed further when they are called upon to provide investigative and evaluative procedures in child sexual abuse cases. Their main concern may be with treating a false allegation as true because it can be traumatizing to the non-abused child and treating true allegations as false. Court appearances are therefore the most stressful aspect of abuse assessments, according to emergency room physicians and specialists in the field (Johnson, 1990; 1999). However, one must prepare to testify as a content expert and a teacher to lay audiences. Meeting with the prosecutor before appearance in court is of value. The physician should educate the prosecutor regarding the medical evidence. A physician may testify for the child due to hearsay exception. This is however, based on the assumption that children do not lie to physicians. This is particularly relevant when the children cannot or will not testify on their own behalf (Peters, 2001).

Major Theoretical Approaches

Several methods have been developed that are considered to be scientifically acceptable procedures for determining the validity of alleged abuse in children. Some of the major theoretical approaches in assessment of the child alleged to have been sexually abused are described below:

1. Gardner's True and False Accusations of Child Sexual Abuse (1992) and Protocols for the Sex-Abuse Evaluation (1995)
2. Greenberg's Conducting Unbiased Sexual Abuse Evaluations (1990)
3. Boat and Everson's Structured Interview Using Anatomical Dolls (1986)
4. Hindman's Sixteen Steps Toward Legally Sound Sexual Abuse Investigations (1987)
5. Raskin and Esplin's Statement Validity Analysis (1991)
6. Michael Lamb "Consensus Statement" (1994)

Raskin and Esplin's (1991), "Statement Validity Analysis" (SVA) is a set of interview techniques and analytical procedures for obtaining and evaluating statements given in a case of alleged child sexual abuse case. These procedures help the evaluator to explore and consider all of the available information and many possible explanations prior to, during and after the interview. SVA essentially incorporates three procedures: firstly, obtaining a free narrative by the child who alleges sexual abuse, without using anatomical dolls as communication aids. This interview is not therapeutic and should not be performed by the child's therapist due to dual role conflicts (Committee on Ethical Guidelines for Forensic Psychologists, 1991; American Academy of Child and Adolescent Psychiatry, 1988). SVA provides guidelines regarding when to use cue questions, direct questions and probe questions. Secondly, is the application of Criteria Based Content Analysis (CBCA) (Raskin & Esplin, 1991) to the narrative provided by the child and recorded verbatim. CBCA is used to analyse the narrative statement for general characteristics, specific contents and motivation related contents. Thirdly, is the application of the Validity Checklist (Raskin & Esplin, 1991) to the entire body of data acquired through both legal and psychological means relevant to the case. The Validity Checklist consists of four categories of information to be analyzed: a) psychological characteristic of the child; b) interview characteristics of the child and the examiner; c) motivational factors relevant to the child and others involved in the allegations and d) investigative questions regarding the consistency and realism of the entire body of data. This procedure involves systematic consideration of all necessary available information thus preventing premature conclusion.

Boat and Everson (1986) have developed a comprehensive set of guidelines on interviewing children who allege sex abuse, using Anatomically Detailed (AD) dolls. This procedure involves a structured interview, which begins by assessing cognitive competencies, and then the AD dolls are used to help children with immature verbal inability to communicate what may have happened to them. The American Psychological Association's Council of Representatives (Koocher et al 1994) has recently published a position paper on the use of AD dolls, in which the use of AD dolls has been endorsed as a communication and memory aid for undergoing sexual abuse interview. However, it has not been identified as a definitive diagnostic test that can say with certainty whether a child has been sexually abused. Subsequently however, researchers (Faller, 2005) have argued whether in a case with possible sexual abuse communication should be limited to only verbal communication or also to allow the child to communicate through demonstrations. There are guidelines present about when and how to use demonstrative communication methods (Faller, 2005).

Hindman (1987) has published two books titled "Step By Step: Sixteen Steps Toward Legally Sound Sexual Abuse Investigations" and "A Very Touching Book". These books give guidelines for interviewing children who allege child sexual abuse. The latter describes the concept of "good touch, bad touch and secret touch" and if it is present in the child then the child is encouraged to describing it. Although, no specific guidelines are given regarding the use of AD dolls however, the author states that these can be used to augment the interview.

Gardner's (1992; 1995) investigative method emphasizes the importance of evaluating not only the victim but also the alleged perpetrator, and the accuser. The evaluation may also include conjoint interviewing wherein all three together are brought to the same room for interviewing. In his 1st book (1992) he gave 30 "differentiating criteria" to assess the likelihood of sexual abuse in a particular child. In his second book (1995), he gave an additional 21 criteria derived from direct enquiry and 11 criteria derived from projective testing. Separate criteria are also mentioned for evaluation of the victim's parents, the accused male/female, and the accuser. However, the author states that there are no cuff-off points that indicate the likelihood of sexual abuse having taken place or not. The greater the number of indicators met the greater is the likelihood that a child has been abused.

Greenberg's technique (1990) involves unbiased investigations of alleged child sexual abuse victims. In his interview format, certain toys that are used as stimuli for verbalizations and behavior are allowed. In this interview format, before judging the victim's speech content, evaluation of the child's linguistic competency should also be assessed. The integral part of the interview includes counterbalanced questions about alleged victimization and the alleged perpetrator apart from questions regarding the sequelae of alleged abuse.

There are however, several criticisms of each of these theories.

"Statement Validity Analysis" has inadequate empirical support and may lack ability to consider individual and age-related differences in linguistic abilities from validity-related differences (Wells and Loftus 1991). Uses of AD dolls have been criticized as well (Faller, 2005). Gardner (1992) opposes the use of dolls because as per him it is a cause of "psychological grief" to children. Moreover, some researchers (Faller, 2005) believe that AD dolls are sexually suggestive. Although, additional research is needed on anatomical dolls, the selective use of anatomical dolls, as communication aids, when interviewing children who may be reluctant or unable to describe sexual abuse is warranted. In contrast to most other methods, Gardner's method emphasizes interviewing the alleged perpetrator whenever possible, and often jointly with the alleged victim, before giving a final opinion as to whether sexual abuse of a child has occurred. Several researchers have stressed on the need for a competent investigative procedure and interview technique so that the competence of the children and the accuracy of the information given can be assessed properly (Bruck & Ceci 1993; 1995; Lamb et al 1995). Memory itself cannot be judged to be accurate or inaccurate unless the investigator's interviewing style and techniques are sound. There are studies on both the accuracy (Terr 1994) as well as the fallibility of children's memory (Loftus & Ketcham 1994).

Areas of consensus amongst investigative formats

In spite of the many criticisms of each method described above there are several issues on which the researchers agree. These are as follows.

1. The investigator must carefully examine his/her own emotions and possible biases regarding child sex abuse before undertaking to interview children with alleged sex abuse. This could jeopardize the assessment as the investigator may easily project those biases into the assessment of child's allegations.
2. A well-trained and experienced forensic interviewer and not the child's therapist should conduct the investigation. This will yield more informative and accurate accounts by children.
3. Free narrative from the child in response to open-ended questions should be encouraged as it gives the maximum accuracy. Higher the level of suggestiveness and coerciveness of an interview technique greater are the inaccuracies.
4. The interviewer should use a structured interview technique he/she is familiar with. Any unstructured interview should be avoided as it could sabotage the accuracy of the information and the competence of the child in giving sexual abuse history.
5. The interviewer and child's behavioral responses should be recorded, preferably by videotape or at least by an audiotape and this should be accompanied with detailed notes. Note-taking alone should be reserved only for special cases.
6. Interviewer must be equipped with special skills while assessing pre-school children as they are prone to suggestiveness, developmental difficulties in differentiating from fantasy and real life events. Some concessions may be given to such children as the child may get confused. The developmental perspective therefore should be kept in mind.
7. Some measure of a child's ability to distinguish between truth and falsehood must be taken. Child's ability to identify colors correctly does not mean that the child can reliably distinguish between truth and falsehood in all applications.

8. Some children's statements will be false and must be distinguished from true statements by the application of structured instruments and not by "gut feelings" or "hunches".
9. Sexualized behaviors are more common in sexually abused children than in non-abused children.
10. Tools and props such as anatomically detailed dolls, puppets, or human figure drawings may be useful when interviewing children under age of 5 years or those older children who are non-communicative.
11. Although medical examination commonly do not show evidence of sexual abuse, they should be conducted and findings should be documented in every case as soon as possible after the allegation, by a highly trained specialist using multiple techniques and sophisticated equipments.

There are guidelines proposed for determining the likelihood of Child Sexual Abuse (U.S. Department of Health and Human Services, 1993; DeVoe & Faller 2002). Firstly, an assessment needs to be made regarding the child's ability to describe the sexual behavior. Issues than need to be addressed are whether the child has sexual knowledge beyond what would be expected for the child's developmental stage, description of the sexual behavior from the child's view point and explicit accounts of the sexual acts. Secondly, issues regarding child's ability to describe the context of the sexual abuse. Ability of the child to describe the place/time of event, coaxing that was done to obtain the child's involvement, where the other family members were, what the child was wearing, whether clothing of the victim and/or perpetrator was removed or not, whether the consequences of disclosing or not disclosing told to the child by the perpetrator, whether the child disclosed it to anyone and what was the reaction of the person to whom the child confided. Thirdly, the child's affect when recounting the sexual abuse should also be taken into account. The child's reluctance, embarrassment, anger, anxiety, disgust, sexual arousal, fear etc should be assessed by the mental health professional dealing with a case of child sexual abuse. Lastly other important evidences like the medical, physical examination reports, confession of the alleged offender, other witnesses etc are important in helping a mental health professional in reaching a conclusion of whether CSA has occurred or not.

V. INSTRUMENTS AND SCALES FOR BEHAVIORAL ASSESSMENT OF CSA

Sexualized behavior in child is recognized as one of the signs of child sexual abuse. The Child Sexual Behavior Inventory (Version 2) (Friedrich et al 1992) is one such scale, which assesses the sexualized behavior seen recently or in the last 6 months. It is a 36-item questionnaire that is scored from 0 (Never seen) to 3 (At least once per week). This questionnaire enquires about a variety of sexualized behavior like talking about wanting to be the opposite sex, touching private parts when in public places, draws sex parts when drawing pictures of people, touches or tries to touch mother's or other women's breasts, imitates the act of sexual intercourse, using words that describe sex acts, making sexual sounds, rubbing body with furniture or people, overtly friendly or hugs with men/children they don't know well, imitates sexual behavior with dolls or stuffed animal, increased interest in opposite sex, overtly aggressive in case of a girl child or suddenly remaining passive in case of a boy etc. The U.S. Department of Health and Human Services has published risk assessment protocol questionnaires that assess the children at risk for Child Sexual Abuse (Faller et al 1993). The questionnaire assesses significant areas e.g. the type of sexual abuse, characteristics of the abuse situation, victim's age, suspect-victim relationship, number of victims, number of perpetrators, functioning of the non-offending parent, response of the suspect (admits but with or without taking responsibility, denies, denies but blames victim), family problems (substance abuse, violence, mental retardation or mental illness, physically handicapped) etc.

During interview of a child alleged to have been sexually abused one can ask to start with general questions. Thereafter one can shift to more focused questions, multiple choice questions, Yes-No questions and lastly leading questions (Faller et al 1993). General questions like "Do you know why you came to see me today?" can be asked. However, it has been seen that children usually are not very responsive to general questions. Then one can ask focused questions about the person the child names in

the general question like “How do you get along with this person? Or What happens when he/she baby-sits? Or what does he use to play with your hole?” The child can be given several choices in the question to describe an object that was used to play with his ‘hole’. Other multiple-choice questions can be “Did he/she say anything about telling or not telling? Or did you have your clothes off or on or some off and some on?” Another alternative could be asking Yes-No questions like “Did he/she tell you not to tell? Or did you have your clothes off?” Finally, one can ask leading questions like did he stick his “Weiner” or “Finder” or “Quot” in your hole? The leading questions like the one above should not be asked when interviewing children as they may answer in affirmative due to suggestibility.

The Trauma Symptom Checklist for Young Children (TSCYC) is a 90-item caretaker-report measure of children’s trauma and abuse-related symptomatology. It contains two reporter validity scales and eight clinical scales (Post-traumatic Stress-Intrusion, Post-traumatic Stress-Avoidance, Post-traumatic Stress-Arousal, Post-traumatic Stress-Total, Sexual Concerns, Dissociation, Anxiety, Depression, and Anger/Aggression) as well as an item assessing hours per week of caretaker contact with the child. In a multisite study using TSCYC, it was found that the scale had good reliability & validity in sexually abused children. The PTS subscales were the most predictive, followed by Sexual Concern scale (Briere et al 2001).

Since eliciting history of CSA can make both the physicians as well as the victim uncomfortable so a step-wise interview (Yuillie et al 1993) is usually used. It includes rapport building → asking open – ended questions → telling the truth → introducing the topic of concern → free narration after topic has been introduced → general questions → lastly specific questions. Secondly, associated psychological aids like drawings (Burgess & Hartman, 1993), anatomical dolls, projective tests (Rorschach, Child Apperception Test) have been found useful (Leifer et al, 1991). Behavioral checklists (Freidrich et al, 1991, Chantler et al, 1993) have also been used. Mental State Examination is an integral part of the whole process of reaching to a diagnosis. Establishing a good rapport, keeping the interviews to a minimum and use of open-ended questions are important aspects of MSE. In addition play observation may be useful mode of examination.

IMPORTANCE OF BEHAVIORAL/PSYCHOLOGICAL ASSESSMENT OF CHILD SEXUAL ABUSE

Apart from behavioral assessment of sexually abused children, it is necessary to make psychological evaluation in child protection issues. The specific purpose of the evaluation is determined by the nature of child protection matter. The primary aim is to determine whether the child’s health and welfare may have been harmed. When it has been established that the child is at risk for harm, the evaluation focuses on rehabilitation designed to protect the child and help the family. An additional purpose may be to make recommendations to promote the psychological and physical well-being of the child, and if appropriate, facilitate reunification with family. In proceedings on the termination of parenting rights, the primary purpose is to assess not only abuse or neglect by parent(s), but also whether rehabilitation efforts have succeeded in providing a safe environment for the child’s return. In cases of CSA, child’s protection and interests are of paramount importance. Apart from this the successful rehabilitation of parents should be an additional focus especially when involuntary termination of parental rights is being considered.

The role of mental health professional (e.g. psychiatrists and psychologists) in conducting evaluations is that of professional expert who strives to maintain an unbiased objective stance. Mental health professional should understand that there are serious consequences of findings of psychological assessment in child protection matters as in the final dispositional hearing, these findings may be a factor in the decision to terminate parental rights. Mental health professionals conducting psychological assessments in CSA should know that competence in performing psychological assessments of children

and their families is necessary but not sufficient. Education, training, experience in areas of forensic practice, child and family development, child and family psychopathology, the impact of separation on the child, the nature of various types of child abuse and the importance of person to person differences are some of the additional areas that a mental health professional should be well versed with while dealing with CSA (U.S. Advisory Board on Child Abuse and Neglect 1995). Mental health professionals engaging in psychological assessments of CSA should be aware of personal biases regarding age, sex, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, culture and socio-economic status as it may interfere with an objective evaluation. Mental health professionals should make an effort to overcome these biases and if they cannot then they should withdraw from the evaluation. Awareness regarding diverse cultural and community methods of child rearing is of importance and these should not be overlooked while giving recommendations.

The scope of psychological evaluation may be limited to the question being asked by the referral agency, non-abusing parents who have brought a child or court. Sometimes it could be whether abuse has taken place or not, sometimes it can be about the rehabilitation of the child and the parents and at other times it could be the critical evaluation of assumptions and methodology adopted by another mental health professional in a case of child sexual abuse. Due to the nature of child protection matters, the complexity of the legal issues involved and the potential serious consequences of the evaluation, mental health professionals should be aware of the importance of issues like informed consent. Efforts toward obtaining informed consent should include a clear mention to the participants regarding the nature of the evaluation, the purpose, to whom the results of the psychological evaluation would be provided and the role of the mental health professional in relation to the referring party. It should be also made clear whether the child understands the nature of the tests and the evaluation process. It should be made clear to the child by professionals handling such cases that the child's interest is the primary interest and because of that interest the information will be shared by others. Mental health professionals conducting a psychological assessment in CSA case should ensure that the participants and the abused child are aware of the limits of confidentiality for the evaluation results. The evaluation results could be sought by a child or a child protection investigation agency, the court, a guardian of the child, or the attorney of either parent involved in the abuse. When an evaluation is court ordered then it is advisable that one should seek to reconcile the APA ethical committee standards with fulfilling demands of the court.

Mental health professionals must strive to use the most appropriate methods available to address the questions regarding the case at hand. Multiple data gathering techniques may be used e.g. clinical interviews, observations and/ or psychological testing. One may also review relevant reports like child protection agencies, childcare providers, law enforcement agencies, schools and institutions. An evaluation of the parenting capacity should be done which must include observation of the child-parent interaction in natural settings. This however, may not always be possible in cases where parental contact is prohibited by the court. It may also be necessary to evaluate other individuals like the caretakers, grandparents, and teachers.

Mental health professionals should refrain from drawing conclusions, which are not supported by data. It should be acknowledged in front of the court regarding the limitations in the methodology or data used. On the other hand, the participating child may be defensive due to the serious consequences of an adverse finding. A psychological evaluation in CSA should be supplemented by an opinion on the psychological functioning of an individual after conducting appropriate tests for the same. Finally, recommendations of the mental health professionals are based on whether the child's health and welfare have been and/or may be seriously harmed.

CONCLUSION

Behavioral/Psychological assessment of CSA is one of the most difficult tasks a mental health professional can face in clinical practice. High degree of physical and psychological consequences results from the complex interplay of individual, family related and social factors. Assessment of validity of alleged CSA is a tedious task with legal and social issues complicating the matter. Interviewer must be equipped with special expertise in assessment of these cases and should follow the general consensus arrived at by several researchers. Children's ability to recall information and or be prompted should be researched thoroughly in the future. There is also need for further research on the normal sexual behavior in children. Individualized treatment and establishment of a sound therapist-patient relationship still remains the corner stone for the treatment of CSA. Various professionals from the medical, social and psychological fields have not approached, understood and learnt to properly handle the issue in a holistic manner. Needless to say, sexual abuse in children (i.e.) is an area where questions definitely outnumber the answers.

References

- American Academy of Child and Adolescent Psychiatry (1988) Guidelines for the clinical evaluation of child and adolescent sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 25, 655-657.
- Atabaki, S. & Paradise, J.E. (1999). The medical evaluation of sexually abused child: Lessons from a decade research. *Pediatrics*, 104 (Supplement), 178-186.
- Bentovim, A., Elton, A., Hilderbrand, J., Tranter, M., Vizard, E. (1988) *Child Sexual Abuse within the Family*. London: Wright.
- Boat, B. & Everson, M. (1986) Using anatomical dolls: Guidelines for interviewing young children in sexual abuse investigations. Department of Psychiatry, University of North Carolina, Chapel Hill, North Carolina.
- Botash, A.S. (1997) Examination for sexual abuse in prepubertal children: an update. *Pediatric Annals*, 26, 312-320.
- Browne, A., & Finkelhor, D. (1986) Impact of child sexual abuse: A review of the research. *Psychological Bulletin*, 99, 66-77.
- Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., & Ernst, V. (2001) The Trauma Symptom Checklist for Children (TSCYC): reliability and association with abuse exposure in a multi-site study. *Journal of Child Abuse and Neglect*, 25 (8): 1001-1014.
- Bruck, M. & Ceci, S. (1993) Amicus brief for case of State of New Jersey v. Michaels presented by committee of concerned social scientists, *Psychology, Public Policy, and Law*, 1 (2), 272-322.
- Budin, L. & Johnson, C. (1989) Sex abuse prevention programmes: offenders' attitudes about their efficacy. *Child Abuse and Neglect*, 13, 77-87.
- Ceci, S. & Bruck, M. (1995) *Jeopardy in the courtroom: A scientific analysis of children's testimony*, Washington, DC: American Psychological Association.
- Chantler, L., Pelco L. & Mertin, P. (1993) The psychological evaluation of child sexual abuse using the Louisville behaviour checklist and human figure drawing. *Child Abuse and Neglect*, 17, 271-279.

- Committee on Ethical Guidelines for Forensic Psychologists (1991) Specialty Guidelines for Forensic Psychologists. *Law and Human Behavior*, 15, 655-665.
- Cotgrove, A.J. & Kolvin, I. (1996) The long term effects of child sexual abuse. *Hospital Update*, September 401-406.
- Conte, J., Wolfe, S. & Smith, T. (1989) What sexual offenders tell us about prevention strategies. *Child Abuse and Neglect*, 13, 293-302.
- DeVoe, E.R., & Faller, K.C. (2002) Questioning strategies in interviews with children who may have been sexually abused. *Child Welfare*, 81 (1), 5-31.
- Faller, K.C. (1993) US Department of Health and Human Services, Child Sexual Abuse: Intervention and Treatment Issues. Risk Assessment Protocol for Child Sexual Abuse, US Government Printing Office: Washington DC.
- Faller, K.C. (1993) US Department of Health and Human Services, Child Sexual Abuse: Intervention and Treatment Issues. Guidelines for Determining the likelihood Child Sexual Abuse Occurred, US Government Printing Office: Washington DC
- Faller, K.C. (2005) Anatomical dolls: their use in assessment of children who may have been sexually abused. *Journal of Child Sex Abuse*, 14 (3), 1-21.
- Finkelhor, D. (1984) *Child Sexual Abuse*. New York: Free Press.
- Friedrich, W.N. Grambsch, P., Broughton, D., Kuiper, J. & Beilke, R.L. (1991) Normative sexual behaviour in children. *Pediatrics*, 88, 456-464.
- Friedrich, W.N. Grambsch, P., Broughton, D., Kuiper, J. & Beilke, R.L. (1992) Child Sexual Behavior Inventory: Normative and Clinical Comparisons. *Psychological Assessment*, 4, 303-311.
- Gardner, R., (1992) *True and false accusations of child sex abuse*. New Jersey: Creative Therapeutics.
- Gardner, R. (1995) *Protocols for the Sex-Abuse Evaluation*. New Jersey: Creative Therapeutics.
- Glasser, M., Kovin, I., Campbell, D., Glasser, A., Leitch, I. & Farrely, S (2001) Cycle of Child Sexual Abuse: links between being a victim and becoming a perpetrator. *British Journal of Psychiatry*, 179, 482-494.
- Greenberg, S. (1990). Conducting unbiased sexual abuse evaluations. In *Preventing Sexual Abuse*, 8-14.
- Haj- Yahi, M.M. & Tamish, S. (2001) The rates of child sexual abuse and its psychological consequences as revealed by a study among Palestinian university students. *Child Abuse and Neglect*, 25, 1303-1327.
- Hanson, R.F., Saunders, B., Kilpatrick, D., Resnick, H., Crouch, J.A., Duncan, R. (2001) Impact of childhood rape and aggravation assault on adult mental health. *American Journal of Orthopsychiatry*. 71, 108-119.
- Hindman, J. (1985) *Avery touching book*. Ontario, Oregon: AlexAndria Associates.

- Hindman, J. (1987) Step by Step: Sixteen steps toward legally sound sexual abuse investigations. Ontario, Oregon: AlexAndria Associates.
- Johnson, C.F. (1990) Child abuse as a stressor of pediatricians. *Pediatric Emergency Care*, 15, 84-89.
- Johnson, C.F. (1999) The use of charts and models to facilitate a physician's testimony in court. *Child Maltreatment*, 4, 228-241.
- Johnson, C.F. (2004) Child Sexual Abuse. *Lancet*, 364, 62-470.
- Kendall-Tackett, K.A., Williams, L.M., Finkelhor, D. (1993) Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113, 164-180.
- Koocher, G., Goodman, G., White, S., Friedrich, W., Sivan, A., & Reynolds, C. (1994) Report of the Anatomical Doll Task Force to the American Psychological Association Council of Representatives: Psychological science and the use of anatomically detailed dolls in child sexual abuse assessments. Washington, DC: American Psychological Association.
- Lamb, M. (1994) The investigation of child sexual abuse: An interdisciplinary consensus statement. *Journal of Child Sex Abuse*, 3 (4), 93-132.
- Lamb, M., Sternberg, K., & Esplin, P. (1995) Making children into competent witnesses: Reactions to the amicus brief In re Michaels. *Psychology, Public Policy, and Law*, 1(2), 438-449.
- Leifer, M., Shapiro, J.P., Martone, M.W. & Kassem, L. (1991) Rorschach assessment of psychological functioning in sexually abused girls. *Journal of Personality Assessment* 56, 14-28.
- Loftus, E., & Ketcham, K. (1994) The myth of repressed memory. New York: St. Martin Press.
- Macfie, J., Cicchetti, D., Toth, S.L., (2001) Dissociation in maltreated versus non-maltreated preschool – aged children. *Child Abuse and Neglect*, 25, 1253-1267.
- McClellan, J., McCurry C., Ronnei, M., Adams, J., Eisner, A. & Storck, M. (1996) Age of onset of sexual abuse: relationship to sexually inappropriate behaviors. *Journals of the American Academy of Child and Adolescent Psychiatry*, 35, 1375-1383.
- McLeer, S., Deblinger, E., Henry, D. & Orvaschel, H. (1992) Sexually abused children at high risk for post- traumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 875-879.
- Molnar, B.E., Buka, B.C. & Kessler, R.C. (2001) Child Sexual Abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American Journal of Public Health*, 91, 753-760.
- Muram, D. (1989) Child Sexual Abuse: relationship between sexual acts and genital findings. *Child Abuse and Neglect*, 13, 211-216.
- Peters, D.F. (2001) Examining Child Sexual Abuse evaluations: the types of information affecting expert judgment *Child Abuse and Neglect*, 25, 149-178.
- Raskin, D., & Esplin, P. (1991) Statement Validity Assessment: interview procedures and content

- analysis of children's statements of sexual abuse. *Behavioral Assessment*, 13, 265-291.
- Raskin, D., & Esplin, P. (1991) Assessment of children's statement of abuse. In *The suggestibility of children's recollections* (Ed. J Doris) pp 153-164, Washington, DC: American Psychological Association.
- SCOSAC (1984). *Definition of Child Sexual Abuse*. London: Standing Committee on Sexually Abused Children.
- Terr, L. (1994) *Unchained memories*. New York: Basic Books.
- U.S. Advisory Board on Child Abuse and Neglect (1995) *A National Shame: Fatal Child Abuse and Neglect in the U.S. (5th Report)*. Washington, D.C.: u.s. Government Printing Office
- Wells, R.D., McCann, J., Adams, J., Voris, J. & Ensign, J. (1995) Emotional behavioral and physical symptoms reported by parents of sexually abused, non- abused and allegedly abused prepubescent females. *Child Abuse and Neglect*, 19, 455-463.
- Wells, G., & Loftus, E. (1991) Commentary: Is this child fabricating? Reactions to a new assessment technique. In J. Doris (Ed.), *The suggestibility of children's recollections*, pp. 168-171, Washington, DC: American Psychological Association
- Willis, B.M. & Levy, B.S. (2002) Child Prostitution: global health burden, research needs and interventions. *Lancet*, 359, 1417-1422
- Wolfe, V., Gentile, C., Michienzi, T., Sas, L. & Wolfe, D. (1991) The children's impact of traumatic events scale: a measure of post- sexual abuse PTSD symptoms. *Behavioral Assessment*, 13, 359-383.
- Yuillie, J.C., Hunter, J., Joffe, R., & Zaparniuk, J. (1997) Interviewing children in sexual abuse cases. In: *Child Victims, Child Witnesses: Understanding and Improving Testimony*. Goodman, G.S., Bottoms, B.L. (Eds.), New York, Gillford.

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