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## Practice Parameters for the Forensic Evaluation of Children and Adolescents Who May Have Been Physically or Sexually Abused

### ABSTRACT

These practice parameters describe the forensic evaluation of children and adolescents who may have been physically or sexually abused. The recommendations are drawn from guidelines that have been published by various professional organizations and authors and are based on available scientific research and the current state of clinical practice. These parameters consider the clinical presentation of abused children, normative sexual behavior of children, interview techniques, the possibility of false statements, the assessment of credibility, and important forensic issues. These parameters were approved by Council of the American Academy of Child and Adolescent Psychiatry in September 1996. *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36(3):423-442. Key Words: child abuse, sexual abuse, forensic, evaluation, practice parameters.

Individuals in private practice, as well as those employed by courts or other agencies, see children who may have been mentally, physically, or sexually abused. There are three distinct roles for them: forensic evaluator; clinician, who is conducting mental health assessments and providing treatment; and consultant regarding public policy.

Working as a forensic evaluator, the practitioner may evaluate children in a private practice for a forensic purpose, evaluate children and collaborate with other mental health professionals in a government agency such as protective

services, or work with an interdisciplinary team at a pediatric medical center. He or she may assist the court in determining what happened to the child, make recommendations regarding placement or treatment, or offer an opinion on the termination of parental rights. A forensic evaluation may involve critiquing the work that was previously done by another mental health professional or by a protective services investigator. The forensic evaluation may be used in a civil suit in which the child is a plaintiff seeking remuneration for damages related to the abuse. The evaluator may be asked to testify in a juvenile court (regarding the issue of abuse and neglect), in a civil court (if a civil suit is being pursued), or in a criminal court (if the alleged perpetrator comes to trial).

Working as clinicians, mental health professionals may provide assessments and treatment for abused children and their families in both outpatient and inpatient settings. Many psychiatric hospitals and residential treatment centers have specialized programs for abused children and adolescents. There are also programs for adolescent perpetrators of sexual abuse, many of whom were also victims of sexual abuse.

Mental health professionals may deal with these issues on the level of public policy by sharing information with and educating attorneys and judges about the psychiatric aspects of abuse and the developmental needs of children (Goldstein et al., 1973, 1979). In some states, clinicians have helped shape the laws that control how the legal system deals with abused children, including the criteria for reporting abuse and the methods of evaluation and procedures for hearing the child's testimony.

There are some differences in the method of evaluating children who may have been abused, depending on whether

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*These parameters were developed by the Work Group on Quality Issues, William Aron, M.D., and John E. Duane, M.D., Chairmen. Members: Elius Benedick, M.D., Carl A. Bernstein, M.D., Fitz Bryant, M.D., Richard L. Cirio, M.D., Robert King, M.D., Henrietta Leonard, M.D., William Licamele, M.D., Jon McJellan, M.D., and Karla Shaw, M.D. Technical Assistance: Gail Carlton, M.D. AACAP Staff: Mary Grothman, Leslie Seigle, Carolyn A. Heier, Michelle E. Wrigley, and Diane Wiegand, R.N. Consultants and other individuals who commented on a draft of these parameters included Peter Ash, M.D., Barbara W. Bout, Ph.D., Stephen Cretz, Ph.D., David L. Carnon, M.D., Carol P. DeAntonio, M.D., Andrew P. Donderyn, M.D., Phillip W. Eplien, Ed.D., Mark D. Everson, Ph.D., Daniel M.A. Freeman, M.D., Richard Gaudin, M.D., Carl S. Goodman, Ph.D., Lawrence Hammann, M.D., J. Ronald Heller, M.D., Stephen Herman, M.D., William Kenner, M.D., Barry Nunnally, M.D., Erna Olsjan, Ph.D., Alvin A. Rosenfeld, M.D., Diane Schetty, M.D., Fredrick Salzman, M.D., Sidney Workman, M.D., and Alysia Yates, M.D.*

*A draft of these parameters was distributed to the entire AACAP membership for comment. The parameters were approved by the AACAP Council on August 22, 1996.*

*Reprint requests to AACAP Public Information, 3615 Wisconsin Avenue, N.W., Washington, DC, 20016.*

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**8.08 Informed Consent.** The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic social policy for which exceptions are permitted: (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forgo needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment. (I, II, III, IV, V)

Issued March 1981.

W. Va. 1995 West Virginia Board of Medicine received a complaint from patient that physician was using depositions treatment. The hearing examiner in part found that there had been a lack of informed consent for such treatment. The Board changed the examiner's report and added sanctions. In doing so, it quoted Opinion 8.08. On appeal, the circuit court reversed, finding the Board's order arbitrary and an abuse of discretion. The appellate court agreed that the Board abused its discretion, but remanded the case for consideration of the issue of informed consent for depositions treatment. *Modi v. West Virginia Board of Medicine*, 465 S.E.2d 230, 236.

Journal 1995 Observes that physicians are unable to obtain informed consent because they can not guess which treatment alternatives will best serve an individual patient's interests. Suggests that this situation would be improved if patients were paired with physicians who share their personal values. Quotes Opinion 8.08. *Veitch, Abandoning Informed Consent*, 25 *Hastings Center Rep.* 3, 6 (March/April 1995).

Journal 1994 Discusses how physicians historically have taken too much license with patient bodies and placed greater value on longevity than on quality of life. Argues that patients should be the ultimate decisionmakers in matters that affect their lives. Suggests that greater emphasis should be given to physician disclosure obligations in order to improve the quality of patient consent. Quotes Opinion 8.07 (1981) (now Opinion 8.08) Katz, *Informed Consent — Must It Remain a Fairy Tale?* 10 *J. Contemp. Health L. & Pol'y* 69, 80 (1994).

Journal 1994 Reviews the evolution of the physician-patient relationship. Describes legal responses to increasing awareness of the importance of ensuring patient autonomy. Examines the changing health care delivery environment. Concludes with a discussion of the impact of these changes on patient participation in medical decision making. Quotes Preamble, Principles I, II, III, IV, V, and VI, Fundamental Elements (1) and (2), and Opinions 1.02 and 8.07 (1981)

# Understanding Bizarre, Improbable, and Fantastic Elements in Children's Accounts of Abuse

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*Children's accounts of abuse sometimes contain descriptions of events that seem bizarre, improbable, or even impossible. This article contributes to an objective analysis of child allegations of abuse by offering 24 possible explanations (with illustrative case examples) for such statements. The central thesis of this discussion is that the existence of improbable or fantastic elements in a child's account should not result in an automatic dismissal of the child's report without consideration of the possible mechanisms underlying the fantastic material.*

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In the past decade, a number of widely publicized cases of alleged day care abuse have called attention to a seldom acknowledged phenomenon in the field of child abuse—that is, that children's accounts of abuse sometimes contain descriptions of events that seem bizarre, improbable, or even impossible. In a number of cases, especially those involving young children, the accounts of abuse seem to contain the stuff of fantasy (or perhaps nightmares) rather than the credible, internally consistent, plausible descriptions of abuse that professionals are trained to expect in bona fide cases of abuse.

Although this problem may be more prevalent and more severe in multivictim, multiperpetrator cases involving preschool-aged children, it is certainly not confined to such cases. As an example, we recently evaluated a bright, articulate 4-year-old whose otherwise credible account of abuse was marred by his claim that the perpetrator had cut off the boy's penis, then reattached it. Many clinicians have been reluctant to report such elements in children's disclosures lest a child's account, which might otherwise be considered credible, not be believed. In addition, some clinicians have been actively discouraged from documenting such statements as a part of the public record. (In the words of one district attorney to a colleague, "Your

report was fine until you mentioned the mask and the candles.")

Evaluating allegations of abuse involving bizarre, implausible, and fantastic accounts by children is one of the most difficult forensic and clinical challenges confronting the field today. If Parts E and F of a child's account of abuse are difficult, if not impossible, to believe, how much credence should the evaluator give Parts A, B, and C? In a survey of child protective services (CPS) investigations, Everson and Boat (1989) found that, after recantation by the child, the most frequent reason for judging a child's report of sexual abuse to be false was the existence of improbable elements in the child's disclosure. This issue not only affects the individual case but also has far-reaching implications for the credibility of the field and the weight we have traditionally placed on the alleged victim's statement.

Dalenberg (1996) has published the only study of the incidence of fantastic elements in children's disclosures of sexual abuse. Her sample included 644 children ages 3 to 17 who had made disclosures of sexual abuse during videotaped forensic interviews. Half of the children comprised a highly certain, or "gold standard," sexually abused group (i.e., the perpetrator had confessed and conclusive medical evidence of abuse had been found), and the remaining half included "questionable" cases in which corroborating evidence for abuse was lacking. Dalenberg defined fantastic elements as either highly implausible or impossible events or gross exaggerations of a plausible event. Fantastic elements were found in the accounts of 12 children for an overall base rate across age, sex, and race of about 2%. Most of these statements ( $n = 10$ ) occurred among 3- to 9-year-olds in the gold standard subgroup, with 7% of the children in

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## Special Article

# On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness

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**Objective:** This article explores the clinical, legal, and ethical problems that typically occur when a psychotherapist serves as both a treating clinician and forensic evaluator (or expert witness) in the same case. **Method:** The professional literature, ethics codes, opinion surveys, and the changing economic and institutional contexts of psychotherapy are reviewed in order to identify obstacles to widespread recognition of this straightforward ethical issue. The processes of psychotherapy and forensic evaluation are then analyzed so as to reveal fundamental incompatibilities between the psychotherapist's clinical and legal functions. **Results:** Attempting to treat and evaluate the same person typically creates an irreconcilable role conflict. This role conflict manifests itself in different conceptions of truth and causation, different forms of alliance, different types of assessment, and different ethical guidelines. **Conclusions:** Although circumstances sometimes compel a practitioner to assume the dual role of treater and evaluator, the problems that surround this practice argue for its avoidance whenever possible.

(*Am J Psychiatry* 1997; 154:448-456)

Should psychotherapists serve as expert witnesses for their patients? Psychotherapists of all disciplines need to confront the potential clinical, legal, and ethical problems involved in combining the roles of treating clinician and forensic evaluator. As clinicians and themselves drawn into proliferating, often ambiguously defined contacts with the legal system, clarity in definitions becomes crucial.

### DEFINITIONS

The term "therapist" refers to a clinician hired by the patient or the patient's family to provide psychotherapy. Therapists treat "patients" or "clients." A "fact witness" testifies as to direct observations that he or she made; a fact witness does not offer expert opinions or draw conclusions from the reports of others. Thus, a therapist who serves as a fact witness testifies as to

observations of the patient during therapy and the immediate conclusions (such as diagnosis and prognosis) drawn from those observations. These conclusions are offered not as an opinion but simply as a report of what the therapist thought, did, and documented during therapy.

An "expert witness" (who may also act as a forensic consultant) is a paid consultant who chooses to become involved in the case and is retained by an attorney, judge, or litigant to provide evaluation and testimony to aid the legal process. Unlike a fact witness, an expert may offer opinions about legal questions. This role typically involves participation in a trial. Forensic experts deal with "examinees" or "evaluatees" rather than with patients or clients. They do not attempt to form a doctor-patient relationship with their subjects.

### COMMON SCENARIOS

Several common scenarios may prompt a clinician to wear the two hats of treater and expert on behalf of the same person. A patient may have suffered a traumatic incident (such as a criminal assault or an automobile accident) during or before therapy, and litigation may ensue. A patient may become involved in child custody litigation. A referral may come from an attorney osten-

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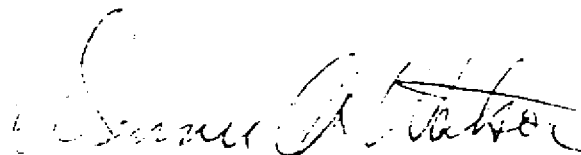


**PROOF OF SERVICE**

Pursuant to Pa. Rule of Appellate Procedure 2187(a), two copies of the within Brief of Amicus Curiae, Program in Psychiatry and the Law and the American Professional Society on the Abuse of Children in Support of Appellants, were served on the following counsel for Appellees, by the method indicated, on December 28, 1998:

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