The Clinical-Forensic Dichotomy in Sexual Abuse Evaluations: Moving Toward an Integrative Model

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Online publication date: 05 October 2010


To link to this Article DOI: 10.1080/10538712.2010.512553
URL: http://dx.doi.org/10.1080/10538712.2010.512553

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The Clinical–Forensic Dichotomy in Sexual Abuse Evaluations: Moving Toward an Integrative Model

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We propose the use of an approach to evaluation that can be undertaken in a clinical setting when concerns regarding child sexual abuse are unclear or ambiguous and other systems are not involved, thus providing an option for the nondisclosing child often discussed in the “delayed disclosure” literature. This approach can also be appropriate for a child with a questionable prior disclosure not being served by other intervention systems. We have labeled this an “integrative” model, incorporating forensically sound practices into evaluations conducted in a clinical setting. The goals of this manuscript are to (a) provide a rationale for conducting child sexual abuse extended evaluations in a clinical setting, (b) delineate the purposes of such evaluations, (c) differentiate this “integrative” model from the forensic–clinical dichotomy framework discussed by Kuehnle (1996), and (d) briefly describe the format, which can be refined by future practice and research.

KEYWORDS clinical evaluation of child sexual abuse, forensic evaluation of child sexual abuse, assessment, evaluation of child

Submitted 17 March 2010; revised 15 June 2010; accepted 16 June 2010.
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Child sexual abuse (CSA) is a highly complex and controversial phenomenon, and a topic of ongoing debate in professional journals. Animated discussions take place relative to definitional issues (e.g., Haugaard, 2000), and professional discourse abounds regarding the frequency of recantation following disclosure (e.g., London, Bruck, Ceci, & Shuman, 2005; London, Bruck, Wright, & Ceci, 2008; Malloy, Lyon, & Quas, 2007), the frequency of false allegations (e.g., Faller, 2007; Lipian, Mills, & Brantman, 2004; Trocmé & Bala, 2005), and whether victims are prone to forgetting (or repressing) memories of sexual abuse experiences (e.g., Freyd, DePrince, & Gleaves, 2007; Ghetti et al., 2006; Greenhoot & Tsethlikai, 2009; McNally, 2004, 2007). Remarkably, however, even among authors who sharply disagree on many aspects of the problem of CSA, there seems to be consensus that children typically delay in telling others about their abuse experiences (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Hershkowitz, Lanes, & Lamb, 2007; London et al., 2005, 2008; Paine & Hansen, 2002; Smith et al., 2000). For instance, while London and colleagues (2005, 2008) argued that children are unlikely to recant disclosures, they acknowledged that children frequently delay disclosing sexual abuse for significant periods of time. Among a cohort of women with documented histories of rape during childhood, Smith and colleagues (2000) found that approximately 50% delayed disclosing these experiences for at least five years while approximately 25% reported not disclosing the abuse until they were surveyed as adults.

Although the factors influencing a child’s decision to disclose are idiosyncratic for each child, they encompass developmental, sociocultural, and psychological/emotional issues. For example, some children are constrained by developmental and language limitations, either because they are too young to effectively communicate their experiences verbally or due to cognitive or language based disabilities, including mental retardation and pervasive developmental disorders. Other factors may also prohibit a child’s disclosure. A nonexhaustive list of the ecological factors potentially relevant to delayed disclosure includes: dependence on a perpetrator for care (e.g., physically disabled children, hearing or visually impaired children), financial dependence on a perpetrator, fear of retribution by a perpetrator, a desire to spare family members the emotional pain likely associated with disclosure, and fear of not being believed or blamed for the abuse. From a psychological standpoint, children are often emotionally attached to perpetrators, especially in-familial perpetrators, and they may experience feelings of self-blame and humiliation as well as a wish to avoid the embarrassment of discussing intimate details of sexual interactions. Children may also be reluctant to disclose information that they fear may destroy/shame the family and/or may result in job loss and possible incarceration of the
perpetrator, who may play a significant role in the child’s life and who may also be well regarded by the extended family and the community (see Goodman-Brown et al., 2003, and Paine & Hansen, 2002, for a review of some of the predominant factors linked to delays in disclosure).

Much of the methodological research on techniques utilized in interviewing children for suspected sexual abuse and/or formats for sexual abuse evaluations has placed emphasis on enhancing assessment conducted as part of the criminal justice process or as part of the probate process. The latter takes place when allegations of CSA have emerged in the context of disputes over custody and parental access in cases of high conflict divorce often following a child’s alleged disclosure. Notably absent from this discourse, however, is another category of cases whereby sexual abuse of a child is suspected but there has been no disclosure or a disclosure may be unlikely, yet the child may be living in the aftermath of either a single episode or ongoing sexual abuse. Prior to disclosure or to their identification as possible victims, these children interact with numerous peers, adults, and siblings in all the contexts of daily life (e.g., home, school, sports, and religious institutions). Literature suggests that children’s reactions to sexual abuse vary, with some exhibiting traumatic reactions and others displaying less discernable responses that can modify over the course of development (e.g., Kendall-Tackett, Williams, & Finkelhor, 1993; Maniglio, 2009; Putnam, 2003). Nevertheless, it is likely that unidentified victims of sexual abuse may be among those children who present in mental health clinics or who are referred for school-based evaluations due to poor school performance or behavioral problems (Tishelman, Haney, Greenwald-O’Brien, & Blaustein, in press).

The general purpose of this paper is to propose the use of an approach to evaluation that can be undertaken in a clinical setting when concerns regarding CSA are unclear or ambiguous and other systems (child protection, legal) are not involved. This provides an evaluation option for the nondisclosing child for whom CSA concerns have been raised. This approach can also be appropriate for a child with a questionable prior disclosure who is not being served by other intervention systems. We have labeled this an “integrative” model, incorporating both clinically and forensically sound practices. The goals of this paper are to (a) provide a rationale for conducting CSA extended evaluations in a clinical setting, (b) delineate the purposes of such evaluations, (c) differentiate this “integrative” model from the forensic–clinical dichotomy framework discussed by Kuehnle (1996), and (d) briefly describe the format of the evaluation, which can be refined by future practice and research. The overarching goal is to explain the logic that forms the basis of the integrative model as well as broad aspects of our clinical approach. We therefore expound in some detail upon general practice issues but refrain from discussion of some of the more nuanced aspects of evaluations, as such elaboration is beyond the scope of this manuscript and
because we anticipate that clinical practices will continue to evolve based on emerging research.

**RATIONALE FOR INTEGRATIVE MODEL**

There is scant literature addressing the methodology for conducting extended evaluations of suspected child victims of sexual abuse for whom typical forensic processes do not appear to meet their needs (e.g., Carnes, Nelson-Gardell, Wilson, & Orgassa, 2001; Carnes, Wilson, & Nelson-Gardell, 1999; Faller, Nelson-Gardell, & Cordisco-Steele, this issue; Herman, 2009). This literature generally focuses on: (a) working within, or in concert with, the legal system; (b) enhancing disclosures believed to be valid or accurate; and (c) the optimal number of sessions required to give the child maximum opportunity to disclose if he or she has something to disclose. Importantly, a number of researchers have noted that multiple forensic interviews can be utilized with some children, without compromising the quality of information obtained if forensic standards are upheld (Faller et al., this issue; Faller & Nelson-Gardell, in press). For instance, Hershkowitz and Terner (2007) found that new details were recounted by children in a second forensic interview. Carnes and colleagues (2001) found that in their National Child Advocacy Center (NCAC) extended forensic evaluation model, more than four sessions were needed to facilitate child disclosure, and they recommended five as the optimal number. Faller and Nelson-Gardell found that children assigned to an eight-session protocol were more likely to credibly disclose CSA than those assigned to a four-session protocol. Others, such as Connell (2009), have noted that more research is needed relative to conducting repeated interviews without confounding the data. Faller and colleagues (this issue) provide a review of literature supporting an extended evaluation framework for interviewing children when CSA is suspected.

In contrast to much of the prior literature, however, we wish to shift the focus from those children whose needs appear to be well served in the forensic arena to those who in the absence of a disclosure, or with vague or partial disclosures, are believed to be at risk for sexual abuse. We believe that there is a need for professional attention, research, and training focused on accurately identifying children suspected of having been sexually abused who have not disclosed yet may be coping with the effects and aftereffects of abuse. Additionally, there is a need to develop research methodologies to validly distinguish victims of CSA from nonvictims for whom concerns regarding possible sexual abuse have been raised in good faith. This should occur without the need to rely exclusively on a child’s disclosure or in effect without relying on a child’s ability to protect himself or herself by recruiting help via disclosure. As noted, we know from past research that children are often unable to ask adults to intervene within an optimal time frame.
Trajectory of Suspected CSA Cases

The trajectory of cases of suspected sexual abuse may be disparate depending on certain key factors. For instance, if a child makes a statement suggestive of sexual abuse, the state child protection agency can be alerted and the child can be referred for a forensic interview. In many cases, representatives of the child protection agency and the legal system are able to coordinate the intervention through Child Advocacy Centers (CAC). If a child makes a clear and convincing disclosure of abuse during a forensic interview, or even multiple forensic interviews, it is much more likely that the abuse will be substantiated, and the systems will be able to intervene on behalf of the child as well as possibly initiate criminal action against the alleged perpetrator. However, if the child’s statements do not meet the standard for the criminal justice system to file charges and move forward with prosecution, it is likely that the allegation will be unsubstantiated and the child protection agency may close the case. It must be noted, however, that an unsubstantiated case of CSA suggests only that there is not enough information to confirm CSA with reasonable certainty. It does not answer the ultimate question of whether or not a child has been sexually abused, and therefore the original concerns about possible sexual abuse may remain. In fact, parents, guardians, teachers, and other significant adults in a child’s life may maintain fixed beliefs about whether or not CSA has occurred (the child definitely has/has not been abused), and their interactions with a child are influenced by these beliefs. Common sense, as well as aspects of the suggestibility literature, indicates that a child may become increasingly confused when conflicting beliefs are held by significant individuals in his or her life. In some cases, the child may be well aware that the abuse is occurring but is unwilling or unable to disclose it. Nonperpetrating adults may also be motivated to keep the abuse a secret for a variety of reasons and/or maintain the belief that the CSA concerns are without basis.

Mental Health Intervention prior to Evaluation

When suspicions of CSA remain unresolved, those individuals involved in a child’s life (e.g., parents, teachers, pediatricians, and others) are often at a loss as to how or whether to intervene on a child’s behalf. Not infrequently, ongoing concerns result in referral of the child and/or family for mental health treatment. As noted by Kuehnle and Connell (this issue), referring a child suspected of having been sexually abused for psychotherapy related to CSA concerns prior to conducting an evaluation to determine the child’s and family’s needs carries with it several very significant risks and may even cause harm for many reasons:

1. If a therapist assumes that sexual abuse has occurred without confirmation, the child may be prematurely engaged in some form of sexual
abuse or trauma treatment. If the concerns about possible sexual abuse are unfounded (e.g., a mistaken interpretation of a child’s statements and/or behaviors), the child may not need psychotherapy. Unfortunately, research has not yet addressed the issue of whether children are harmed by being treated for sexual abuse sequelae if the abuse never occurred. Nevertheless, common sense suggests that it is hardly in a child’s best interest to grow up incorrectly believing he or she was sexually abused. At the very least, such treatment could not only be confusing to a child but also convey the erroneous yet potent message that he or she is struggling with mental health issues or social/family problems for misconstrued reasons.

Without an in depth understanding of the child and family’s strengths and weaknesses and an exploration of the factors prompting concerns about possible CSA and potential risks, mental health interventions may actually jeopardize the child’s well-being. In the case of a nondisclosing victim in therapy, a perpetrator with ongoing access to the child (e.g., parent, priest, teacher, coach) may become aware of the concerns and therapeutic interventions and further pressure a child to maintain secrecy, whether through coercion, threats, or other means. In other cases, sexual abuse concerns may have been raised erroneously and interventions for problems other than CSA are sorely needed yet would be unlikely to be accessed without an evaluation uncovering causes for the presenting concerns. For instance, sexualized behavior may be related to sexual abuse but can also serve a self-soothing function, may reduce anxiety, may be an attention-seeking behavior or reflect ignorance of social norms (sometimes associated with age or certain developmental disabilities). It is of paramount importance that an evaluation be conducted by a forensically sophisticated clinician knowledgeable about CSA and ongoing risks who can then recommend interventions tailored to the child and family’s needs.

2. Consistent with the previous discussion, treating a child for the sequelae of CSA, whether or not the CSA actually occurred, can confound any subsequent attempts to address the sexual abuse concerns (Kuehnle & Connell, this issue). In other words, beginning psychotherapy prior to a thorough evaluation runs the risk that a child will adopt the beliefs about CSA presented to him or her through inadvertent or directly suggestive interactions at home and/or in therapy (see Bruck & Ceci, 2004; Malloy & Quas, 2009, for further discussion of child suggestibility). Thus, precipitous intervention may actually obstruct future attempts at criminal prosecution and/or contaminate custody/access decision making in a family court process even when a child has been sexually abused because valid information may no longer be accessible. Even if a child eventually discloses sexual abuse, it is possible that his or her disclosure will be viewed with considerable skepticism. As in many cases of adult rape, CSA usually occurs in private and there may not be any medical or forensic evidence to corroborate it; it is thus critical not to contaminate a child’s memory and/or report. Most mental health
professionals lack the training to provide services to children and families in a therapeutic setting in a way that avoids conveying to a child their own beliefs about whether a child has been sexually victimized. In summary, if a child has been sexually abused, certain therapeutic practices could potentially call into question any subsequent disclosures, preclude the child protection agency’s ability to protect the child, obstruct criminal prosecution, and confound probate determinations regarding an alleged perpetrator’s access to a child.

3. Finally and perhaps most importantly, absent a disclosure children for whom concerns of CSA are raised may be unsafe and endure chronic abuse. Extended evaluation, while not necessarily definitive, provides an opportunity to gather extensive information to help ameliorate a crisis or obtain new information to allow protective services and other systems to provide services to the child or family. Without such evaluation, the most vulnerable children may elude our best efforts to help.

Child Protection Clinical Services

Child Protection Clinical Services (CPCS) was an outpatient clinic at Children’s Hospital, Boston (CHB) in which extended evaluations of children were conducted when CSA was suspected but for a variety of reasons the children were unable to be served by the formal intervention system. These reasons could include: (a) CSA concerns were never reported to a state child protection agency due to insufficient information; (b) suspicions of CSA rose to the level of a mandated report to the state child protection agency but the report was either screened out or not investigated due to a paucity of information, screened out because the alleged perpetrator was not a caregiver, or unsubstantiated following a brief investigation period; (c) the child was unable to participate in a forensic interview (e.g., the child was too young and/or had communication limitations, or the case was not involved in the criminal justice system); and/or (d) the child provided insufficient or confusing information during a forensic interview, resulting in ambiguity regarding the suspected sexual abuse.

Preliminary intake data at CPCS

Tishelman, Meyer, and Haney (2005) conducted a preliminary analysis of intake information of 101 cases referred to CPCS during a six-month period in 2004. The four most frequently identified factors underlying suspicion of CSA that motivated requests for CSA evaluations over a six month time period, as reported during a telephone intake interview, were (a) sexualized behaviors and/or activities (e.g., masturbation, sexual activity with peer or younger child, other sexualized behavior), 58.7%; (b) disclosure requiring further evaluation, 40.6%; (c) nonspecific sexual statements, 16.8%; and
TABLE 1 Bases for Referral for Extended Sexual Abuse Evaluations (N = 101)

<table>
<thead>
<tr>
<th>Basis for referral</th>
<th>%</th>
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<tbody>
<tr>
<td>Disclosure (requiring further evaluation)</td>
<td>40.6</td>
</tr>
<tr>
<td>Sexualized Behavior</td>
<td>26.9</td>
</tr>
<tr>
<td>Nonspecific Suggestive Statement</td>
<td>16.8</td>
</tr>
<tr>
<td>Medical Findings (actual or suspected)</td>
<td>15.8</td>
</tr>
<tr>
<td>Sexual Activity with Peer</td>
<td>14.9</td>
</tr>
<tr>
<td>Masturbation</td>
<td>12.9</td>
</tr>
<tr>
<td>Statement of Unusual Bodily Concern</td>
<td>11.9</td>
</tr>
<tr>
<td>Sexual Activity with Adult or Older Child</td>
<td>11.9</td>
</tr>
<tr>
<td>Behavioral Symptom (not sexual)</td>
<td>8.0</td>
</tr>
<tr>
<td>Exposure to Distrusted Individual</td>
<td>7.0</td>
</tr>
<tr>
<td>Sexual Activity with Younger Child</td>
<td>4.0</td>
</tr>
<tr>
<td>Disclosure by Other</td>
<td>3.0</td>
</tr>
<tr>
<td>Unusual Sexual Statement</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Note: Children could present with more than one concern.

(d) medical findings (actual or suspected), 15.8% (note: children could present with more than one concern). It is notable that a child's disclosure was not the most frequently cited reason for seeking a sexual abuse evaluation, with only 40% of referrals involving children who reportedly had made prior disclosures suggestive of CSA. Instead, inconclusive or ambiguous behavioral data accounted for many concerns, especially sexualized behavior that was considered to be age-inappropriate by the child's caregivers and/or others in the child's life (e.g., school personnel, mental health providers, etc.). Many of these children had never had mandated reports filed with a child protection agency, and if reports were made they were screened out due to insufficient data to warrant an investigation, yet caregiver worries concerning the possibility of CSA remained. A number of children had never been referred, nor were they eligible, for an investigative interview at a CAC or anywhere else. In some cases, referred children were in foster care for other forms of maltreatment when concerns regarding CSA emerged. Table 1 lists all of the reasons children were referred to CPCS for extended evaluations during the period of this pilot analysis.

CLINICAL–FORENSIC DICHOTOMY VERSUS INTEGRATIVE MODEL

Some authors have proposed that when working in the realm of CSA, clinical and forensic practices are distinct, nonoverlapping, and incompatible. Kuehnle (1996) differentiated clinical and forensic models along the following dimensions: identity of the client, focus of the evaluation, role of the evaluator, goals of the evaluation, confidentiality, assumptions, and decision making. She noted the following distinctions:
• Client: While in the forensic model the court is the client, in the clinical model the client is the child/family.
• Focus: Parameters are set by the court and legally defined in a forensic model, while they are broader in a clinical model.
• Evaluator role: In a forensic model the evaluator must adopt a neutral and objective stance, in contrast to the clinical model whereby the evaluator is an advocate for the child and therefore not considered neutral.
• Evaluator goals: While in the forensic model the evaluator gathers information to inform the court, in a clinical model the goal is to help the child.
• Confidentiality: In the forensic model it is presumed that there is no confidentiality, in contrast to the clinical model where confidentiality is “complete.”
• Assumptions: In the forensic model the evaluator is obliged to consider multiple hypotheses, while in a clinical model the clinician assumes trust in the client report.
• Decision maker: Finally, in a forensic process the decision maker is the trier of fact, while in the clinical context clinicians ultimately make decisions regarding the client.

Tishelman, Meyer, Haney, McLeod, and Wilson (2004) developed a model that draws on and expands the Kuehnle (1996) framework described previously. Their model is tailored to the evaluation of children and families in an outpatient setting when CSA is suspected but outside systems either are not yet involved with the family or cease active involvement. This framework of evaluation, labeled an “integrative” model, is best utilized when the sexual abuse evaluation is undertaken in a clinical rather than forensic setting and thus the client is the child and family rather than the court. In these cases, the format of the evaluation must incorporate techniques utilized by forensic evaluators in order to ensure that the information obtained does not compromise future legal involvement and that any information related to CSA that may be obtained is optimally helpful both clinically and forensically. This framework is depicted in Table 2. Notably, it is incumbent on

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>Sexual Abuse Evaluations: Integrative Model</th>
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<tbody>
<tr>
<td>Factors</td>
<td>Integrative model</td>
</tr>
<tr>
<td>Client</td>
<td>Child/Family</td>
</tr>
<tr>
<td>Focus</td>
<td>Multifaceted</td>
</tr>
<tr>
<td>Evaluator’s Role</td>
<td>Objective–Empathic</td>
</tr>
<tr>
<td>Evaluation Goals</td>
<td>Multipurpose, Fluid</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Limited</td>
</tr>
<tr>
<td>Assumptions</td>
<td>Multiple Hypotheses</td>
</tr>
<tr>
<td>Decision Maker</td>
<td>Clinician</td>
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clinicians practicing outside of the forensic arena to have sufficient knowledge of forensic standards in order to be able to balance the needs and goals of their clients (child/family) while maintaining objectivity regarding the question of whether sexual abuse occurred while the evaluation process is ongoing. Holding multiple hypotheses and maintaining neutrality regarding the ultimate findings of the evaluation is critical but not much different from any psychological evaluation process involving the objective collection and interpretation of data, to the extent possible. Just as a neuropsychologist should not at the start of an evaluation assume any specific results from the assessment (as that risks tainting findings), a CSA evaluation in an outpatient setting should be conducted in the absence of biasing assumptions regarding the likelihood that a child has been sexually abused and/or is traumatized. Therefore, the goal of evaluation is not defined as facilitating a disclosure but instead to develop a broad understanding of the presenting concerns, as for some children (those never abused, for instance) a disclosure should not be forthcoming. Instead, the clinician must generate and explore multiple hypotheses related to the presenting concerns in order to avoid what is typically referred to as confirmatory bias. In addition, sexual abuse evaluations are by definition requested when there are concerns that a child has been sexually abused and if the evaluation raises suspicion of CSA mandated reports to child protection agencies are obligatory. Thus, families need to be specifically informed that confidentiality applies but is limited by mandated reporting requirements as well as possible future requests for records by a probate or criminal court, if these systems subsequently become involved. Finally, as noted in Table 2, this model of evaluation includes goals beyond those typically associated with forensic interviews:

- To assess factors relevant to sexual abuse
- To assess the general mental health of the child, including possible trauma
- To assess risk factors in a child’s life (e.g., developmental, medical, psychosocial, and cultural)
- To assess the child, family, and ecological/cultural strengths/protective factors
- To provide the family with psychoeducational resources
- To make recommendations suited to the needs of the child and his or her family

In a hospital setting, evaluations such as the model described previously can include child sensitive medical examinations by highly trained physicians or nurses with special expertise in the area of CSA when such examinations have not previously taken place. Such medical examinations can provide useful information complementing the psychosocial information and at times can be reassuring to children and families (e.g., Newton
& Vandeven, in press). In rare cases, such examinations can provide critical information useful in comprehending the presenting concerns. This is particularly relevant in the exceptional cases when medical findings in a nondisclosing child are strongly indicative of CSA.

In no way are extended CSA evaluations conducted in clinical settings meant to obviate the need for criminal investigation when sexual abuse is suspected. Instead, this model of evaluation has the potential to identify children at risk so that an initial report can be tendered and forensic processes pursued as appropriate or to identify possible resources to assist the family in addressing their concerns even if the data obtained during the evaluation do not appear to support sexual abuse or is nonconfirmatory.

INTEGRATIVE MODEL

The components of the integrative model utilized by the authors in an outpatient clinic included: (a) child interviews (2–6), (b) parent/caregiver interviews (multiple), (c) document review, (d) interviews with collateral sources, and (e) use of standardized measures to supplement understanding of the child’s behavioral and emotional functioning. This approach, based on a modified and adapted version of the NCAC model (Carnes, 2002) and Kuehnle (1996), was flexible depending on the age of the child and the presenting concerns of the child and family, and it was primarily aimed to illuminate whether a child seemed to be at immediate risk; evaluate whether concerns of CSA were high, indeterminate, or low based upon the information gathered; and provide information about best steps for the family and child following the evaluation. A trauma evaluation and mental health screening was embedded within each evaluation. Again, it is notable that these evaluations differ from forensic interviews because the primary goal was not to generate a disclosure but to address the needs of the children and their families with concerns of CSA as well. In addition, concerns regarding CSA were able to be explored even if the possibility of disclosure was minimal, as was the case with very young children and children with certain disabilities. Therefore, the interviews of caregivers and collaterals were often particularly critical to the understanding of the child and family concerns and risk factors related to CSA. The preliminary intake data examined revealed that approximately 50% of children were five years old or younger and approximately 25% had been either diagnosed with developmental disabilities such as mental retardation or pervasive developmental disorders or concerns had been voiced regarding the possibility of developmental problems. Arguably, such children are least likely to disclose sexual abuse within the context of a single, or even multiple, forensic interview(s) and were unlikely to provide a clear and well-sequenced disclosure that would meet a forensic standard.
Introduction to the Evaluation

At the beginning of the evaluation, clinicians explained the purpose and structure of the process to the child and his or her family. As noted, some evaluations were requested due to nonspecific concerns regarding possible sexual abuse based on behavioral data. Unlike children participating in forensic interviews/evaluations, the children in the CPCS sample were often unaware that their caregivers or others had concerns regarding possible CSA. Therefore, it was sometimes inappropriate to raise the issue of CSA directly with children initially. Clinicians discussed consent/confidentiality with children and guardians and defined the interviewer’s role either with the children and caregiver separately or jointly, decided on a case-by-case basis. All individual child interviews were conducted in a room separate from parents and guardians. However, as young and/or anxious children were sometimes reluctant to separate from caregivers, the child’s best psychological interest was prioritized and children were asked to part from caregivers only when they appeared comfortable and emotionally ready to do so. Caregivers were discouraged from making any reference to their concerns in the child’s presence. In addition, children were informed that they could request to check in with a caregiver at any point.

Child Sessions

Given that a primary focus of the integrative model is on the safety and mental health needs of a child and his or her family, the initial child meetings were structured to broadly address the child’s general mental health and psychosocial concerns using free play and semistructured interview techniques, consistent with the NCAC model (Carnes, 2002). Goals for these sessions included rapport-building, conducting a general developmental screening, assessment of a child’s overall life concerns and positive activities and strengths, assessment of the child’s ability to talk about feelings and past events, and emotional presentation. Interactions were geared toward a child’s developmental and comfort level. Following several sessions that were not abuse-focused, the child sessions segued into an exploration of the abuse concerns, following appropriate forensic practices for interviewing children as discussed in numerous articles, including reviewing appropriate rules for communication (Reed, 1996) and maintaining a nonauthoritarian stance. Practitioners used interview techniques that were as nonleading as possible while balancing this consideration with an understanding of the communication limitations of the children involved in the evaluation. Structured techniques or screening instruments such as the Touch Continuum (Hewitt & Arrowood, 1994) and others were often utilized within a flexible framework. At the final session, safety practices were discussed as appropriate.
Caregiver Interviews

Although sometimes recommended to be limited to one session (see Carnes, 2002), interviews with caregivers were generally elevated in importance within the integrative model. Typically, it was helpful to form an evaluation team because this enabled the child and caregiver to be interviewed concurrently and had the added benefit of allowing multiple perspectives when analyzing the data obtained during the evaluation. It was sometimes useful to interview caregivers together initially, but it was also important to interview them individually as well. Again, a flexible approach makes sense, especially when a suspected perpetrator (if known) is a parent figure or a legal guardian. In some cases, it was not possible to interview the suspected perpetrator because he or she declined for personal reasons or on the advice of counsel. Additionally, interviewing a suspected perpetrator might be contraindicated in a clinical setting when the individual’s presence could potentially endanger others, especially children who may be present in a hospital or clinic. When it was possible and deemed appropriate to interview a suspected perpetrator, these appointments took place at a separate time from the child and nonperpetrator caregiver’s interviews so that the child was not in the clinic simultaneously with an individual suspected to be a CSA perpetrator.

There may be many caregivers involved in a child’s life and at times it was important to contact multiple adults depending on the referral information, the information that emerged during the evaluation, and the availability and accessibility of the caregivers, including foster, biological, and stepparents. Experience also suggests that it is helpful when staff has expertise regarding all forms of family violence, because a plethora of family issues often emerged, some of which posed an immediate risk to family safety, including children living in homes with credible concerns of domestic violence.

Among the multiple purposes of family/caregiver interviews were gathering information pertaining to the child’s history across a variety of domains as well as parental functioning and reactions to the CSA concerns. Generally (but not always), information collected included (a) chronology of events prompting concerns regarding possible sexual abuse; (b) the child’s developmental history; (c) information pertaining to the child’s cognitive, social, and psychological functioning and past history of same; (d) a history of any sudden behavioral or emotional changes exhibited by the child; (e) trauma/abuse history of family members; (f) family substance abuse history; (g) family psychiatric history and other risk factors (e.g., homelessness and general family stress); (h) reaction to suspected sexual abuse, including the meaning and implications of CSA for the family; (i) caregiver’s ability to entertain the possibility that CSA did/did not occur and any fixed beliefs they may hold regarding the meaning of CSA to a child’s life and mental health;
(j) parent–child relationship factors; (k) social and other family supports; (l) coping mechanisms; and (m) family strengths and community/personal resources. Some standardized measures were also used to complement interview information.

Other Information Sources

As needed, and with written consent of the child’s legal guardian, documents were reviewed when available. These included reports to state child protection agencies, school incident reports, and medical reports. In addition, professional collateral informants were contacted when indicated (e.g., school personnel, prior therapists and pediatricians, among others) with the written consent of the child’s guardian. Standardized measures of trauma symptoms and behavioral data were gathered from multiple sources (e.g., the child, parents, and teachers), as utilized in the NCAC framework. The CPCS integrative model included a semistructured form for parents to complete that requested information pertaining to the child’s developmental and health history as well as the Child Sexual Behavior Inventory (CSBI; Friedrich, 1997); Life Incidents of Traumatic Events (LITE; Greenwald, Rubin, Russell & O’Connor, 2002), used with both adults and children; the Achenbach behavioral checklists, teacher and parent versions (Achenbach & Rescorla, 2000, 2001); and the Trauma Symptom Checklist for Children (Briere, 2005). When indicated, a medical examination was typically performed on completion of the psychosocial portion of the evaluation, unless a parent or child declined such an examination. Finally, the team members met to discuss and review findings, entertain multiple hypotheses regarding the meaning and etiology of CSA suspicions, the family and child’s needs, the level of concern regarding the possibility that CSA occurred, and current safety concerns. The final family session was often conducted with caregivers, during which the findings were shared, as were recommendations for next steps. As may be anticipated, in some circumstances a mandated report was necessary and the ramifications of the filing and other family issues were discussed as appropriate to the particular circumstance.

Cultural Considerations

Importantly, a cultural perspective was integrated into the evaluation format, including an understanding that basic definitions, assumptions, and expectations regarding CSA are widely variable. Anecdotally, the authors noted a variety of presenting concerns in families, including but not limited to personal or cultural beliefs about the meaning of a child losing virginity, concerns about sexual development of boys and girls possibly exposed to homosexual interactions, and assumptions that children will be removed
from their families if they have been sexually abused, even when parents have been appropriate and protective (see Fontes & Plummer, this issue, for a more complete analysis of cultural factors). Clinicians attempted to recognize and validate such concerns as well as provide appropriate educational information. Thus, although the goal of an extended CSA evaluation is primarily for assessment purposes, some limited intervention in the form of education and helpful advice for coping with the immediate circumstances (e.g., how to talk to children about the evaluation, how parents can manage their own anxiety) could be included without contaminating the data gleaned from the evaluative process.

Qualifications

All clinicians conducting comprehensive evaluations in cases of suspected CSA should be trained adequately, in line with qualifications set forth by the American Professional Society on the Abuse of Children (1997) and other professional groups. Training and expertise in the following areas is recommended: (a) broad general background in the area of mental health, allowing for differential understanding of presenting emotional and behavioral concerns and symptoms; (b) family violence and CSA, in particular; (c) interviewing techniques relevant to children suspected of having been sexually abused; and (d) knowledge of research in the area of CSA, including children’s suggestibility, sexualized behavior, and trauma.

When CSA Evaluations are Contraindicated

CSA evaluations may be contraindicated when (a) a child is in emotional crisis and not stable enough to participate in an evaluation during which he or she may be asked to speak about possible CSA and other adversities; (b) a child’s circumstances are in flux (e.g., when custodial changes have recently occurred or are about to be implemented, such as a recent move into foster care). In the best of circumstances (although admittedly not always possible), a child will have a stable and safe support system so that if the child makes a disclosure during the course of the evaluation, he or she will have emotional support and be appropriately cared for and protected; (c) the child has already been evaluated and/or the child has given a clear and credible disclosure during a forensic interview, unless the child was referred specifically for an abridged evaluation to provide further in-depth information related to clinical needs; (d) the child is a sexually acting out adolescent and a risk assessment needs to be included in the trauma/abuse evaluation; and (e) concerns arise during custody or parental access disputes, in which case a court-ordered evaluation typically is essential.
SUMMARY AND LIMITATIONS

We acknowledge that the model we describe is novel and that evaluation research should be encouraged, especially to address the most vulnerable of potential victims (younger children and children with disabilities and children with support systems that inhibit disclosures). One of the fundamental limitations to the integrative approach we describe is how to validate the findings of the evaluation and how to fund them. Cases of suspected sexual abuse, especially those with no disclosures, fit awkwardly between mental health and forensic arenas. Thus, when unsubstantiated concerns of CSA occur in the absence of disclosure, the child cannot be deemed a victim or receive services funded by victim service streams yet does not necessarily have a mental health problem either, or at least not one that can be identified absent further evaluation. Often, caregivers remain concerned or even convinced that a child may have been sexually abused and seek professional evaluation of the child. However, the child may not qualify for insurance coverage for a forensic or clinical evaluation in the absence of further assessment to document a mental health problem or child victimization, in this catch-22 type scenario. Therefore, funding streams need to be identified and clinicians need to be adequately trained for such services to be more widely accessible.

Accurately identifying sexually abused children, especially in the absence of a disclosure, is extremely challenging yet critically important, with implications for children for whom concerns are unfounded as well as for those who have been egregiously victimized. Even when the results of evaluations are inconclusive, the data obtained often suggest whether further psychological/psychiatric intervention is warranted and suggest some of the initial purposes and goals for therapeutic intervention. Thus, in addition to possibly yielding information suggesting CSA and prompting a report to a child protection agency, extended evaluations in a clinical setting can provide needed direction for subsequent mental health providers and yield information relevant to child and family risks and strengths, caregiver ability to adequately protect children, pockets of resilience, areas of function and dysfunction both for the child and within the family, and cultural/environmental issues that may impact the child and family.

REFERENCES


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