

Child Sexual Abuse and Forensic Psychiatry: Evolving and Controversial Issues

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Child sexual abuse has received growing attention in recent years, and the topic continues to spark controversy among mental health and legal professionals as well as in the popular media. This paper will review the concept of child sexual abuse, cover relevant definitions, address the clinician's role, and then will address the principal evolving and controversial areas. These areas include psychic damages, false allegations, improper investigatory techniques, use of anatomical dolls, admissibility of expert testimony, hearsay testimony, and the competency of minors to testify.

Historically, sexual use of children and adolescents has not been considered as "abuse." For instance, sexual relations between adults and boys—pederasty—was viewed as normative behavior in ancient Greece. In ancient Rome, sexual relations between adult men and young children of both sexes was accepted. Laws prohibiting the sexual use of children emerged during the Middle Ages in Great Britain, but were weakly enforced since children were considered property.

By the nineteenth century, attitudes toward children had begun to change, and the concept of sexual "abuse" of children gained wider acceptance.

Krafft-Ebing, a renowned German psychiatrist, published *Psychopathia Sexualis* in 1886.¹ This text on sexual disorders categorized pedophilia as a pathological condition. Despite Krafft-Ebing's observations about the existence of pedophilia, Victorian society remained mostly unaware of the occurrence of child sexual abuse. This was exemplified by Freud's revision of his initial seduction theory that childhood sexual trauma caused hysteria to his later view that such memories were fantasies rather than actual experiences of his patients.

In the United States, child sexual abuse has received increasing recognition since the 1970s in both the professional literature and popular media. Much of this interest results from an increased focus on child abuse in general. Other factors are the women's movement, victims speaking out

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through the media, and increased research interest.

This article will cover the definition of child sexual abuse, discuss the role of the forensic clinician, and then provide an overview of the evolving and controversial forensic psychiatry issues that have emerged as child sexual abuse has become a recognized social problem. These areas include psychic injury, false allegations, use of anatomical dolls, the types of mental health testimony that are admissible, whether hearsay testimony is admissible, and the competency of minors to testify.

Part I. Definition of Child Sexual Abuse

Although "child sexual abuse" is a widely used term, there is no universally accepted definition. Clinically, sexually abusive behaviors have been broadly defined to include: nudity; disrobing; genital exposure; observation of the child undressing, bathing, or performing bodily functions; kissing; fondling; masturbation; fellatio; cunnilingus; digital or penile penetration of the rectum or vagina; and intercourse.² The AMA's recommended definition is "exploitation of a child for the gratification or profit of an adult."³ Standards for what constitutes "appropriate" sexual behaviors vary among cultural and socioeconomic groups, and among families within these groups. Child abuse statutes typically define sexual abuse to include only those behaviors clearly accepted as deviant by community standards.

Cases of child sexual abuse are prosecuted under various laws, including

abuse statutes and those laws prohibiting child molestation, sexual assault, rape of a minor, indecent exposure, and corrupting the morals of a minor.⁴ Another important definition in this area is that of incest. Although all cultures have some form of incest taboo, what behaviors are prohibited and between what degree of relative varies considerably. Incest is generally defined as a subcategory of child sexual abuse; that is, "intrafamilial" abuse. Strictly defined, incest is restricted to sexual intercourse between relatives who are too closely related to marry. However, as used in the professional literature, incest includes a broader range of sexual activities.⁵ Consent is not a factor in incest as it is in rape.

Other definitions of importance are those of child molestation and pedophilia. Broadly defined, child molesters are "older persons whose conscious sexual desires and responses are directed, at least in part, toward dependent, developmentally immature children and adolescents who do not fully comprehend those actions and are unable to give informed consent."⁶ As pointed out by Barnard *et al.*,⁷ the terms child molester and pedophile are not synonymous. Pedophile implies that the perpetrator has a diagnosable mental disorder, while child molester is a more general term covering sexual misuse of children.⁸

In part because of confusion about the definition of child sexual abuse, precise figures regarding incidence and prevalence are lacking. Statistics in the U.S. reveal that between 150,000 and 200,000 new cases are reported each

year,⁹ but figures on prevalence suggest that a large proportion of cases go unreported. Recent studies show that the prevalence of child sexual abuse ranges from 10 to 60 percent.⁷ Studies restricted to intrafamilial sex abuse report prevalence figures from five to 15 percent in women, and three to five percent in men.⁵

Part II. Clinician Involvement in Child Sexual Abuse Proceedings

As noted by Schetky,¹⁰ child sexual abuse evaluations "are often minefields fraught with difficulties." Psychiatrists and other mental health professionals may become involved in a variety of legal proceedings concerning allegations of child sexual abuse. The type of proceeding involved has bearing on the type of court (family/juvenile court, criminal or civil court), the standard of evidence used, type of testimony admissible, and whether the case is heard by a jury. Allegations of child sexual abuse may appear in the following eight types of legal proceedings: (1) criminal prosecutions, (2) juvenile delinquency litigation, (3) juvenile court proceedings to protect abused children, (4) child custody and visitation litigation related to divorce proceedings, (5) termination of parental rights, (6) civil suits brought by victims against perpetrators for monetary damages, (7) civil litigation against child protective service agencies and professionals that allege failure to protect children from sexual abuse, and (8) administrative proceedings to suspend or revoke professional or facility licenses.¹¹

In these proceedings, psychiatrists

may take part in a number of ways. For example, Guyer and Ash¹² have described the multiple stages of juvenile court proceedings to protect abused children (type 3 proceedings above) in which mental health professionals may be involved. These begin with evidentiary hearings, in which the juvenile/family court may order an evaluation of the parent(s) or child, and the mental health professional produces a report. The evaluator may be asked to testify as the court considers whether to grant the protective services petition and take control over the child. Next, the clinician may be asked to assist the court in dispositional hearings that consider placement and treatment. Finally, the mental health professional might be asked to take part in the periodic review hearings, which follow disposition.

To help prepare clinicians to walk through the "minefield" of these legal proceedings, the American Academy of Child and Adolescent Psychiatry in 1988 issued "Guidelines for the Clinical Evaluation of Child and Adolescent Sexual Abuse."¹³

The forensic clinician occasionally may be asked to critique evaluations done by another clinician. Such a task has been made considerably clearer since the publication of the Academy Guidelines. As Guyer¹⁴ has stated, the promulgation of a standard of care for conducting sexual abuse evaluations will allow both clients and professionals to be better served "at the expense of those who thrive on litigation." The previous lack of standardized guidelines made it simpler for the unhappy litigant to locate

an expert to dispute disadvantageous findings: it also contributed to much professional disagreement in general.¹⁵ Clinicians who evaluate sexual abuse must remain cognizant of their increased liability in terms of duties to both patients and third parties. This liability was highlighted in the Colorado Court of Appeals case of *Montoya v. Bebensee*¹⁶ in which an abuse allegation evaluation was found to have been performed in a negligent manner.

In assessing the adequacy of other's sexual abuse evaluations, Quinn^{17,18} recommends determining such factors as: 1) the circumstances and location of the previous evaluation, 2) who was present, 3) the training of the evaluator, 4) techniques used, 5) number of sessions, 6) type of documentation, 7) who received feedback, 8) whether leading or coercive techniques were used, and 9) any evidence of contamination or other flaws. Virtually all reports will have some inadequacies, and particular attention to the child's responses are helpful in determining if these weaknesses were actually problematic.¹⁸

Part III. Evolving and Controversial Issues

A recent editorial in the *Journal of the American Academy of Child and Adolescent Psychiatry* begins by stating, "No problem in child and adolescent psychiatry stirs up more heated discussion than does child sexual abuse."¹⁹ The following section of this article discusses six of the most prominent evolving and controversial forensic issues in child sexual abuse. These are psychic injury, false

allegations, improper investigatory techniques, use of anatomical dolls, admissibility of expert testimony, hearsay testimony, and the competency of minors to testify.

Psychic Injury The impact of child sexual abuse on victims is a topic of considerable clinical and research interest in both adult and child psychiatry, and the assessment of psychic damages is a commonly asked question for the child psychiatrist expert witness. The research on the long-term effects of childhood sexual abuse has commonly found symptoms of depression, suicidal behavior and self-mutilation, anxiety (including post-traumatic stress disorder), substance abuse, borderline personality disorder, somatization disorder, eroticization, learning disabilities, dissociative disorders, conversion disorders, impaired interpersonal relationships and trust, running away, prostitution, and revictimization.²⁰⁻²⁷

Recovery for such psychic damages resulting from sexual abuse is a fairly recent development. Historically, our legal system did not allow recovery for psychic injury in and of itself without accompanying physical injury.²⁸ Hoffman and Spiegel²⁹ estimate that psychic injury cases now comprise two to three percent of all tort cases. In spite of the fact that a number of these cases involve child plaintiffs, scant literature is available on this topic.^{28,30}

From a clinical perspective, Terr³⁰ described her consultation experience in 13 personal injury cases. Five of these cases involved psychic trauma and physical injury, while the remainder of the

cases involved psychic trauma alone. These cases were remarkable for substantial delays prior to psychiatric evaluation (sometimes years), delays prior to settlement, delayed treatment, or no treatment despite a clear indication for therapy. Only two of the 13 cases made it to the trial phase, and the need to provide expert testimony in court was required in only one of these. Three practical issues that arise in personal injury cases with psychic injury were identified: (1) liability (who is at fault?), (2) damages—either the presence of current emotional damages or a high probability of future resultant emotional damages, and (3) collectability (assessed by attorneys early in the case).

Important questions for forensic child psychiatrists involved in psychic trauma litigation are whether the victim exhibits psychological symptoms compatible with having been sexually abused, and whether the psychic injury is due to the sexual abuse. A national conference held in 1985 focused on developing criteria for a "Sexually Abused Child's Disorder," with initial plans for inclusion in DSM-III-R. The concept was eventually rejected due to the lack of data to support or refute the concept,³¹ thus underscoring the current difficulty professionals have in coming to a consensus on this topic.

Presently, several theoretical frameworks exist for describing or explaining the immediate and delayed effects of child sexual abuse on victims: 1) Summit's³² "Child Sexual Abuse Accommodation Syndrome," 2) the "Traumatogenic Model" proposed by Finkel-

hor and Browne,³³ 3) the DSM-III-R diagnostic model of post-traumatic stress disorder, and 4) Terr's³⁴ descriptions of Type I and Type II Childhood Psychic Traumas.

Summit³² proposed a five-step model to explain the dynamics of intrafamilial (specifically, father-daughter) sex, focusing on the child's attempts to cope with the abuse. His "Child Sexual Abuse Accommodation Syndrome" identified five progressive stages:

1. *Secrecy.* This is the initiation of the sexual relationship, and the perpetrator tells the child, often using threats, not to tell anyone about their "secret."

2. *Helplessness.* The child, being smaller and dependent on the perpetrator, submits to the abuse. The child typically feels guilty and ashamed.

3. *Entrapment and Accommodation.* The sexual relationship continues. The child is unable to blame the older family member (on whom she depends for nurturing), and blames herself instead. The child is afraid of what she regards as her considerable power to destroy her family if she "tells." This fear may result in acting out behaviors, depression, or self-mutilation.

4. *Delayed, Conflicted, Unconvincing Disclosure.* In Summit's model disclosures are incidental, such as during the investigation of the child's behavior problems. The child may be accused of making up the abuse to rationalize her own misconduct. The father usually denies the relationship, and the mother and siblings may be torn between the father and daughter.

5. *Retraction.* The child may retract

her disclosure in an effort to avoid breaking up the family.

Finkelhor and Browne³³ have proposed the Traumatogenic Dynamics Model of Child Sexual Abuse to account for the variety of symptoms encountered by clinicians who work with sexually abused children. They believe that using a PTSD framework to explain the sequelae of sexual abuse is inadequate, in part because it is purely descriptive. The four "traumatogenic dynamics" of this model are:

1. *Traumatic Sexualization.* These are the conditions in sexual abuse under which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways. An example is the child learning to use sexual behaviors to manipulate others to meet the child's needs.

2. *Betrayal.* The child realizes that someone upon whom she is dependent is causing her harm, or isn't protecting her. This sense of betrayal can encompass the perpetrator, and also can be extended to nonoffending family members, such as the mother, who deny or overlook the abuse.

3. *Stigmatization.* These are the negative messages about self communicated to the child by the abuser ("you seduced me"), and comments from those around the child, particularly after the abuse is disclosed (i.e., "spoiled goods," or "queer, fag" in the case of male victims).

4. *Powerlessness.* This results from the repeated invasion of the child's body territory against his or her wishes, and

the experience of violence, coercion, and threats that may accompany the abuse.

The post-traumatic stress disorder (PTSD) diagnosis is probably the most frequently used model in describing the effects of child sexual abuse. Several authors have addressed the issue of child sexual abuse in the framework of PTSD.³⁵⁻³⁷ It appears that PTSD develops in approximately one-half of sexually abused children.^{37,38} In a recent study of child psychiatric outpatients (n = 31) who had been sexually abused, McLeer *et al.*³⁸ found that one-half (48%) met full DSM-III-R criteria for PTSD. Identity of the perpetrator was linked to development of PTSD; 75 percent of children abused by their natural fathers had PTSD compared with 25 percent of those abused by trusted adults, and no children abused by an older child met criteria for PTSD.

The DSM-III-R PTSD model is limited in its ability to actually explain the traumatic effects of sexual abuse, and it does not account for all the symptoms seen in victims, nor does it apply to all victims. Moreover, PTSD symptoms are often manifested differently in children than in adults, and are dependent on such factors as age, developmental level, length and type of abuse, and relationship with the offender. Thus, the use of the PTSD diagnosis has certain limitations for clinical and forensic use.

Terr³⁴ has described four characteristics common to most cases of childhood trauma: (1) visualized or otherwise repeatedly perceived memories, (2) repetitive behaviors, (3) trauma-specific fears, and (4) changed attitudes about people,

life, and the future. Additionally, Terr³⁴ has defined different features that are characteristic of either single-blow traumas (Type I) or longstanding, repetitive traumas (Type II). The features of Type I disorders include full, detailed memories, omens, and misperceptions. Type II disorders have the features of denial and psychic numbing, self-hypnosis and dissociation, and rage.

False Allegations The issue of false allegations has lately been receiving considerable attention. As noted earlier, there is no unique symptomatology which "proves" that abuse took place. Standards for determining whether allegations are true or false vary between evaluators, and this variation is confirmed by studies of the rate of false allegations. However, there seems to be a trend for an increase in the number of false allegations. Yates³⁹ has offered three possible explanations for this apparent increase. There is the dramatic increase in the total reported cases of sexual abuse, the exposure of school children to programs designed to prevent molestation, and the heightened awareness of adults that creates a higher index of suspicion for emotional or behavioral symptoms (such as nightmares or enuresis) that formerly might have been attributed to other problems.

Large scale studies have found rates of false allegations from two to eight percent.⁴⁰ Jones and McGraw⁴¹ found two percent false allegations in their study of 576 sexual abuse complaints. Another study found three percent false allegations in a sample of 142 children referred to a child abuse program for

alleged sexual abuse.⁴² In the largest study to date, Everson and Boat⁴⁰ studied 1,249 cases reported to child protection workers in North Carolina. Workers assigned to these cases determined that slightly less than five percent of the allegations were false. The rate of false reports varied by age, from less than two percent for those children under six years old, to eight percent for the adolescent sample.

Everson and Boat⁴⁰ also examined workers' rationales for deciding when allegations were false, and their findings suggest that the five percent rate of false allegations may be inflated. Reasons cited for determining false reports included subsequent retraction by the child, inconsistencies in the report, failure of others to corroborate the abuse, and absence of medical evidence. As discussed earlier, Summit's model for the sexual abuse accommodation syndrome identifies retraction, conflicting and unconvincing disclosure, and denial by family members as common factors in cases of genuine sexual abuse; yet these same features were those cited by workers in determining that allegations were false. These findings suggest that some workers in the sexual abuse field are biased toward believing that all reports are valid, whereas others are prejudiced against believing children's allegations of sexual abuse.

Several reports suggest that the rate of false allegations may be higher than two to eight percent in those cases referred to forensic and child psychiatrists, particularly in cases that include custody/visitation disputes, and cases in which

allegations are brought by the parent rather than the child.* Benedek and Schetky⁴⁴ found that allegations were false in 10 of 18 (56%) cases referred for sexual abuse evaluations in custody or visitation disputes. In a study of 11 allegedly sexually abused children in custody/visitation cases, Green⁴⁵ determined that four allegations were false.

One model for examining fabricated sexual abuse claims in custody disputes is the "parental alienation syndrome" described by Gardner.⁴⁶ He proposed that this "brainwashing" disorder is present in about 90 percent of children involved in custody disputes. Briefly described, the parental alienation syndrome consists of efforts by a parent to alienate the child from the other parent by denigrating that parent. Gardner believes that this syndrome is present in many cases of sexual abuse allegations raised in the context of custody or visitation litigation.

Improper Investigatory Techniques

An issue related to false allegations is that of overdiagnosis. Many, if not most experts in this field, are critical of the overall adequacy of child sexual abuse investigations. Quinn⁴⁷ cites six factors in "improper investigatory techniques (which lead) to premature and incorrect assessments of the child's experiences and to overdiagnosis of child sexual abuse."

*Although authorities such as Benedek, Schetky, Green and Gardner have publicized the higher incidence of false allegations in custody disputes, it should be noted that sexual abuse allegations are rare even in these situations. A 1988 study by Thoennes *et al.* found that less than two percent of 9,000 contested custody and visitation cases involved an allegation of sexual abuse (as cited by Berliner and Sauzier⁴³).

1. *Lack of Professional Resources and Training.*

2. *Lack of Investigatory Independence.* Evaluator may ally with certain parties or interview only one parent (compromised external independence) or may pursue a personal agenda to prove or disprove abuse allegations (compromised internal independence).

3. *Improper Interview Techniques.* Leading questions, coercion, and repetitive questions may be experienced by young subjects as a demand for information or as a signal that they are not giving the "correct" answer.

4. *Inadequate Data Base.* Investigator fails to take into account episodes of sexual stimulation, exposure to sexually explicit materials, and child abuse prevention program materials that are unrelated to the alleged abuse.

5. *Contamination by External Influences* such as communications between parents and children, media coverage, and community discussions.

6. *Failure to Consider the Possibility that Allegations May Be False.*

Other developments related to concerns about overdiagnosis are attempts to use behavioral indicators to validate sexual trauma and the use of anatomically correct dolls. Although many clinicians accept the premise that certain signs and symptoms suggest sexual trauma, the courts have been less convinced. The Maine Supreme Court⁴⁸ specifically rejected this type of testimony in criminal trials on the grounds that there is "no scientific basis for determining that a causal relationship ex-

ists between sexual abuse and the clinical features of sexual abuse.”

Anatomical Dolls Courts have been reluctant to admit evidence based on interviews using anatomically correct dolls. Such dolls, which can be equipped with extras such as exchangeable circumcised and uncircumcised penises, sanitary napkins and tampons, and a baby with an umbilical cord, have found increasing use in sexual abuse investigations in the past 10 years. Their use has risen without baseline studies to document reliable differences between children who have been abused and those who have not. Furthermore, in many cases, the dolls are used by untrained individuals. A 1988 study⁴⁹ found that less than 50 percent of evaluators (child protection workers, law enforcement officials) had received any training in the use of these dolls.

Use of anatomically correct dolls has been challenged in court in at least five ways: (1) as hearsay from out-of-court interviews; (2) as a “psychological technique”; (3) in evaluations; (4) in trial preparation; and (5) as props in court testimony (see reference 50, for citations of specific cases). In 1987, California’s Supreme Court⁵¹ specifically rejected evidence based on anatomical dolls, stating that “evidence based on a new scientific method of proof is admissible only upon a showing that the procedure has been generally accepted as reliable in the scientific community in which it was developed.”⁵¹ Since this ruling, there has been a flurry of literature about the scientific reliability of these dolls.^{50,52-56} Issues of debate are whether the dolls

themselves are suggestive or overstimulating, and what can be concluded about whether a child has been sexually abused based on his or her response to the dolls.

Admissibility of Expert Testimony Most courts that have considered child sexual abuse cases have not directly addressed the difficult issue of what type of expert testimony is admissible in these cases. As explained by one reviewer, “In the area of child sexual abuse, expert testimony is especially troublesome because it often reflects directly or indirectly on the credibility of a child-victim-witness, resulting in a situation where one witness assesses the credibility of another.”⁵⁷

Two recent law review articles^{11,57} discuss the types of expert testimony that have been offered in child sexual abuse cases. Serrato⁵⁷ proposes a theoretical framework for analyzing such testimony. His framework places seven different types of expert testimony on a spectrum, ranging from low to high impact on the ultimate issue in question (the defendant’s guilt or innocence). The types of testimony and applicable case law as described by Serrato⁵⁷ are as follows:

1. *Refutation of Defense Counsel’s Claims* The expert witness describes specific characteristics of sexually abused children such as delayed reporting or recanting, to challenge the defense attack on the child’s credibility. Courts have consistently admitted this type of testimony.

2. *Common Characteristics of Sexually Abused Children* The witness describes symptoms typically seen in chil-

dren who have been sexually abused. Most courts admit such testimony to aid juries in determining the child's credibility. The most common objection to this type of expert testimony is that it concerns an area of common knowledge already available to jurors.

3. *General Veracity of Children Alleging Sexual Abuse* In this type, the witness testifies about sexually abused children as a group, and does not refer to any specific child. Courts are divided on the admissibility of this type of testimony. The most common challenges to such testimony are it "invades" and "prejudices" the jury's responsibility to determine the credibility of the child-witness.

4. *Veracity of Particular Child-Witness* The witness gives an opinion about whether the child-witness involved in the case is telling the truth. The vast majority of courts have not allowed this type of testimony. Arguments against this type of testimony declare that: (1) it addresses the ultimate issue, (2) an expert's belief in a witness's credibility is inadmissible because it is nothing more than advice to the jury on how to decide the case, (3) it gives an unwarranted "stamp of scientific legitimacy" to the child's credibility, (4) juries are able to determine credibility without the help of experts, and (5) there is no scientific knowledge base about whether victims are telling the truth. In *United States v. Azupe*⁵⁸ the Eighth Circuit Court of Appeals decided not to admit expert testimony on the truthfulness of the child who alleged sexual abuse on the grounds that the jury could evaluate

the child's credibility without assistance from an expert witness. This is one of the few federal cases that has addressed the topic of expert testimony in child sexual abuse cases. The court did, however, state that testimony about the truthfulness of children as a group (type 3 testimony) was admissible.

5. *Matching General Characteristics of Sexually Abused Children with Those of Child-Witness* The expert compares the child's symptoms to characteristics typical of sexually abused children, and then concludes (implicitly or explicitly) that the child was sexually abused. In general, courts have found that this type of expert testimony is admissible.

6. *Common Characteristics of Sexual Child Abusers* Here the expert witness describes "profiles" of sexual offenders or of incestuous families. Most courts have ruled against admitting this type of testimony, concluding that the potential for unfair prejudice, or unfair identification of the defendant outweighed the value of such testimony. Only one court has allowed this type of testimony. The Colorado Court of Appeals⁵⁹ held that testimony about characteristics of typical incestuous families was admissible because this was information not normally available to the average juror, and was useful in evaluating the child's credibility.

7. *Expert Testimony Identifying the Defendant as the Abuser* Courts have not allowed this type of testimony, on the grounds that the expert witness has not evaluated the defendant and/or that such testimony invades the province of the jury.

Case law on expert testimony also has been reviewed by Myers *et al.*,¹¹ who describe eight categories of testimony. Many of these are similar to Serrato's types of testimony.

Admissibility of Hearsay Evidence

Hearsay evidence concerns "a statement, other than one made by the declarant while testifying at the trial or hearing, offered into evidence to prove the truth asserted."⁶³ Hearsay evidence is generally excluded, but may be allowed under certain exceptions. Quinn and White⁶⁴ reported that 27 states have enacted legislation to allow special hearsay exceptions that allow testimony about a child victim's out-of-court statements regarding the abuse. Courts are divided on the admissibility of hearsay evidence in child sexual abuse cases. When allowed, hearsay is most commonly admitted under the "diagnosis or treatment hearsay" exception. This exception allows hearsay about "(s)tatements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms . . . insofar as reasonably pertinent to diagnosis or treatment."⁶⁵ Less frequently used are the "excited utterances" (*res gestae*) and residual hearsay exceptions. As noted by Guyer,⁶⁶ there "appears to be a general trend that allows the diagnosis or treatment hearsay exception to be used in child sexual abuse allegation cases, thereby permitting the testimony of mental health professionals who have interviewed the children concerning the allegations."

Courts have allowed hearsay to be admitted to help prove that the sexual

abuse did take place, and also (less frequently) to prove the identity of the alleged abuser. As discussed by Turkheimer,⁶⁷ the Supreme Courts in both Wisconsin⁶⁸ and Arizona⁶⁹ have allowed hearsay testimony from expert witnesses about the child's statements concerning both sexual abuse and the identity of the abuser.

Admission of hearsay testimony on the diagnosis or treatment exception has been successfully challenged in other states. The Colorado Supreme Court⁷⁰ held that, because the child involved was found to be an incompetent witness (she could not understand the obligations of a witness), she could not have understood that her out-of-court statements to the expert witnesses were for diagnosis or treatment purposes. Other objections to the use of the diagnosis or treatment exception center on whether the exception can be used for statements made in evaluations conducted primarily to determine who abused the child. Guyer⁶⁶ reported that courts tend to reject hearsay testimony obtained in the course of such evaluations.

Competency of Minors to Testify

Legally, the competency of minors to testify is based on their ability to understand the facts about which they will testify in addition to their ability to understand the concept of telling the truth.⁷¹ The competency issue generally is not raised with children who are age 10 or older. There is no absolute minimum age for testimonial capacity, and Federal Rules of Evidence⁷² declare that "every person is competent to be a wit-

ness except as otherwise provided in these rules.”

Ultimately, the determination of a child's competence to testify is left to the discretion of the judge, who may or may not ask for assistance from medical experts to help make this decision. In performing a psychiatric examination for competency to be a witness, Quinn¹⁸ lists two basic questions to be answered: (1) Is there a mental disease or defect?, and (2) Does this mental disorder or defect directly impair the functions relevant to being a witness? On a practical note, she suggests that this evaluation should include a thorough document review, a developmental, emotional, and behavioral history from the parents, a careful clinical examination and mental status, and an assessment of the child's ability to relate basic data and to engage in a focused verbal exchange.

In many instances, the child witness explains his or her story to a mental health clinician, and this evaluator then speaks for the child, thus bypassing the child's direct testimony.⁷¹ This is an appealing alternative according to some legal scholars who view children's testimony with skepticism.¹⁵ However, as mentioned earlier, a majority of courts hold expert testimony about the veracity of a particular child witness inadmissible because it invades the province of the jury.⁵⁷ It should be noted that the credibility of the child witness is influenced by such factors as cognitive development, free recall and recognition functions of memory that are to some extent age dependent, the suggestibility of young children to leading questions, and

the possibility of deception by the child.¹⁸

Two recent Supreme Court cases involving child sexual abuse merit attention in a discussion of the competency of minors to testify. These cases have addressed the Sixth Amendment right of the accused to have a face-to-face confrontation with his accuser. In *Coy v. Iowa*,⁷³ the Court upheld the right of the defendant to confront the accuser, and left unanswered whether there might be exceptions to actual physical confrontation.^{15,17} The majority opinion appeared to disregard the emotional trauma that the child sexual abuse victim might experience in testifying.⁷⁴ In the 1990 case of *Maryland v. Craig*,⁷⁵ the Supreme Court gave greater consideration to the best interests of the child than the constitutional rights of the accused. This time, the justices decided that the Sixth Amendment does not give the defendant an absolute right to direct confrontation with the accusing witness.¹⁸ The Court decided, in a sharp split, that television monitoring satisfied the Sixth Amendment requirement of confrontation.⁷⁴ The use and constitutionality of such alternative testimonial approaches awaits further judicial clarification.

Conclusion

Increasing professional and public attention to the topic of child sexual abuse has been accompanied by controversy among the disciplines and professions involved. These controversies cover a broad spectrum, from the complex topic of psychic injury to more discrete issues such as whether anatomically correct

dolls should be used in evaluating sexually abused children.

Most professionals believe that it is healthy to foster discussion and focus research attention on these issues, and that through such efforts will come more definitive "answers." Other professionals are concerned that raising questions about these topics will undermine the (recently acquired) credibility of all victims. It is unlikely that the forensic controversies about child sexual abuse will abate, nor will they be definitively answered in the near future.

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