SUPREME COURT OF MISSISSIPPI
NO. 2006-KA-01957-SCT

AARON BISHOP **APPELLANT**

VERSUS

STATE OF MISSISSIPPI **APPELLEE**

APPEAL FROM THE CIRCUIT COURT OF ATTALA COUNTY, MISSISSIPPI

BRIEF OF THE APPELLANT

ORAL ARGUMENT REQUESTED

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STATEMENT REGARDING ORAL ARGUMENT

Aaron Bishop respectfully requests that the court allow oral argument in this case. This case presents an extremely important question as to the use of pseudo-scientific testimony under M.R.E. 702 and also a constitutional violation of his rights to confrontation under the United States Supreme Court's decision in Idaho v. Wright.

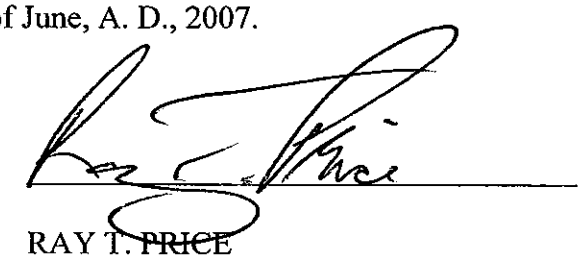
In reviewing prior case law, it appears that the court has either not been presented with or fully considered the issues involved in this case and prior cases. This case presents an issue of true general importance to the Administration of Justice in the state of Mississippi. As these types of allegations are becoming more and more frequent, and this court should establish, through this case, clear guidelines for admission of or non admission of the pseudo-scientific type of testimony admitted in this case, as well as establish that testimony derived from a person adjudicated to be incompetent may not be rendered competent simply by being introduced through a heresy exception, denying a criminal defendant the crucial right to confront the witnesses against him.

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the Justices of the Supreme Court and/or the Judges of the Court of Appeals may evaluate possible disqualification or recusal.

Aaron Bishop, appellant
Hon. Clarence E. Morgan, III, Circuit Court Judge
Mike Howie, Assistant District Attorney
Bill Phillips, Assistant District Attorney
Mark Burton, appellant's trial counsel
Beth Burton, appellant's trial counsel
Ray T. Price, appellant's appeal counsel

Respectfully submitted on this the 8th day of June, A. D., 2007.



RAY T. ~~PRICE~~

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STATEMENT OF THE CASE

Aaron Bishop was initially charged with sexual battery and lustful touching of a child in the Justice Court of Attala County on April 18, 2006. Subsequently, a jury indicted him on August 9, 2006. After numerous pre-trial motions had been heard, the case proceeded to trial before a jury, which convicted him on September 29, 2006. Aaron filed post-trial motions which were heard and denied on October 2, 2006. From this judgment, he prosecutes this appeal.

STATEMENT OF FACTS

Aaron Bishop was convicted of this terrible crime based upon factual testimony which was incompetent and alleged "expert" testimony which was received in evidence despite being not only based on the incompetent witness' hearsay but also clearly inadmissible under Daubert.

Aaron and Christie Bishop had been married for five years at the time these events allegedly occurred. They had previously been separated and filed for divorce, but had reconciled at the time these allegations arose. They have one child, Madison, who had just turned four immediately prior to her alleged statements to her mother. The family lived in a rural part of Attala County and shared a small home with Christie Bishop's sister, Missy. Aaron worked for a railroad company and was frequently away from the home for extended periods of time.

Christie Bishop appeared at the Attala County Sheriff's Department on the morning of April 5, 2006 and alleged that Madison made statements to her the previous evening and the following day which would constitute sexual abuse against Madison by her father, Aaron. According to her testimony at a pretrial hearing, Christie alleged:

> Madison was taking a bath, and she came to me, and she asked me -- well, first off, she had what they call "slap cheek." It's the common name for it, had bumps all over her body. And she asked me if she could show her daddy her bumps on her tutu. And I told her, I said, "No, we don't show daddies our tutus, and you don't see daddies' tutus either." And then she said to me, "well, I have already seen it." and she told me that it was long and tall and that she had sucked it. And I asked her later on that evening whenever we were alone if she could tell me more about what she had been talking about previously. And she said, "well, I sucked it," and she told me it tasted really nasty. She said that he told her never to bite it, and she told me that it spit on her. And I didn't ask her anything else about it (TR-49).

At the Sheriff's Department, Christie Bishop reported these allegations and the Sheriff's Department arranged for an interview of Madison by Glenda Nell, a worker with the Department of Human Services. Also present during this interview were Amy Lee, also of the Department of

Human Services and Mr. Zelle Shaw, of the Attala County Sheriff's Department. During this interview, which was not recorded in any manner, Madison did not repeat any allegations of abuse by her father or anyone else.

Glenda Nell informed Christie Bishop that no abuse was confirmed by the interview, but stated "the worker informed Christie that the forensic interview would hopefully obtain information from Madison in regards to the allegations. Christie agreed to take Madison to see Dr. Betty Turner at the Kosciusko Medical Clinic due to the allegations." (C-64) Still on April 5, Madison was taken by her mother to see Dr. Betty Turner at the Kosciusko Medical Clinic as agreed. Although the purpose of the visit was to attempt to ascertain any physical signs of abuse, Christie Bishop repeated the allegations and statements she claimed Madison had told her to Dr. Turner in Madison's presence. After a thorough examination, Dr. Turner found absolutely no physical signs of abuse.

Next, on April 10, 2006, Christie Bishop took Madison to Trudi Porter, Ph.D., whom Glenda Nell had stated she wanted to use because "she has been known to get through to children." (CP-65)

Despite Dr. Porter's familiarity with nationally recognized protocols for forensic interviewing of children of alleged sexual abuse, Dr. Porter did not follow those guidelines, "because of time constraints." According to Dr. Porter, "and I spoke with her and attempted to get her to talk to me by use of non-leading, non-suggestive questions. And she basically exhibited some very concerning behaviors. She was not old enough or developmentally advanced enough to give a clear narrative account of her experiences, and in fact, her language skills were not developed enough to even give real clear direct answers to all questions." (TR-14) Dr. Porter, deviating from the standard protocols allegedly because of the child's unresponsiveness, then resorted to leading questions. According to Dr. Porter's testimony, she asked Madison "did somebody show you his tutu? Did some body make you touch his tutu, kiss his tutu?" And she initially said no. And then she spontaneously said, "not

my daddy's tutu." And I said, "what about your daddy's tutu?" And that was the first time I used the word daddy was after she did, and that's when she said , "it's nasty. Yuck. Yuck." Asked by the prosecutor whether she thought Madison's story was credible, Dr. Porter candidly admitted "I really unfortunately can't judge the credibility of her story. There is too many, there is just too many missing pieces that we don't have a -- we don't have the ability in science at this point to say what a typical story of sexual abuse looks like." (TR-16)

Aaron's trial counsel questioned Dr. Porter as to the purpose of a forensic psychological interview. She answered "The purpose is simply to document what the child has to say about what has given rise to these allegations. It's not a fact finding mission. That is the purpose of the fuller investigation, that the interview is a piece of that investigation, but not the full investigation. But it is an important part of it, and it's biggest role being that it documents what the child has to say and protects the child from multiple interviews. So if it's done well, it gets everything that the child has to say down, and then the next person who needs information doesn't' have to come behind you and ask that child questions again; and then the next person asks the child questions again and again and again because those repeated questions tend to compromise the quality of the statement that you are going to get and tend to harm the child." Counsel further inquired "Do those repeated interviews that you are discussing lead to distortion of the child's memory?" To which she responded "Quite often." (TR- 19-20) When later questioned about suggestibility of children's recollections, Dr. Porter explained "It means exactly what it says; that the suggestibility of a child witness that you can effectively say something to them and it can get them confused to the point that they remember things that didn't happen, or they incorporate things into their memory so their memory becomes distorted, and they can, they can just become quite confused, and their memory can get distorted." According to Dr. Porter, Madison Bishop at age 4 was at the peak age of suggestibility. (TR-36)

Dr. Porter further opined that Madison was not competent to testify and did not know the difference between the truth and a lie. (Tr. 43) Finally, Dr. Porter testified that she believed it would be harmful to Madison to be forced to testify in open court in front of Aaron regarding the allegations. That harmful effect, she further opined, would be reduced if Madison were allowed to testify in the judges chambers via closed circuit television. (Tr. 47) Dr. Porter's report after her interview with Madison was inconclusive and had two simple recommendations. "Number One: Non abuse explanations for the child's disclosure should be sought. At the time of this interview, none were apparent. Number Two: The child should not be repeatedly questioned about these events, as repeated interviewing can lead to distortions of memory." (Cp-21) It should be noted that Dr. Porter had unquestioned credentials as a forensic child psychologist and at least attempted to follow scientifically validated protocols in interviewing Madison and rendering her opinions.

At the recommendation of the Department of Human Services and/or the Attala County Sheriff's Department, Madison was referred to and "treated" by Brenda B. Donald, who's qualifications, or rather lack thereof, were hotly contested. Brenda Donald was a licensed clinical social worker who admitted that she was not an expert in forensic interviewing of children. (TR-163) Despite her lack of expertise, the trial court allowed her to give extensive testimony concerning statements allegedly made by Madison to her during the course of "play therapy." These statements which were repeated by Ms. Donald to the jury over Aaron's objection were unreliable and went far beyond the initial alleged disclosure made to Christie Bishop by Madison.

In the pretrial hearings to exclude Ms. Donald's testimony, the prosecution asked Ms. Donald "All this that you in these therapy sessions, is that based on some kind of national protocol or some kind of –" to which Ms. Donald responded "It is based on the type of therapy that is rooted from, I mean from years and years ago that has to do with expression, whether it was in the sand tray, arts,

play, just verbal expression, et cetera, that she was able to express the same information, when she would bring that up about her dad, and there was constancy." The prosecution then asked, "What was the purpose of these therapy sessions?" Ms. Donald responded "My purpose of it is for healing. She was at the point that she was coming in, they said that she was very moody. She was acting out. She acted angry. She had torn up toys like her Barbie, et cetera just — but the purpose of it was to try to heal the trauma that she was describing." (TR-181) Ms. Donald also stated "And in this situation, what we were trying to do is try to separate that and help them on their own experience, try to separate it and try to keep it as pure as possible because sometimes it is tainted by others. But help them to connect because there is such a disintegration between what they went through and what they were told about it. There is distortion a lot of times. It is to try to get the experience in their words and then try to integrate the emotions that go with it, and then to be able to express. (TR-178) Ms. Donald was admitted by the court as an expert in "child therapy." (TR-168) It is critical to point out that Brenda Donald never expected to be called into court to testify regarding her therapy sessions. When questioned closely about the purpose and nature of her sessions with Madison, she made this abundantly clear. She was pressed by trial counsel who asked, "are you aware that repeated interviewing can lead to distortions in the child's memory?" She answered "Yes." And then was asked "And are you also aware that you were the sixth or seventh person to interview Madison about this subject?" She responded "Yes. Well, not about the subject as much as when she would bring it up – if she brought it up, I would reflect back, but I did not go into this with a protocol with specific quizzing of this child or interviewing of this child about sexual abuse. Better, a better expression of that was I was the sixth person that she expressed this to, not that I quizzed her about. And I was in a very different role in law enforcement, DHS, or Trudi Porter as far as doing that type of interviewing." (TR - 193)

When counsel pressed her as to whether or not the interviews she conducted should be recorded for accuracy, she responded "No. Maybe if it's for the purpose of – if it was for the purpose of doing this forensic interview, that is one thing. But I think, I meant I don't, I mean I want this child safe. I want her to be ok. I want her to grow up and be a healthy individual. But I don't feel comfortable ever coming into a courtroom and sharing what someone has told in confidence to me." Trial counsel further pushed "My question was if in a very serious matter someone asked you to rely on the statements a child made during an interview, don't you think it would be important to have the best recollection of the interview humanly possible?" She responded "I didn't know that is what I was asked to do though. That is not, that wasn't my role." Trial counsel then stated and asked " I'm not saying it was, ma'am. I'm not accusing you of doing anything wrong in your job. I am just asking you if you had to rely on a statement made by a four year old and your life depended on it, would you want that interview to be recorded?" She responded "Probably so." (TR-195-96)

In spite of the objection to Dr. Donald's testimony, she was allowed to repeat statements made to her by the child during the course of her "play therapy" sessions. These statements went far beyond those made during the previous five interviews of Madison, which were incredible enough, and morphed over time into bizarre statements belied by and contradicted by the physical facts. The child's mother stated that the child told her she'd seen daddy's tutu, it was long and tall and she had sucked it, it tasted nasty it spit on her and he told her never to bite it (Tr. 49, 55). The child did not disclose any abuse to DHS and sheriff's personnel in their interview. The physical exam conducted by an M.D., where the child was present while the mother described these statements revealed no evidence of trauma to the child's vaginal or rectal areas. At Dr. Porter's forensic interview, the child "was not old enough or developmentally advanced enough to give a clear narrative account of her experiences, and in fact, her language skills were not developed

enough to give real clear direct answers to all questions" (Tr. 14). In response to leading questions after departing from the interview protocol the child initially denied abuse then repeated the same things she had told the mother. Dr. Porter testified that "I had asked her in order to direct her attention to the subject matter at hand, "Did somebody show you his tutu? Did somebody make you touch his tutu, kiss his tutu?" And she initially said no. And then she spontaneously said, "Not my daddy's tutu." She then made statements consistent with the mothers (Tr. 15). Dr. Porter was concerned but believed non-abuse explanations should be ruled out and could not say whether abuse had occurred or not. (Tr. 16).

After the child began the nine "play therapy" sessions with Brenda Donald, the following additional and inconsistent statements were supposedly made by the child to Ms. Donald. "She then said that he touched her tutu when she pointed to herself" (Tr. 169). "He put a toy that makes noise in his booty." She said it was "blue with stripes." She said he keeps it "under his bed." (Tr. 170). She said, "he put his tutu, his big old tutu in my hiney. And she held her hands about two feet apart indicating the size." She said "it hurt." She "talked about seeing poo-poo come out of his poo-poo thingie." (Tr. 172). She said "his tutu squirted on her here. She pointed to her genital area." She said "it hurt" in the genital area. She pointed to her genital area and said "he licked me here, and it tickled." (Tr. 173). She said of the toy "sometimes he puts it in the closet. She talked about him showing pictures of his tutu, "in his hand to my eyes to see" and that he kept the pictures "in a box." She said "I pee-pee on my Daddy." She said "Pee-pee came down my booty" and drew a line "from his genital area to her anal area." (Tr. 174).

SUMMARY OF THE ARGUMENT

The conviction obtained against Aaron Bishop resulted solely from the trial court's decision to allow testimony regarding hearsay statements allegedly made by a four-year old child, whom the trial court had properly ruled incompetent as a witness due to her inability to distinguish the difference between the truth and a lie.

After ruling the child incompetent, the trial court erred in allowing others to testify as to statements allegedly made to them by the child. Since the child did not know the difference between the truth and a lie, none of the statements should have been admitted, as they were irrelevant and unreliable.

The trial court further erred in allowing the testimony of a therapist, Trudi Porter, who elicited hearsay statements from the child using "play therapy." Ms. Porter elicited was not Daubert-qualified to testify, nor does play therapy meet the standards required to pass the Daubert test of being a science.

The trial court further erred in finding and considering that there was evidence corroborating the hearsay statements, under M.R.E. 803(25), violating Aaron Bishop's confrontation rights under the Supreme Court of the United States decision in Idaho v. Wright, 497 U.S. 805 (1990).

ARGUMENT

I. THE LOWER COURT ERRED IN ADMITTING THE SUPPOSED HEARSAY STATEMENTS OF THE CHILD PURSUANT TO M.R.E. 803(25) IN VIOLATION OF AARON BISHOP'S SIXTH AMENDMENT RIGHT TO CONFRONT THE WITNESSES AGAINST HIM AS WELL AS UNDER ARTICLE 3, SEC. 26 OF THE MISSISSIPPI CONSTITUTION OF 1890.

The circuit court admitted numerous hearsay statements by the child regarding the alleged abuse under M.R.E. 803(25). Since there existed not a scintilla of physical evidence and the only other evidence received was an alleged corroborating statement made by Aaron, this evidence was extremely important to the State's case at trial and its erroneous admission undoubtedly resulted in the finding of guilt by the jury. It is crucial to first consider the reason why the State was required to resort to this type of evidence: the trial court found the child incompetent to testify. Such finding resulted from the testimony of the State's own forensic psychologist who was the first and only properly qualified examiner to interview the child. At pre-trial hearings, Trudi Porter, Ph.D., testified in response to questioning by the Court "I don't think she is competent, your honor, to testify. . . . I do not think she has the ability to communicate with the jury. She doesn't always answer questions directly. She does not verbally communicate in a reliable fashion. You could even ask her, you know, can you count to ten, and if she feels like answering your question, she will. But if she doesn't she might look out the window and tell you about the tree. She is just too immature." (Tr. 43). In response to Aaron's trial counsel's question, ". . . was she able to demonstrate to your satisfaction that she understood the difference between a truth and a lie?" Dr. Porter flat-out stated, "No." (Tr. 35).

Dr. Porter further noted that Madison was at the peak age for suggestibility, meaning that, ". . . you can get them confused to the point that they remember things that didn't happen, or they

incorporate things into their memory so their memory becomes distorted, and they can, they can just become quite confused, and their memory can get distorted." (Tr. 36).

The State's other "expert" testified most extensively regarding statements of the alleged abuse by the child to her, despite her clearly not intending to ever be used to provide forensic testimony, not intending to elicit accurate information to be used in court, her clearly not being Daubert-qualified to testify and her own admissions that the child's statements to her might not be accurate but the product of repeated questioning. The statements she testified to went far above and beyond anything the child had ever said to anyone else and some were clearly not possible as far as what the other statements and evidence demonstrated.

Although the trial court made its ruling regarding Ms. Donald's testimony under M.R.E. 803(25)(the tender-years exception), the court also seemed to strongly rely on M.R.E. 803(4), Statements for Purposes of Medical Diagnosis or Treatment. Neither is a firmly-rooted hearsay for Confrontation Clause purposes. Idaho v. Wright, 497 U.S. 805 (1990). Therefore any such statements, in order to be admitted above a confrontation clause assertion as made by Aaron, must contain "particularized guarantees of trustworthiness" equivalent to those recognized by the firmly-rooted hearsay exceptions. None of the statements admitted at trial met this standard, most glaringly those which were admitted through Ms. Donald.

The trial court seemed to ignore both Ms. Donald's own admission of her lack of qualification, lack of intent to obtain forensic statements and the difference between forensic and therapeutic psychology, particularly with regard to childhood sex abuse allegations and reliance on statements made in this child's "play-therapy" sessions with Ms. Donald. With regard to Ms. Donald's testimony, it clearly therefore does not exhibit constitutionally sufficient particularized guarantees of trustworthiness.

The trial court found that the child was incompetent as a witness due to Dr. Porter's testimony and opinion then allowed her testimony indirectly through Brenda Donald. The trial court's ruling flies in the face of the law, common sense and Aaron Bishop's rights under the State and federal constitutions to confront the witnesses against him.

By determining that the child was incompetent due to her inability to determine the difference between the truth and a lie the trial court should have concluded, *ipso facto*, that any testimony concerning statements made by her were inadmissible. That conclusion is the only logical next step in considering the admissibility of her statements. If the court determines that she is not qualified to testify under oath and be cross-examined in front of the jury because of her inability to distinguish between the truth and a lie, then how can her statements made out of court, to her mother or in "play therapy" be deemed reliable? Every single witness questioned on the subject, including Brenda Donald, testified that the repeated discussion of the allegations had been proven to lead to distortions in children's memory. The progression and escalation of the child's statements to include ever more severe allegations totally inconsistent with the findings of her physical examine point strongly to distortion of this child's recollections. The child's later statements included references to penetration of her and to use of sexual toys by Aaron which were not corroborated by either her initial interviews, examinations or any independent evidence of the existence of such toys. Because the testimony was incompetent, it was therefore not relevant under M.R.E. 402.

A. LACK OF DAUBERT QUALIFICATIONS

Ms. Donald quite candidly admitted that she was not qualified in forensic interviewing and did not want to be, preferring to focus her practice on therapy. In therapy in the child-abuse context, the truth or falsity of the allegation is not the focus, as demonstrated by Ms. Donald's own testimony and demonstrated by any credible literature on the subject. Therefore, testimony on such therapy not

only does not even fit the rationale necessary to be admissible under M.R.E. 803(4), that the person making the statement would not make it were it not true, it by definition therefore does not contain particularized guarantees of trustworthiness necessary under confrontation clause analysis.

Ms. Donald had a graduate degree in clinical social work and was board certified in social work. Social work is not a scientific field. Ms. Donald also testified she was a "registered play therapist." This was the area of treatment she testified she performed with the child in this case.

Ms. Donald was asked by the State on direct examination, "All this that you do in these therapy sessions, is that based on some kind of national protocol or some kind of–" and responded, "[I]t is based on the type of therapy that is rooted from, I mean from years and years ago that has to do with expression, whether it was the sand tray, art, play, just verbal expression, et. cetera. . ." She also summarized play therapy as follows, "It is helping the child to be able to put words as to what they are feeling and also to help them play out. A lot of times they work out what is going on with them through play. They can't directly express their anger toward an adult. They essentially have three, three options. You know, they can try to run away from a situation, fight it, or align with the abuser or the aggressive person. And in this situation, what we are trying to do is to try to separate that and help them on their own experience, try to separate it and try to keep it as pure as possible because sometimes it is tainted by others. But help them to connect because there is such a disintegration between what they went through and what they were told about it. There is distortion a lot of times. It is to try to get the experience in their words and then try to integrate the emotions that go with it, and then to be able to express." (Tr. 178). In response to questioning from the Court, Ms. Donald stated that her therapy was "all about healing." The trial court accepted Ms. Donald as an expert in Child Therapy and allowed her testimony about the statements she elicited from the child using play therapy.

The question at issue is whether the statements elicited from the child by Ms. Donald, which went far and beyond what the child revealed to anyone else, were elicited by a reliable, scientific method as required by M.R.E. 702. Ms. Donald's methods, summarized by herself above, are woefully inadequate to meet the standard of Rule 702. Pursuant to Rule 702 and the previous decisions of this Court following Daubert, the trial court clearly erred in allowing the testimony of Ms. Donald.

In order for expert testimony to be admissible, it must be reliable. As stated in Daubert, "[t]he subject of the expert's testimony must be scientific . . . knowledge. The adjective "scientific" implies a grounding in the methods and procedures of science. . . . But, in order to qualify as "scientific knowledge," an inference or assertion must be derived by the scientific method. Proposed testimony must be supported by appropriate validation – i.e. "good grounds," based on what is known." Daubert v. Merrell, Dow Pharmaceuticals, Inc., 509 U.S. 579, 590 (1993). A judge considering a challenge to expert testimony must make a "preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue." Id. at 593. The Court in Daubert set out some factors for trial courts to consider in making this determination. They included whether the theory or technique could be tested, whether it had been subjected to peer review and publication, known or potential rates of error and the existence and maintenance of standards controlling the technique's operation. Id. at 593-94.

The play therapy Ms. Donald used to elicit the statements from the child meets none of these criteria. As two highly qualified researchers have noted:

> Psychology is the only scientific discipline within the mental health professionals. Psychiatrists and social workers are not trained as scientists and the practice of psychiatry and social work are not scientific disciplines

(McHugh, 1994; Saari, 1994). Unfortunately the practice of psychology by clinicians is divorced from the science of psychology and the credible scientific research in psychology has little or no impact on practitioners (Campbell, 1994; Dawes, 1994; Stricker, 1992). Dawes (1989) described the result of this separation:

> The major thrust of APA (American Psychological Association) policy has been to convince the American public that its practicing members have a special expertise and power that simply doesn't exist . . . . And the willingness of psychologists, without facing APA sanctions, to hypothesize in court settings child abuse in the absence of physical evidence–but on the basis of interviews, unvalidated tests, and tests that have been shown to be invalid– is appalling.

"Special Problems with Sexual Abuse Cases", Ralph Underwager, Ph.D and Hollida Wakefield, M.A., in Coping With Psychiatric and Psychological Testimony, Fifth Edition (J. Ziskin, Ed) at pp. 1315-1370. (Copy of complete text attached hereto as Addendum 1). The authors further propose that "there is more pseudoscience, more poor science, and greater misunderstanding of what is scientific and what is not in this system than in any other." Id. The authors further find that in reviewing scientific studies on error rates in child abuse cases, "[t]he error is massive, unacceptable, and in the direction of false positives . . . . The lowest ratio is three false positives to one true positive while the highest is over two hundred to one." Id.

Such an error rate is simply unacceptable under Rule 702 and Daubert, even if Ms. Donald were a qualified psychologist. The state had the burden of supporting Ms. Donald's supposed expertise by demonstrating the reliability of her testimony. It failed miserably. When asked the basis of her methodology, Ms. Donald explained vaguely, "[i]t is based on the type of therapy that is rooted from, I mean from years and years ago that has to do with . . ."

Obviously, this does not meet the definition of scientific testimony required under M.R.E. 702 or Daubert. Contrast the results of Ms. Donald with those of Dr. Trudi Porter, the psychiatrist

who did perform a forensic interview attempting to use a standard, generally accepted protocol. Dr. Porter, who admitted she deviated from the protocol, found that the child initially denied the abuse altogether, then denied Aaron was the perpetrator, then stated that Aaron forced her to perform oral sex on him. Dr. Porter was not convinced on the truthfulness of the child's statements as to Aaron's guilt and suggested that other possibilities be fully investigated, which they never were. Furthermore, Dr. Porter unequivocally stated that the child should not be further questioned about the alleged abuse, "as repeated interviewing can lead to distortions in memory." (Cp. 31).

The court also heard testimony from Dr. Huffman regarding her thorough evaluation of the case and her conclusion that the child's memory had been distorted in this case. Dr. Huffman was clearly the most qualified person to testify, yet the trial court found her to be the least convincing, apparently due to her lack of practical experience. Practical experience has reasoned by the trial court as simply not enough to earn someone the qualifications necessary to give testimony under Daubert. Dr. Huffman supported her testimony with abundant citations to scientific studies in support of her conclusions. Her complete report is in the court papers on numerous times in support of Aaron's pretrial motions. The trial court clearly erred in discounting her opinion as opposed to that of Trudi Porter, whose opinion was based merely on pseudo-scientific methods and which by her own admission was not intended to prove or disprove the truth of any allegations nor intended by her to be repeated in court. Aaron believes that the trial court clearly abused discretion in allowing the testimony of Dr. Porter and Brenda Donald as incompetent and inadmissable under M.R.E. 702 and that this case be reversed and rendered due to a lack of any competent evidence.

B. VIOLATION OF RIGHT OF CONFRONTATION

Pursuant to Idaho v. Wright, 497 U.S. 805 (1990) a hearsay statement not falling within a deeply-rooted hearsay exception is not admissible under the Confrontation Clause unless it contains

substantially particularized guarantees of trustworthiness equivalent to the firmly-rooted hearsay exceptions. The trial court here admitted the statements of the child under M.R.E. 803(25) and 804(5), both of which are recently adopted rules of evidence made in order to make statements such as those in issue more easily admissible.

The trial court ruled that the child was unavailable as a witness due to Dr. Porter's opinion that she was incompetent as not being able to distinguish between the truth and a lie. Idaho v. Wright sets forth twelve factors that a trial court should consider and weigh in determining whether a particular statement meets the standards required for admissibility under the Confrontation Clause. The Supreme Court made clear, however, that it was not imposing a mechanical test and that the ultimate issue was whether the circumstances surrounding the statement, standing alone and without consideration of any corroborating evidence, make the statement so likely to be true that it is the equivalent of one of the firmly-rooted hearsay exceptions. If so, the statement can pass muster under the Confrontation Clause, since cross-examination of the declarant would not be likely to undermine the believability of the statement.

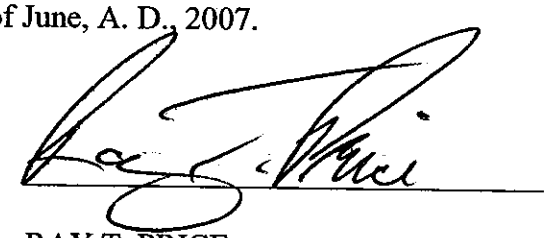
M.R.E. 803(25) plainly runs afoul of Idaho v. Wright, supra, in allowing the trial court to consider, "when the child is unavailable as a witness, such statement may be admitted only if there is corroborative evidence of the act." The trial court in this case, having found the child unavailable because she was incompetent, used this portion of the rule and found that a statement made by Aaron provided sufficient corroboration. The trial court's ruling applying this language of M.R.E. 803(25) clearly violated Aaron's rights under the Confrontation Clause as explained by the Supreme Court in Idaho v. Wright. "To be admissible under the Confrontation Clause, hearsay evidence used to convict a defendant must contain sufficient indicia of reliability by virtue of its inherent trustworthiness, not by reference to other evidence at trial." Id. Thus, even if Aaron's supposed

corroborating statement were indeed corroboration, which we do not concede, consideration of that statement in deciding to admit the child's statements clearly violated Aaron's right to confrontation.

CONCLUSION

For all of the above and forewarned reasons, Mr. Bishop prays that this Court reverse and render the decision of the Circuit Court and order that the Defendant be immediately discharged from custody.

Respectfully submitted on this the 8th day of June, A. D., 2007.

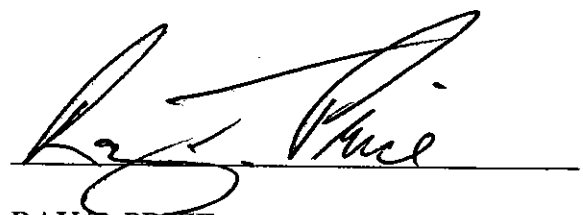


RAY T. PRICE
Of Counsel for Appellant

CERTIFICATE OF SERVICE AS TO FILING

I, Ray T. Price, being the attorney of record for the Appellant in this case, certify that I have this date mailed, postage prepaid, the original and three copies of the foregoing Brief of the Appellant to the Clerk of the Supreme Court, Supreme Court of Mississippi, P. O. Box 117, Jackson, MS 39205.

This the 8th day of June, A. D., 2007.



RAY T. PRICE

CERTIFICATE

I, Ray T. Price, of counsel for Appellant, certify that I have this date mailed, postage prepaid, a true copy of the foregoing Brief of Appellant to the following:

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Special Problems with Sexual Abuse Cases

1. In J. Ziskin (ed.), Coping with psychiatric and psychological testimony, Fifth Edition (pp. 1315-1370). Los Angeles, CA: Law and Psychology Press.

Ralph Underwager and Hollida Wakefield (fl)

More than any other forensic area, the interaction between the justice system, governmental authorities, and the mental health professions in dealing with child sexual abuse has the greatest potential for iatrogenic harm to individuals, adults and children, the family, and the society. The entire structure and system dealing with sexual abuse struggles to make the classification decisions-sexual abuse or not sexual abuse. Once that decision is made, the consequences to every person involved, all participating institutions, relevant social structures, and the nation inexorably march on. We suggest there is more pseudoscience, more poor science, and greater misunderstanding of what is scientific and what is not in this system than in any other. We suggest there is more error, more foolishness, and more poor practice by legal, judicial, medical, psychological, social work, and bureaucratic professionals in dealing with allegations of sexual abuse than any other social issue. There is greater and sharper polarization, more bitter acrimony, more intense emotional involvement, and deeper and more alienating divisiveness in all the professions involved in responding to accusations of sexual abuse than in any other arena (Ceci, 1994; Ceci and Bruck, 1993a).

However, there is one goal-increased accuracy-which everyone should agree on. The justice system, science, bureaucracies, and institutions may be aimed at many different goals and purposes but no participant player can disagree with the value of striving to increase the accuracy of the classification decisions made. There can be no denial that actual benefit to all people is advanced by increased accuracy.

The need to unite about the goal of increased accuracy is underscored by the fact that every scientific analysis we have found of the level and type of error made by the various scientific and mental health disciplines in the effort to deal with allegations of child abuse reaches the same conclusion. The error is massive, unacceptable, and in the direction of false positives-decisions that there is abuse when there is not (Abel et al., 1994; Altemeier et al., 1984; Caldwell et al., 1988; Gambrill, 1990; Horner, 1992; Horner and Guyer, 1991a, 1991b; Kotelchuck, 1982; Lindsay and Read, 1994; Melton, 1994; Milner et al., 1984; Paradise, 1989; Realmuto et al., 1990; Schachter, 1985; Starr, 1979; Wakefield and Underwager, 1988a; Zeitlin, 1987). The lowest ratio is 3 false positives to 1 true positive while the highest is over 200 to 1. Horner and Guyer (1991a, 1991b) demonstrate a ratio of 21 false positives to 1 false negative. Such unanimity across 16 years, different countries, and different areas of practice and technique, is rare in science. It strongly suggests that this system does more harm than good. The need for increasing the accuracy of the decisions made is imperative.

The Beginning of the Problem

Decision making is the heart of the institutions, professions, processes, procedures, and practices that make up the way we respond to allegations of child sexual abuse. Decisions are made at

varying levels of complexity and structure throughout the process, ranging from the first decisions made in responding to initial information that may suggest the possibility of abuse to the final adjudication where a person is found guilty or not guilty, or it is determined that abuse happened or didn't happen. Decisions are made about seeking help, whom to blame, calling authorities, what information to pursue in investigation, whom and what to charge or allege, the weight and importance to be given to hints, cues, or actions, and whether to accept a plea bargain, hire an attorney, or seek a different judge. These judgments are difficult, complex, and have farreaching consequences.

The judgment tasks include descriptions of people, situations, possible events, decisions about what causes what and thus generates problems, and making predictions about possible outcomes. A psychologist may make a decision to accept or not accept a mother's claim that, when she was bathing her daughter after her return from an overnight visit with the father, who she knows was abused as a child, she noticed redness in the vaginal area, asked a simple, non leading question, and the daughter said to her, "Daddy did it!" She may then recommend sexual abuse play therapy for the child. She may make a prediction as to outcomes and advise the mother on whether to send the daughter on the weekly Wednesday evening visitation.

Errors may occur at any place in the chain. They may include:

· Error in description (redness was present when it was not).

· Error in assessing covariation (redness means abuse when it does not).

· Error in assuming causal relationships (being abused as a child causes adults to abuse their own children).

· Error in prediction (insight-oriented, feeling-expressive play therapy benefits a sexually abused child. Given the abuse is true, such therapy has no demonstrated efficacy. If not true, it likely causes harm to the child).

It is the quality of thinking that leads to accuracy or error. It is the very nature of the decision-making process that there are many sources of error. There may be a lack of information or mistaken information. There may be ignorance or information that is not used. There may be lack of understanding of social influence and interpersonal context. Errors may occur because of personal characteristics of the decision maker (i.e., intolerance of ambiguity, ambition, need for approval, anger and rage).

Decision theory research shows conclusively that the human mind does not process information very well (Meehl, 1993). Even in relatively simple, straightforward decisions involving a limited number of factors but requiring thoughtful choices, we resort to short cuts or heuristics, biases, many of which produce errors (Arkes, 1989; Crocker, 1981; Dawes, 1988; Einhorn and Hogarth, 1978; Kahneman and Tversky, 1979; Turk and Salovey, 1985). It is simply the case that rational thought using a $3.95 calculator to add up empirically derived weights does far better than our brilliant intuitive, insightful, and creative subjective hunches or certainties (Dawes et al., 1989). The importance of decision theory research and the demonstration of the error-producing biases is dealt with in more detail elsewhere in these volumes. In this chapter, when we are discussing behaviors or procedures which demonstrate one or the other of the biases discovered by decision

theory research, we will briefly identify it.

Misconceptions That Increase Error

The practice of law includes a heavy emphasis upon examination of prior cases, comparison of analysis and decisions, and distinguishing between the reasoning in this case or that case as it applies to the facts of the instant case. The search for relevant precedents, lining up authorities, and arguing for a position is the major pursuit of attorneys and judges. This most naturally leads to the assumption that science proceeds in the same way. Therefore, when the legal practitioner evaluates scientific information, the natural habit is to look for cases, studies, experiments, or opinion that supports a desired decision and to expect that there will be some opposing cases, studies, experiments, or opinions. Then the conflict will be argued out on the basis of whose authorities appear the most weighty or can be most persuasively presented to the finder-of-fact. This assumption, uncritically accepted and imposed upon scientific data, leads to the frequent question addressed to scientific experts, "Well, doctor, aren't there studies that disagree with you?" Judges may exclude expert testimony by saying they do not want a battle of the experts, that it is controversial in the scientific community, and that the juries already know all of that stuff anyway. The assumption is that science proceeds like a baseball game box score.

Most scientists understand that knowledge is incremental so that we are always building knowledge on what has gone before that is agreed on as accurate. We may never possess full or perfect knowledge about a phenomenon but we must make our decisions on the most scientifically rigorous evidence available. This means we do not rely upon case studies, anecdotes, experience, or elaborate theories built on little or no empirical data. Effective practical applications of the science of psychology are derived from tested and replicated scientific investigations using scientific methods.

Unfortunately, it is the very success of this approach that has led to the climate in which pseudoscience and poor science flourish. People have learned to be impressed by psychology so therefore they accept current fads and unsupported claims. Anything goes in psychology, so lose weight through hypnosis tapes, learn Chinese while you sleep, and find self-actualization by beating drums in the woods.

Scientific psychology proceeds through the application of systematic observation so that through the observation some concepts are supported and others are rejected. Science grows cumulatively by having the systematic observations publicly verified. Findings are presented so that others can replicate them, criticize, extend, or reject them. Ideas that survive this process are understood to be usable. However, it must also be understood that in the process a single result that falsifies a concept must be given more credence than many that may support it (Meehl, 1978). It is not simply a matter of counting noses as the U. S. Supreme Court decision, *Daubert vs. Merrell, Dow* (61 U.S.L.W. 4805, 113 S Ct 2786, 1993) also recognizes. The decision, as is discussed below, sets forth the primary criterion for what is scientific as falsifiability and replication.

Psychology is the only scientific discipline within the mental health professionals. Psychiatrists and social workers are not trained as scientists and the practice of psychiatry and social work are not scientific disciplines (McHugh, 1994; Saari, 1994). Unfortunately the practice of psychology by clinicians is divorced from the science of psychology and the credible scientific research in psychology has little or no impact on practitioners (Campbell, 1994; Dawes, 1994; Stricker, 1992). Dawes (1989) described the result of this separation:

The major thrust of APA (American Psychological Association) policy has been to convince the American public that its practicing members have a special expertise and power that simply doesn't exist. . . .And the willingness of psychologists, without facing APA sanctions, to hypothesize in court settings child abuse in the absence of physical evidence-but on the basis of interviews, unvalidated tests, and tests that have been shown to be invalid-is appalling. It is one thing to push for professional status and income based on true expertise. Doing so in the absence of evidence for such expertise-or in the face of evidence that it does not exist-is socially fraudulent. (pp. 14-p;15)

In the justice system reliance upon expert opinion is based on the assumption that there is a real expertise so that an expert has knowledge that can assist the finder-of-fact in reaching the most accurate decision possible. If that expertise does not exist, there will be a large amount of incompetent and error-ridden opinion offered to the courts under the mantle of objective science. It may be that the most appropriate and helpful expert opinion is to show that there is no trustworthy evidence on either side (Meehl, 1989). If asked whether or not there is general agreement in the scientific community, an expert may in good conscience answer yes, there is consensus but it is wrong.

At the same time, it is necessary to assert what can be offered as solidly supported by scientific knowledge. There is no virtue in attempting to maintain some sort of balance, saying, "on the one hand...but on the other," when there is data demonstrating a given direction. In dealing with child sexual abuse, there is a discernible tilt in the direction of supporting defense consideration of false positives and concern about false accusations (Ceci, 1994).

The Child Witness

When referring to the child witness, never refer to the child as the "victim." Call the child the complaining witness or the child witness. If the defense is that there was no abuse, then there is no crime and with no crime there is no victim. If others refer to the child as the victim, make an objection or move for a mistrial. Also permitting the complaining witness to be identified as the victim may subtly but powerfully condition the jury to believe there was a crime. If the mental health professional ever, in reports, depositions, or notes, refers to the child as the victim, use this as evidence that the professional had made up his mind from the beginning.

Understanding the nature of memory is necessary in evaluating child sexual abuse. The fact that memory is reconstruction is generally accepted in the scientific community (Dawes, 1988; Goodman and Hahn, 1987; Loftus and Ketcham, 1991; Wakefield and Underwager, 1994b, 1994c). People may believe that their memories are a process of uncovering what actually happened, as though a videotape had been made and stored in the brain and is being replayed, but our memories are largely determined by our current beliefs and feelings. Through this process of reconstruction, people can come to believe firmly in events that never happened.

When there is an allegation of sexual abuse, children may be repeatedly interviewed by adults who believe that the abuse is real. The adults may ask leading questions and provide information to the child about what supposedly happened. They may even tell the child that they already know about the abuse. The child may be placed in "disclosure-based" play therapy and further

encouraged to elaborate on the abuse. Through this process of social influence, adults may inadvertently encourage false stories about abuse which can become part of the child's memory.

Interviews of Children

During the 1980s there was a major change in professional opinions concerning the susceptibility of children to suggestive and leading interviews. The first time a psychologist testified in a courtroom as an expert was 1896 when Schrenk-Notzing testified in Munich that witnesses were influenced by suggestion to produce "retroactive memory-falsification" (Bartol and Bartol, 1987). From then until fairly recently this was the prevailing view of children's vulnerability to suggestion. Then a shift occurred. The testimony of young children was generally accepted as truthful and the prevailing opinion was that young children could not be led or "coached" to make statements about abuse that never happened. The belief was that, although children might be led through suggestive interviews to make unimportant errors concerning peripheral details, they could not be led to make statements about important, central events.

But, as researchers became involved in actual cases and reviewed videotapes of actual interviews, they observed that the research supporting the above claims did not begin to duplicate what often happens in the real world. As a result, there has been new research that has changed the consensus of scientific opinion. A number of writers have examined memory development, cognitive and moral development of children, and suggestibility of children to adult social influence (see Doris, 1991; Garbarino and Stott, 1989; Lepore, 1991; Lindsay, 1990; Loftus and Ketcham, 1991; Underwager and Wakefield, 1990; Wakefield and Underwager, 1988a, 1994c). The best summary of this research is in articles by Steve Ceci and Maggie Bruck and in an *Amicus Curiae* brief they presented to the New Jersey Supreme Court in *New Jersey vs. Michaels* (Bruck and Ceci, 1994; Ceci, 1994; Ceci and Bruck, 1993a, 1993b).

The fact that children can be led to make statements about and even believe in events that have not happened does not necessarily mean that children lie, but rather that they are influenced by the adult's beliefs. Some recent studies have provided dramatic demonstrations of the degree to which young children can be influenced by an interviewer (Ceci, 1994; Ceci and Bruck, 1993a, 1993b; Ceci et al., 1994; Clarke-Stewart et al., 1989; Leichtman and Ceci, in press; Thompson et al., 1991).

In situations where a child will eventually testify, the memory will consist of a combination of recall and reconstruction influenced by all of the interviews, conversations, and therapy sessions that have occurred during the delay. The longer the delay, the greater the possibility of social influence and the more the memory may consist of reconstruction rather than recall.

In a careful and thorough review, Ceci and Bruck (1993a) state there are several conclusions that are accepted by the scientific community and would meet "a traditional *Frye* test standard" (p. 431). Attorneys must be familiar with this article and any mental health professional who makes contrary claims should be questioned concerning it. Any mental health professional who does not know and understand the relevant research in this area is extremely vulnerable to cross-examination by a knowledgeable attorney.

Ceci and Bruck's (1993a) major three conclusions are:

First and foremost, contrary to the claims made by some...there do appear to be significant age differences in suggestibility, with preschool-aged children being disproportionately more vulnerable to suggestion than either school-aged children or adults. (p. 431)

Ceci and Bruck also observe that the literature does not support the claim that children are not suggestible concerning central events:

Our review of the literature indicates that children can indeed be led to make false or inaccurate reports about very crucial, personally experienced, central events. (p. 432)

Ceci and Bruck's next major conclusion is:

The second major conclusion is that contrary to the claims of some, children sometimes lie when the motivational structure is tilted toward lying. (p. 433)

Finally, they state:

Third, notwithstanding the aforementioned two points, it is clear that children-even preschoolers-are capable of recalling much that is forensically relevant. (p. 433)

They add that is is extremely important to examine the conditions prevalent at the time of the child's original report:

If the child's disclosure was made in a nonthreatening, nonsuggestible atmosphere, if the disclosure was not made after repeated interviews, if the adults who had access to the child prior to his or her testimony are not motivated to distort the child's recollections through relentless and potent suggestions and outright coaching, and if the child's original report remains highly consistent over a period of time, then the young child would be judged to be capable of providing much that is forensically relevant. The absence of any of these conditions would not in and of itself invalidate a child's testimony, but it ought to raise cautions in the mind of the court. (p. 433)

The important point is that, although young children can provide forensically useful information, the major problem is that adults do not know how to let them do it (Garbarino and Stott, 1989). Young children recall less than adults (Lepore, 1991). But the less information the child gives in free recall, the sooner the interviewer may start using leading questions, which can influence the child and distort the story. Also, young children may perceive the interview task differently from adults and try to tell the interviewer what they believe the interviewer wants them to say (Ceci et al., 1987; Cole and Loftus, 1987). They may answer questions they do not understand and about which they have no information (Hughes and Grieve, 1983).

Therefore, the interviewer must encourage the child to tell in his or her own words what has happened. Several professionals have made recommendations for conducting an unbiased evaluation and noncontaminating interview (e.g. Annon, 1994; Daly, 1991, 1992a, 1992b; Powell and Thomson, 1994; Quinn et al., 1989; Raskin and Yuille, 1989; Slicner and Hanson, 1989; Wakefield and Underwager, 1988a; 1994c; White, 1990; Yuille, 1988). There is general agreement among scientists as to how investigatory interviews should be conducted. The

interviewer should ask open-ended questions and encourage the child to provide a free narrative. Details should be encouraged by responses such as "and then what happened." Pressure and coercion, leading questions and selective reinforcement of responses, and unvalidated techniques must be avoided. The child should be discouraged from trying to answer questions when the answer is not known. Discussions of "good touch" and "bad touch" should not be used since these are confusing and potentially contaminating.

Repeated questions should be avoided since this tells the child the previous answers were not acceptable. The effects of leading questions and coercive interviews will be worse with a long time lag, which is typical in actual cases. Poole and White (1991, 1993) found that young children were accurate if repeated but appropriate (open-ended) questioning was used immediately or one week after the event. But when questioned again two years later, repeated questioning increased inaccuracy. The children often seemed to simply make up responses and the authors conclude that, although children can be prompted to discuss a remote event, this procedure is not without risks. It cannot be assumed that results from research studies using short retention intervals can be generalized to actual cases which often have long delays.

A technique for interviewing children and analyzing the resulting interview is Criterion Based Content Analysis/Statement Validity Analysis (CBCA/SVA). This technique assumes an account based on memory for an actual event will differ in content and quality from accounts that are based on fabricated, learned, or suggested memory. The procedure requires a relatively complete statement obtained as soon as possible after the child has disclosed an incident and the interview must be designed to obtain as much free narrative as possible. Leading questions and suggestions must be avoided. The interview is tape-recorded and transcribed for later analysis (Honts, 1994, Köhnken and Steller, 1988; Raskin and Esplin, 1991a; Undeutsch, 1989). There is research on this technique, but most professionals encountered will not have used it and few interviews in actual cases meet the above standards. A leading, suggestive interview cannot be analyzed with this technique.

Also, if the use of this technique is encountered, the attorney will want to be familiar with observations about and criticisms of the technique. Wells and Loftus (1991) are concerned about the adequacy of the empirical support for CBCA/SVA, the ability of the technique to differentiate individual and age-related differences in linguistic abilities from validity-related differences, and the potential for judges and juries to give the technique too much weight. McGough (1991) observes that many of the criteria are found in standard texts on cross-examination and closing arguments on witness credibility. Since an expert using this technique would therefore be testifying about the truthfulness of the statement, the reliability of the expert would then become an issue. Raskin and Esplin (1991b) defend the empirical basis of the technique and state that they do not advocate the use of CBCA as the basis of expert testimony that a child is or is not truthful. They believe that expert testimony based on CBCA is consistent with both the rules of evidence and the growing body of case law regarding expert testimony by psych

All interviews of the child should be videotaped, or at least audiotaped, since a tape is the only means whereby the procedures and information obtained during the interview can be accurately documented (DeLipsey and James, 1988; Goodman and Helgeson, 1985; Herbert et al., 1987; Jenkins and Howell, 1994; Lamb, 1994a, 1994b; Raskin and Yuille, 1989; Underwager and Wakefield, 1990, Wakefield and Underwager, 1988a, 1994c). A major research project on child

victim witnesses reported by Myers (1994) found a clear consensus that investigative interviews of children should be videotaped. Videotaping was seen as providing an incentive for interviewers to use proper techniques.

In practice, this is often not done. Many prosecutors do not want the defense to get a tape so that they can criticize the interviewer's techniques during the trial (Stern, 1992). We believe that there are no good reasons for failing to at least audiotape investigatory interviews with the child witness; there are only bad reasons. Without a tape, there is no way to know what was said by either the child or the interviewer. When cross-examining a professional who has not taped the interview, assume that the interview *was* leading and suggestive, and do not accept assertions that it was not.

Despite the fact that the standards for investigatory interviews are accepted in the scientific community, these guidelines are often not followed by people in the field. Deficiencies in interviews and evaluations can be pointed out in trial. Judges and juries can readily understand why such interviews are unreliable once the problems are explained to them; we have frequently testified concerning appropriate interviewing techniques and contrasting these with those in a particular case. Such testimony, since it is about the interview techniques and not about the credibility of the child, does not invade the province of the finder-of-fact. Attorneys, once they become familiar with how interviews should be conducted, can bring out the problems in a particular interview or investigation in their cross-examinations of the professionals involved.

The progress of the case, including the procedures followed by the interviewers and evaluators, must be carefully examined (Wakefield and Underwager, 1988a; White and Quinn, 1988). It is essential to analyze all contacts with the child in which abuse was discussed. When children have been subjected to multiple leading and coercive interviews and/or disclosure-based therapy their recollections may become so contaminated that it becomes extremely difficult to determine what is likely to have happened. The New Jersey Supreme Court in *New Jersey vs. Michaels* (642 A.2d 1372, N.J. 1994) states:

[1] We therefore determine that a sufficient consensus exists within the academic, professional, and law enforcement communities, confirmed in varying degrees by courts, to warrant the conclusion that the use of coercive or highly suggestive interrogation techniques can create a significant risk that the interrogation itself will distort the child's recollection of events, thereby undermining the reliability of the statements and subsequent testimony concerning such events. (p. 1379)

Heuristics are specific mental strategies, rules, or short cuts that allow us to solve specific problems. An example of a heuristic is the assumption that a low-number license plate is associated with power or wealth. Although we all use heuristics regularly, they are often without empirical support or justification and may be completely wrong. Some of the heuristics uncovered in decision theory research that are likely operative in the investigation and interviewing process may be underutilization of base rates, the confirmatory bias, the selective recall of illusory correlations, the availability fallacy, and the representativeness fallacy. Confusions of correlation and causation may also occur (Arkes, 1989).

Some Common But Unsupported Interview Techniques

Mental health professionals often use unsupported interview techniques when interviewing children. Although the anatomical dolls are most frequently used, books, puppets, drawings, projective cards, play dough, games, and play therapy are also used (Kendall-Tackett, 1992). None of these are reliable or valid for assessing possible sexual abuse. They have not shown acceptable validity or reliability for any scientific assessment purpose. Their use is apt to contaminate the statements children may make, especially if the the interviewer encourages the child "to pretend." Experts who have used such techniques should be challenged to produce the scientific evidence supporting their proper and appropriate use for assessment along with any contrary scientific evidence.

Anatomically-Detailed Dolls

Although the anatomically-detailed dolls are widely used by many different types of professionals (Boat and Everson, 1988; Conte et al., 1991; Kendall-Tackett and Watson, 1992), they are extremely controversial and there is disagreement in the professional community as to whether they should be used (e.g., Koocher et al., in press; Yates and Terr, 1988). The mental health professional is especially vulnerable if the child's interaction with the dolls forms the basis for an opinion or conclusion about sexual abuse. Even professionals who believe it is all right to use the dolls as interview aids are sharply critical of this use. For example, doll supporters Everson and Boat (1994) state:

Although there seem to be widespread perceptions in both lay and professional circles that young children's behavior with the dolls is commonly used to make definitive diagnoses of sexual abuse (Diagnostic Test Use), such a use of the dolls was not endorsed by any of the guidelines reviewed and is open to significant criticism. (p. 113)

The American Psychological Association anatomical doll task force (Koocher et al., in press) concludes it is all right to use the dolls with certain caveats:

First, AD dolls are not a psychological test with predictive (or post-dictive) validity per se.

Second, diagnostic statements about child sexual abuse cannot be made on the basis of spontaneous or guided "doll play." A clinical interview by a skilled clinician is not play.

Third, particular caution is called for when interpreting the reports of children ages 4 and under, at least so far as reports of "being touched" are concerned and when repeated misleading questioning has been employed.

Fourth, in light of current knowledge, we recommend that APA reconsider whether valid "doll-centered assessment" techniques exist and whether they still "may be the best available practical solution" for the pressing and frequent problem of investigation of child sexual abuse.

Finally, special recognition of normative differences between children of different racial groups and socioeconomic strata should be a part of training professionals who use AD dolls in clinical inquir

These have been seldom, if ever, observed in the hundreds of cases we have reviewed. The attorney may therefore be able to use these in questioning a mental health professional who has

used the dolls.
We, as well as many other scientists, believe that the dolls should never be used, even with these caveats. There are no commonly accepted standards for the use of the dolls nor normative data on them (APA Council of Representatives, 1991). The dolls may become a modeling and learning experience for a child (Wakefield and Underwager, 1988a; Underwager and Wakefield, 1990). Interviewers model handling the dolls, suggest that they be undressed (or undress them for the child) and label them for the child. They ask the child to show with the dolls what the accused perpetrator did and they may even place the dolls in sexually explicit positions for the child. Although some researchers claim the dolls are not suggestive (e.g., Everson and Boat, 1994), studies show that some nonabused children engage the dolls in sexual play (Dawson and Geddie, 1991; Dawson et al., 1992; Everson and Boat, 1990; Gabriel, 1985; Glaser and Collins, 1989; McIver et al., 1989).

The studies that claim to show differences between the doll interactions of sexually abused and nonabused children have major methodological shortcomings which limit any conclusions that can be drawn from them (Ceci and Bruck, 1993a; Skinner and Berry, 1993; Underwager and Wakefield, 1990; Wakefield and Underwager, 1988a, 1989, 1994c; Wolfner et al., 1993). DeLoache (1995), whose research is on the developmental aspects of symbolic representation, notes that the basic reason for using anatomical dolls is the belief that the dolls will elicit information from children that they are unable or unwilling to give verbally. But she observes that, not only is there no good evidence that dolls help in interviews with very young children (age 3 and below), but that the presence of the dolls might result in the youngest children providing *less* information. Younger children cannot understand the basic self-doll relation assumed by interviewers who use the dolls. They cannot use dolls as symbols or representations for themselves and therefore cannot use the dolls to enact their own experiences. She concludes:

To my mind, the most important research finding about the use of dolls with very young children is that there is no good evidence that the dolls help. . . .My study...suggested that the presence of the doll might even interfere with the memory reports of the youngest children . . .(p. 178)

Levy (1989) argues that any statement by a child that is the product of a doll-aided evaluation should be inadmissible as evidence:

There is literally neither theoretical nor any empirical basis for drawing *any* conclusion about what a given child's play with the dolls means. In addition, there is at least a possibility that some children, evaluated by professionals who want them to acknowledge sexual abuse, may come to use the dolls in a fashion that leads fact finders to easily to believe incorrectly that the children have been abused. Mental health professionals who testify have made, and if the testimony is admissible, are likely to continue to make extravagant and baseless claims about the significance of children's play with dolls. And because the dolls purport to be a scientific demonstration that establishes an "aura of infallibility," the implicit message of doll-play testimony is likely to be much more influential with fact finders than any other uncorroborated clinical conclusion by an expert. (p. 407)

Skinner and Berry (1993) observe that distinct patterns of play of abused versus nonabused children have not been identified and that the lack of norms calls into question the forensic use of the dolls and conclude that:

The lack of sufficient evidence supporting the psychometric properties of AD dolls calls into question the use of those dolls in the validation of child sexual abuse allegations. . . .Moreover, given that validity is the principal issue underlying the admissibility of psychological evidence in the courtroom. . .and the inadequate evidence for the construct and criterion-related validity of AD dolls, evidence collected using AD dolls should not be admitted in court in child sexual abuse cases at this time. (p. 418)

Wolfner et al. (1993) point out that the necessary research to determine whether using the dolls has any incremental validity in establishing abuse would involve a group of children who were all *suspected* of being abused who, based on subsequent evidence, could be definitely divided into those who have and have not been abused. The doll interviews would have to take place prior to the children undergoing the standard procedures for investigating sexual abuse, since the process of being questioned about abuse could affect their reactions to the dolls. Such research has not been done-the studies that are claimed to support the use of the dolls only compare children suspected of abuse to those who are not suspected. Wolfner et al. conclude:

We are left with the conclusion that there is simply no scientific evidence available that would justify clinical or forensic diagnosis of abuse on the basis of doll play. The common counter is that such play is "just one component" in reaching such a diagnosis based on a "full clinical picture" (or portrait). ADD play cannot be validly used as a component, however, unless it provides incremental validity, and there is virtually no evidence that it does. . . . we urge that the lack of evidence for the incremental validity of ADD use in diagnosing such abuse, and the interpretive and research problems highlighted in this review, be taken very seriously. We believe that the ethical principle that application should follow knowledge gained from research results, rather than precede it, is self-evident, particularly in an area where an incorrect diagnostic conclusion can have horrific effects on people's lives. Using a diagnostic technique that may simply exacerbate error benefits no one. (p. 9)

In summary, there is no evidence that doll interviews are a valid and reliable method for getting accurate information about sexual abuse, including the claim that they can be used as demonstration aids. The use of the dolls as an assessment or investigatory technique is not generally accepted within the scientific community and would not meet the *Frye* test. Rather, their use remains highly controversial and the scientists quoted above who have carefully reviewed the body of research on the dolls recommend that they *not* be used. For the reasons discussed by Skinner and Berry (1993) and Wolfner et al. (1993) they also fail to meet *Daubert.*

Interpretation of Drawings

Children's drawings, such as the House-Tree-Person (HTP) and Kinetic Family Drawings, as well as free drawings, which are often used in assessing possible sexual abuse, are subject to the same criticisms as the dolls (Underwager and Wakefield, 1990; Wakefield and Underwager, 1988a, 1989, 1994c). The assumption is that the drawings of children who have been abused will differ from those of nonabused children. Qualitative features of the drawings, such as the colors used, the size and detail of body parts, and the shape of the figures may be used to support the claim of abuse.

Drawings lack validity and reliability as projective assessment devices. In a review of the Draw-A-Person test in the *Seventh Mental Measurements Yearbook,* Harris (Buros, 1972) notes that there is very little evidence for the use of "signs" as valid indicators of personality characteristics. There is so much variability from drawing to drawing that particular features of any one drawing are too unreliable to say anything about them. Reviews by Cundick and Weinberg in the *Tenth Mental Measurements Yearbook,* (Buros, 1989, pp. 422425), support the consistent finding that interpretations of drawings (as are often done in forensic evaluations) are not supported by data. Both reviewers note that there are no normative data establishing reliability and validity of the Kinetic Drawing System.

Another type of drawing often used in interviews and evaluations of children is an outline of the back and the front of a boy or a girl. The child is shown the outline and instructed to put an X where he or she was touched. There is no research on this technique. It may give the child the message: "You were touched, now show me where." The use of booklets with outline drawings is essentially a programmed text that teaches the child to focus on genitalia and produce statements about sexuality.

There are serious problems with the few studies which claim to find differences between the drawings of abused and nonabused children. For example, Hibbard et al. (1987) concluded that, since five abused children but only one nonabused child in their samples had genitalia in their drawings, genitalia in drawings is an indicator of possible sexual abuse. But the drawings were obtained by different people for the abused and the nonabused groups and no information was given about how often the abused children had been interviewed about abuse. In addition, the differences between the groups were not statistically significant.

In summary, as with the anatomical dolls, there are no data establishing that the drawings can be used diagnostically to substantiate sexual abuse.

Other Unsupported Techniques

Similar criticisms apply to children's books about sexual abuse, such as *Red Flag Green Flag People* (Rape and Crisis Abuse Center, 1985). In this book, after being led through a series of pages that present good touch and bad touch, children are told to color portions of a figure where they were touched. But neither this book nor any others have been validated for diagnosing child sexual abuse.

Two techniques have been developed for assessing suspected satanic ritual abuse. The *Projective Story Telling Cards* (Northwest Psychological Publishers, 1990) and *Don't Make Me Go Back Mommy: A Child's Book About Satanic Ritual Abuse* (Sanford, 1990) contain explicit pictures illustrating satanic rituals and are used to encourage the child to describe the abuse. Both lack adequate validation.

A child's behavior in play therapy may be used to substantiate abuse. Such therapy is sometimes called *disclosure-based* and the sessions focus on reenactments in play, expressing feelings, and talking repeatedly about the alleged abuse. Although there is no evidence that play therapy is an effective therapeutic procedure (Campbell, 1992a; Underwager and Wakefield, 1990; Wakefield and Underwager, 1988a, 1994; Weisz and Weiss, 1993) children are frequently given therapy for

sexual abuse before there has been any legal determination that sexual abuse has occurred. But there is no support for the supposition that behaviors in play therapy can be used as signs to establish the truth of past events. This type of play therapy can influence children to accept the beliefs of the therapist and can be a contributing factor in cases of false allegations (Campbell, 1992b). Jones (1991) comments that the use of the term "disclosure work" itself suggests the interviewer has a preconceived bias and is not able to consider the alternative that there may be nothing to disclose.

Medical Evidence

Assertions identified as medical evidence are given considerable credence in sexual abuse allegations. Often what is represented as medical evidence or opinion is given unwarranted weight. Although mental health professionals do not perform physical examinations of children, nor ordinarily give testimony concerning them, the results of such examinations may convince a professional involved in investigation or therapy that the child has, in fact, been abused. Such a mind set is likely to bias the interview or evaluation.

Much medical "evidence" is actually inconclusive and nonspecific. Abuse allegations may involve exhibitionism, fondling, and masturbation so one would not expect physical evidence. But when there are allegations of anal or vaginal penetration, the medical report will often state the findings are "consistent with abuse" or "typical of abuse." If a physician makes such a claim, it may exceed the competence of physicians. Many physicians are not trained in causality, statistical inference, nor the laws of probability. If a medical opinion includes such opinions that is in the area of competence of a trained scientist, not the physician.

Unfortunately, many observations commonly seen in medical reports are not supported by scientific, empirical data. A 1983 paper by Cantwell is still sometimes cited to support the claim that a vaginal opening size above 4 millimeters indicates abuse, although there has been little empirical support for this assertion. Vague and ambiguous findings, such as genital redness, are deemed to be "consistent with" sexual abuse. The physician generally obtains a history from the person who brings the child in for the examination and then concludes, "sexual abuse based on history." Such statements are taken seriously by police, social workers, prosecutors, defense attorneys, and therapists and used as evidence that the physical examination has substantiated the allegation.

Such medical findings are apt to be in error (Coleman, 1989). Paradise (1989) estimates that 65% false positives occur when assessing penetration and 73% false positives with assessment of digital penetration. This raises serious questions about the validity and reliability of medical examinati

Until recently, the greatest difiiculty in evaluating physical findings was the absence of baseline data-that is, information about the appearance of the genitals in normal, nonabused children. But McCann and his colleagues have now conducted research on 267 prepubertal nonabused children (McCann et al., 1989, 1990a, 1990b). They report a high incidence of nonspecific findings such as erythema, tags, fissures, scars, adhesions, notches, thickening, and anal relaxation in their sample of nonabused children. They also report a large range of vertical and horizontal hymenal orifice diameters that varied, not only by age group, but according to the technique and position used to measure them. Emans et al. (1987) also report a large range of hymenal openings in their

subjects and note that the genital findings of sexually abused girls were similar to nonabused girls who had other genital complaints, such as vaginitis, vulvitis, bleeding, or dysuria.

Even sexually transmitted diseases do not unequivocally establish sexual abuse. Although sexual contact is the most common means of transmission, there are alternative explanations for contracting the disease (Wakefield and Underwager, 1988a). In addition, the test used may be inaccurate or inappropriate. For example, a chlamydia screening test meant for an adult may be highly inaccurate with a child, and produce false positives because the test reacts positively to certain bacteria which are normally found in the intestinal tract of children (Fay, 1991). The only specific and unambiguous physical findings demonstrating sexual contact are pregnancy or sperm in the vagina or anus. As Krugman (1989) observes:

The medical diagnosis of sexual abuse usually cannot be made on the basis of physical findings alone. With the exception of acquired gonorrhea or syphilis, or the presence of forensic evidence of sperm or semen, there are no pathognomic signs for sexual abuse. (pp. 165-166)

There is no diagnosis of sexual abuse. No nosology or disease nomenclature includes such a diagnostic category. Sexual abuse is an event, not an illness. Just as it would be foolish to diagnose an emergency room patient as "auto accident" instead of a fractured tibia or concussion, so it is foolish to speak of diagnosing sexual abuse. Any medical professional using the term diagnosis to refer to sexual abuse is confusing the medical procedure of ruling out all but one possibility with the investigative process of gathering all relevant information.

Behavioral Indicators and Child Abuse "Syndromes"

Mental health professionals may testify about behavioral characteristics of a particular child that are "typical" of sexually abused children. Such behavioral indicators include a wide variety of symptoms such as regression, withdrawal, aggression, nightmares, bed wetting, fears, masturbation, and tantrums but are completely nonspecific (Wakefield and Underwager, 1991b). They appear in many different situations, including conflict between parents, divorce, economic stress, wartime separations, father absence, natural disaster, and physical, emotional, but nonsexual abuse (Emery, 1982; Hughes and Barad, 1983; Jaffe et al., 1986; Porter and O'Leary, 1980; Wallerstein and Kelly, 1980; Wolman, 1983). There are no behaviors that occur only in victims of sexual abuse. With the exception of sexualized behavior, the majority of symptoms shown in sexually abused children characterize child clinical samples in general (Beitchman et al., 1991).

Even sexualized behavior cannot be used as proof of abuse. What children normally do sexually is more involved than most people believe (Best, 1983; Gundersen et al., 1981; Langfeldt, 1981; Leung and Robson, 1993; Martinson, 1981; Okami, 1992). Friedrich et al. (1991) asked mothers of 880 nonabused two- to twelve-year-old children to complete questionnaires concerning sexual behavior. Although behaviors imitative of adult sexual behaviors were rare, the children exhibited a wide variety of sexual behaviors at relatively high frequencies. Mannarino et al. (1991) report no differences in sexual behavior between abused girls and a clinical control group, although both scored higher than did the normal controls. Gordon et al. (1990) found no differences in sexual knowledge between their samples of sexually abused and nonabused children. Haugaard and Tilly (1988) found that approximately 28% of male and female

undergraduates reported having engaged in sexual play with another child when they were children. Lamb and Coakley (1993) report that 85% of their sample of female undergraduates described a childhood sexual game experience. A third of these experiences, which the respondents rated as "normal," involved genital fondling with or without clothing and some reported oral-genital contact and attempts at sexual intercourse.

In addition, since many sexually abused children do not suffer significant trauma (Browne and Finkelhor, 1986; Finkelhor, 1990; Gomes-Schwartz et al., 1990; Kendall-Tackett et al., 1993; Wakefield and Underwager, 1988a), an abused child may fail to exhibit any behavioral signs. It is a mistake to use the *absence* of behavioral signs as support for an allegation being false.

Using behavioral indicators to assess sexual abuse may result in a mistake in either direction. Besharov (1990) observes that behavioral indicators, by themselves, are not a sufficient basis for a report. Levine and Battistoni (1991) state that none of these indicators, in any combination, are valid without a direct statement by the child about sexual involvement or sexual knowledge. A statement representing the consensus of a group of international, interdisciplinary experts in child sexual abuse (Lamb, 1994b) concluded:

No specific behavioral syndromes characterize victims of sexual abuse. Sexual abuse involves a wide range of possible behaviors which appear to have widely varying effects on its victims. The absence of any sexualized behavior does not confirm that sexual abuse did hot take place any more than the presence of sexualized behavior conclusively demonstrates that sexual abuse occurred; rather, both pieces of information affect the level of suspicion concerning the child's possible experiences and should to serve to promote careful and nonsuggestive investigation. (p. 154)

There are few scientific data supporting the claim of a sexual abuse syndrome or a child sexual abuse accommodation syndrome (CSAAS) (Summit, 1983). These syndromes are speculative and meet neither *Frye* nor *Daubert.* The revisers of DSM-III refused to include them in DSM-III-R because there is no evidence to support them (Corwin, 1988).

Myers (1993) notes that both diseases and syndromes share the medically and forensically important feature of diagnostic value. Both point with varying degrees of certainty to particular causes. However, whereas with many diseases the relationship between symptoms and etiology is clear, with syndromes, this relationship is often unclear or unknown. The certainty with which a syndrome points to a particular cause varies with the syndrome. Two syndromes often offered in expert testimony in cases of alleged child abuse are the battered child syndrome and CSAAS. The battered child syndrome has high certainty since a child with the symptoms is very likely to have suffered nonaccidental injury. Therefore, this syndrome has high probative value and, in fact, has been approved by every appellate court to consider it. This can be contrasted with the child sexual abuse accommodation syndrome (CSAAS) which does not point with any certainty to sexual abuse. The fact that a child shows behaviors of the CSAAS does not help determine whether the child was sexually abused.

The CSAAS is a nondiagnostic syndrome. It does not meet the test of falsifiability when used to support abuse since there is nothing that can count against it. Therefore *Daubert* would lead to the judicial decision that use of the CSAAS is inadmissible. By contrast, in the battered child syndrome there is research evidence accumulating to demonstrate that nonaccidental injuries can

be successfully discriminated from accidental injuries by the nature of the injuries.

The Nature of the Allegations

Normal parenting behaviors such as bathing, toileting, tickling may be mistakenly labeled as sexual abuse. Rosenfeld and his colleagues (Rosenfeld et al., 1986, 1987) stress getting normative information on nakedness, genital touching and bathing practices before deciding whether any of these behaviors support a suspicion of sexual abuse since they found that many behaviors which could trigger suspicion of abuse occurred often in normal families.

In many cases of false allegations, the behaviors alleged are simply implausible. Here, it is necessary to attend to the base rates. There is information about the behavior of known sexual abusers (e.g., Erickson et al., 1988; Kendall-Tackett and Simon, 1992, Wakefield and Underwager, 1994a, 1994b). In actual sexual abuse physical violence is rare. Vaginal and anal penetration are rare in very young children because it is so painful. Bribery is more common than threat. When there is no corroborating evidence, and the behaviors alleged are highly improbable, it is unlikely that the allegations are true.

Allegations involving satanic ritual abuse must be treated very skeptically. Although there have been presentations on this topic at professional conferences along with media attention to such cases, there have been no findings of physical evidence corroborating the claims of satanic cults, human sacrifice, or a widespread conspiracy. Despite hundreds of investigations by the FBI and police, there is no independent evidence supporting the existence of organized cults of outwardly normal people who engage in ritual abuse, animal and human sacrifice, murder, and cannibalism of children (Hicks, 1991; Lanning, 1992; Mulhern, 1994; Richardson et al., 1991; Victor, 1993; Wakefield and Underwager, 1992, 1994b).

Occasionally disturbed people abuse and murder children, and the disturbance may include unusual religious mentation and rituals. There may be claims that such a person' s behavior looks like a satanic ritual. In addition, the child may have been abused in some fashion, even if the ritual abuse allegations are not true. But there is simply no evidence for organized conspiracies of outwardly normal people who ritually abuse and torture children.

Mental health professionals who believe in the facticity of bizarre, improbable claims should be confronted with the lack of hard evidence for the allegations. The more bizarre the story, the more unlikely it will appear to be true to the finder-of-fact. The less credible will be an expert who admits to believing in the satanic cult conspiracy. But, at the same time, the judge or jury needs to understand how the interrogation process can induce a child to make statements about implausible abuse, and may even result in memories for events that never happened.

Post-traumatic Stress Disorder

This diagnosis of PTSD is frequently used when there are allegations of sexual abuse. However, it is often given in error and is used to buttress the claim that the alleged abuse is, in fact, true.

According to the DSM-III-R, this diagnosis is made following a traumatic event that is "outside the range of usual human experience...(and) would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness" (American Psychiatric

Association, 1987, p. 247). The DSM-IV is similar: "...extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity....The person's response must involve intense fear, helplessness, or horror" (American Psychiatric Association, 1994, p. 424).

But observed behaviors on the part of the alleged victim cannot be used to reason backwards to prove that the claimed event actually occurred. Such erroneous reasoning should not be allowed to imply the truthfulness of assertions about prior events. The Task Force Report of the American Psychiatric Association (Halleck et al., 1992) maintain that a DSM-III-R diagnosis cannot be used to conclude that criminally actionable conduct has occurred. They state: "In the absence of a scientific foundation for attributing a person's behavior or mental condition to a single past event, such testimony should be viewed as a misuse of psychiatric expertise." (p. 495)

When a diagnosis of PTSD is made in child sexual abuse allegations, often the intent is to buttress the allegation by essentially saying these are symptoms seen now and they are caused by the abuse done in the past. This is the formal logical error known as affirming the consequence. It may appear to have the form of a valid argument but relevant facts have been left out, evaded, or distorted. This logical error is also a confusion between one way and bidirectional implication. The argument may be like this: If the child has been sexually abused, she should have night mares. She has nightmares. Therefore, she has been sexually abused. The fact evaded is that nightmares can be caused by many things, including eating green apples. Any attempt to introduce the PTSD diagnosis in this fashion must be challenged. Also the basis for the diagnosis must include sufficient documented symptomatology to meet the requirements of DSM-III-R and DSM-IV.

In addition, the event must be traumatic, outside the range of usual human experience, and experienced with intense fear, helplessness, or horror. Fondling that causes little discernible distress at the time does not fit this definition, but we have seen many such cases in which the PTSD diagnosis is given.

Assessment of the Accused Adult

No psychological test nor evaluation procedure can ascertain whether a given individual has, in fact, abused a child or committed any other specific behavior. Hall and Crowther (1991) observe: "In sum, there appears to be no psychological method of identifying sexual aggressors and predicting recurrence of sexually abusive behavior that has unequivocal empirical support." (p. 80) Myers (1992) notes that "There is no psychological litmus test to detect sexual deviancy." Erickson et al. (1987) report that there is no typical sex offender MMPI profile and that "Attempts to identify individuals as likely sex offenders on the basis of their MMPI profiles are reprehensible." (p. 569)

Although the terms are often used interchangeably, a distinction must be made between "sex offender against a minor" and "pedophile." The former refers to a criminal sexual behavior and the latter to an anomalous sexual preference. Many pedophiles never act on their impulses. The DSM-IV (American Psychiatric Association, 1994) defines pedophilia in terms of recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children, and requires that the fantasies, urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of

functioning. It is therefore possible for an individual who meets these criteria to have never engaged in illegal sexual behaviors. At the same time, not all sex offenders against a minor are pedophiles. All mental health professionals acting in an expert witness capacity should know this distinction.

The psychologist may make unsupported claims concerning the defendant. For example, although some professionals distinguish between "fixated" and "regressed" pedophiles, empirical research does not support the existence of this typology (Conte, 1990; Knight, 1989; Knight et al., 1989; Simon et al., 1992).

Another unsupported claim is that most sexual abusers were themselves abused as children. In some cases, the mental health professional will use a history of sexual abuse to bolster the claim that an individual who is denying abusing a child has the characteristics of an abuser. But the empirical evidence does not support the claim that most sexual abusers were themselves sexually abused (Garland and Dougher, 1990; Langevin and Lang, 1985; Murphy and Peters, 1992; Rivera and Widom, 1990; Widom, 1989a, 1989b, 1989c). Although the DSM-III-R (American Psychiatric Association, 1987) stated that "Many people with this disorder were themselves victims of sexual abuse in childhood," (p. 285) this statement is *not* found in the DSM-IV. Murphy and Peters conclude that "Clearly there is insufficient evidence to correlate historical items with sex offending in any fashion that would be reliable enough for use in a courtroom." (p. 33)

Although sex offenders are likely to have psychological problems, they are heterogeneous in personality characteristics. There is no typical MMPI profile for child abusers, although they often have various types of pathology that are reflected in their MMPIs. But a significant minority of sex offenders produce normal MMPIs. Erickson et al. (1987) found that 19% of their convicted sex offenders had profiles within normal limits, and Shealy et al. (1991) report on MMPIs of incarcerated sex offenders against children and found two of four subgroups with mean MMPI profiles that were within normal limits (although all four groups had various types and levels of difficulties in personality functioning). Therefore, a "normal" personality based on an MMPI or other assessment techniques does not mean that the individual could not be a sexual abuser. And the presence of psychological problems does not mean the abuse is real, since the great majority of people with psychological problems are not sexual abusers.

If the results of an evaluation are presented in terms of the person fitting or not fitting the "profile" of an abuser, this is especially problematical. Psychologists and psychiatrists do not deal with profiles; this concept comes from the FBI's Behavioral Science Unit. There is no "profile" of a typical child sexual offender. Profile evidence is usually not admissible in court and Myers (1992) points out that many courts hold sex offender profiles are a form of novel scientific evidence that has not found general acceptance in the scientific community. Peters and Murphy (1992) summarize appellate rulings and conclude, "With the notable exception of courts in California, virtually every appellate court that has ruled on the admissibility of expert testimony regarding the psychological profile of child molesters has rejected it." (p. 39)

When a woman is accused of committing sexual abuse and the mental health professional testifies that she did it, the base rates for women as child sexual abusers must be considered. Despite several highly publicized day care cases which have involved women and the belief of

some professionals that sexual abuse by women is a serious and under-detected problem, sexual abuse by a woman remains unusual (Wakefield and Underwager, 1991a). Professionals who fail to carefully examine the evidence when a woman is accused of sexual abuse may cite the research of David Finkelhor and his colleagues (Finkelhor et al., 1988a, 1988b), who, in a national study of 270 day care cases, report that 40% of the perpetrators were women. These women tended to be intelligent, educated, highly regarded in their communities, and not likely to have a history of known deviant behavior. Many of these women were alleged to have engaged in extremely deviant, low base rate behaviors such as oral-genital penetration, urolagia and coprophagia, and ritualistic, mass abuse.

There are significant problems with the methodology of this study. Although the researchers required the abuse to be "substantiated," substantiation was defined in terms of any one of the people assigned to investigate the report believing that the abuse was real, despite whoever else may have thought it was false. They say, "our way of defining substantiation is only a way of approximating the truth. . . . Whenever we refer to cases, the reader should not automatically assume that we, or anybody else, knows with absolute certainty that these are cases of abuse rather than mistaken allegations" (Finkelhor et al., 1988a, pp. 14-16). Their sample therefore includes an indeterminate number of cases which ended in dismissals or acquittals, or convictions that were later reversed. For example, the McMartin case, which later ended in dropped charges and acquittals, is included. So is the Kelly Michaels case in New Jersey, which was overturned on appeal in 1993. No responsible professional believes that Kelly Michaels was guilty

Psycological Testing

Psychological testing is discussed in detail elsewhere in these volumes so we will limit ourselves here to testing in cases involving sexual abuse allegations. Attorneys should obtain all the raw test data underlying any reports and conclusions and then have their own expert examine them. We frequently encounter reports and depositions in which claims are made that simply are not supported by the test results (Wakefield and Underwager, 1993). In addition, tests may be incorrectly scored and misstatements made.

Misuse of the MMPI and MMPI-2

Ziskin (1981) notes that the MMPI better fits the forensic requirements for evidence to be believable and understandable than do other assessment methods. The MMPI has years of validation research and the data obtained from it are objective and quantifiable. The goal of the MMPI-2 revision committee was to develop the MMPI-2 so that the research on the original MMPI was still relevant and usable. There is dispute, however, as to whether this goal was realized (see Chapter 12 in this volume).

The major problem with the MMPI and MMPI-2 is that mental health professionals may give testimony that is far beyond what the test can assess. In their reports, depositions, and testimony these professionals make interpretations and draw conclusions about how an individual's MMPI is in some fashion typical or not typical of sex offenders.

The MMPI and the MMPI-2 have no scales that determine whether or not an individual is a pedophile or a sex offender. There has been research on MMPI scale elevations in sex offenders, but there is no typical sex offender MMPI profile. Although mean profiles often involve scales 4 and 8, with 9 and 2 also sometimes elevated, these elevations were also found in murderers,

arsonists, and property offenders in a forensic psychiatric facility (Quinsey et al., 1980). Elevations on scale 4 are common in prison populations (Murphy and Peters, 1992). *The MMPI cannot establish whether an individual is a sex offender.*

The MMPI and MMPI-2 can provide information about personality characteristics that can be useful in the overall analysis of a case. It is most useful when there are allegations of highly deviant, low base rate, or sadistic abuse which the individual denies, and a valid, within normal limits MMPI suggests the absence of psychopathology. In such cases, the clinician must pay attention to the discrepancy.

We have observed several specific errors in interpretation made with the MMPI in child sexual abuse cases. MMPIs are often overinterpreted and misinterpreted. Such erroneous interpretations are not simply a matter of a difference of opinion; they are wrong and cannot be justified by the literature. Psychologists making such interpretations should be confronted and required to produce the research supporting their claims.

Scale 5 0verinterpretations

A scale 5 (masculinity-femininity) elevation may be interpreted as reflecting sexual conflict and sexual dissatisfaction and thus making it likely that the person committed a sexual offense. We have seen a psychologist testify that a scale 5 elevation meant the person had a tendency to act out sexually with a child.

It is mistake to interpret an elevation on scale 5 as reflecting sexual conflicts or as meaning it is likely that the person is homosexual or a child molester, since there are many factors behind such an elevation. The MMPI-2 norms have resulted in much lower scale 5 elevations in males, so perhaps the frequency of this particular misinterpretation will be less in the future. Scale 5 is the least well defined and understood of the MMPI clinical scales (Butcher, 1990).
An elevation on 5 in males is believed to reflect an intelligent, tolerant, imaginative, creative, sensitive, and empathic individual with a wide range of interests which do not fit the masculine stereotype. Scale 5 is highly correlated with education, intelligence, and social class and interpretations must take these factors into account (Butcher, 1990). A very high elevation (76 and above) is believed to be found in males who do not identify with the traditional masculine role and such elevations may indicate passivity and conflicts over sexual identity. However, there is no indication in the MMPI literature that child molesters or other sex offenders are more likely to score high on scale 5. Any testimony that a scale 5 elevation is typical of pedophiles or child sexual abusers should be countered by the lack of empirical support for such an assertion.

Overinterpretation of the K Scale in Court or Custody Settings

An overinterpretation of a high K (defensiveness) scale in a court or custody setting is a common error. Any conclusions about defensiveness on the MMPI must be qualified in terms of the testing situation. Elevations on the K scale in persons taking the MMPI in custody and court situations are common and must not be interpreted as signifying defensiveness as a personality characteristic. It is a normal and adaptive response to the situation. Graham (1988) notes that, if he doesn't see an elevation on K in a custody evaluation, he wonders what is the matter-doesn't the person want the child?

We have seen numerous forensic cases where a K elevation in an otherwise within normal limits MMPI was interpreted by the psychologist as "clinically significant." In one case, the psychologist claimed the K elevation meant that the client was defensive and was trying to "present himself in the best light psychologically and emotionally" and was "trying to answer the questions in the direction of looking good." He further claimed that "Sexually, this kind of thing (an elevation on the K scale) is expected." There were no qualifications in terms of the setting in which the MMPI was taken. In addition, this was a professionally and occupationally successful man with college education. The person's social class and educational level must be considered in interpreting K since persons from higher social classes typically produce K scores on the MMPI-2 between 55 and 65 (Butcher, 1990).

Failure to Recognize the Situational Factors in a Scale 6 Elevation

An elevation in scale 6 (paranoia) is a common response in persons who have been accused of sexual abuse and who deny the allegations. This is due to the affirmation of such items as *he knows who is responsible for most of his troubles, someone has it in for him, he believes he is being plotted against,* and *he is sure he is being talked about.* Rather than reflecting anger, hostility, suspiciousness, and paranoia as a pathological personality trait, the endorsement of these persecutory items reflects the individual's current reality and is a normal response to the situation. We have done research on this (Wakefield and Underwager, 1988a and 1988b), and Ziskin (1981) also discusses such situational effects on scale 6 and recommends caution in interpreting scale 6 elevations in such circumstances.

It is an error to interpret a scale 6 elevation in such a situation as indicating high defensiveness, anger, distrust, sexual conflict, poor behavioral controls, and tendencies toward acting out conflicts and impulses. In one case, a scale 6 elevation in a person accused of sexual abuse was labeled "seriously abnormal," a "very pathological profile," "scary" and the conclusion was made that the person was very likely to be a sexual abuser.

Departing from Standard Administration Procedures

Occasionally, a psychologist will send MMPIs home to be finished, or deviate from the standardized administration in other ways. In one case, the client left several items unanswered and the psychologist called him up and read the questions and recorded the answers over the telephone

Whereas psychologists may sometimes deviate from standardized administrations with therapy clients, it is never acceptable for a forensic evaluation where the results of the evaluation are to be presented in the justice system and are to be used in making decisions about people's lives. Ziskin (1981) warns against this practice:

The "take home" MMPI should be avoided in the forensic situation. . . . Thispractice can lead to questions as to whether the individual took the test in the standard way and whether all of the responses are purely his own, as highlighted by Graham's amusing anecdote about the mental hospital patient who had his ward colleagues assist him by voting on the appropriate answers. (p. 7)

Overinterpretation of the MMPI Supplementary Scales
The supplementary scales must be interpreted cautiously when the basic clinical scales are within normal limits and the interpretations must be on the basis of rules based on research. For example, in one case in a custody evaluation, the clinical scales for the father were all well within normal limits but the dominance scale was elevated. The MMPI was interpreted as indicating that the father had a "highly assertive and domineering style," whose leadership is "characterized by determination, inflexibility, and an almost autocratic control." In his trial testimony, the psychologist said that the father was "a very willful man" who has "not played the game right" and added that "All the time, I suspect what I saw in my tests undercuts that quite a bit, because assertiveness, being aggressive, dominance, can become autocraticness, and I think that's what has happened."

This is a misinterpretation of a dominance scale elevation in an otherwise within normal limits profile. Caldwell (1988) says the following about the appropriate interpretation of the Do (dominance) supplementary scale:

Although based on peer nominations of subjects as strong, confident, influential, unintimidated in face-to-face situations, and showing initiative and leadership. . .the title "dominance" may be partially misleading. That is, the scale reflects taking charge of one's own life-or not taking charge-considerably more than bossiness or being overbearing. Do should be interpreted as taking charge of one's life. . .e.g. as self-organizing, making workable plans, and meeting deadlines. (p. 56)

This description, was, in fact, quite accurate for this man.

Ignoring a Within Normal Limits Profile and Finding Pathology with Projective Tests
We see this frequently. The MMPI or MMPI-2 is valid and within normal limits, but a Rorschach or TAT, or even a Bender, often administered and scored idiosyncratically, forms the basis for a diagnosis of serious psychopathology. Two examples:

· The MMPI-2 was within normal limits and not defensive (K = 56). But the evaluator, who was very sympathetic to the woman who had accused her former husband of sexually abusing their child, said that this was because the man, a physician, was "in a sophisticated way, understating concerns in his life." On the basis of his clinical impressions, a few TAT stories, and a Rorschach interpreted with no scoring system, he diagnosed the man as Paranoid Schizophrenic and said that he was threatening and potentially dangerous. The man, a successful physician, had no history of mental illness nor dangerous or violent behavior, but expressed his anger at being falsely accused of sexually abusing his child.
· The MMPI was moderately defensive and within normal limits. But, on the basis of a Rorschach and the House-Tree-Person test, the man was said to have tied up his son with a blue bicycle chain and sodomized him. The Rorschach (which had no unusual responses) was interpreted as: ". . .highly defensive stance which is accompanied with blocking, censoring, and inhibition of his underlying affect. . . .an undercurrent of anxiety, unrequited love, and cloaked sexuality...difficulty with relating appropriately to others...latent polymorphus perverse orientation to the environment. . .fantasies (that may include) homosexual, bisexual, and exhibitionist feelings. . .hostility toward women. . ."

In such cases, the attorney can have the psychologist read the interpretation out loud, ask for the scientific literature supporting the assertions and the scientific literature supporting any contrary interpretations and make it clear to the finder-of-fact that this is meaningless jargon.

Millon Clinical Multiaxial Inventory (MCMI and MCMI-II)

When the Millon Clinical Multiaxial Inventory, along with the computerized interpretation is used, the psychologist is apt to report significant psychopathology. The computerized interpretation of the MCMI-II may be lifted verbatim and without qualification from the computerized printout which accompanies the test scoring.

This practice is a particular problem with the MCMI-II, which is normed on and intended to be used for a clinical population. When used for other assessment purposes, the MCMI-II must be interpreted extremely cautiously because of its tendency to overpathologize. The result of using these computerized interpretations greatly exaggerates psychopathology.

The problem is not in the test, but in its misuse. The test is normed entirely on clinical samples and is only intended for persons who have psychological symptoms and are being assessed for treatment and evaluation. The manual (Millon, 1987) clearly states that this test is "not a general personality instrument to be used for 'normal' populations or for purposes other than diagnostic screening or clinical assessments." (p. 7) Millon has repeatedly warned against using the inventory with people who are not psychiatric patients because the test norms may not be valid if the subject does not fit the standardizing (psychiatric) group (Choca et al., 1992) .

The MCMI can provide useful information when interpreted cautiously and conservatively. Choca et al. (1992) state that there is nothing intrinsically wrong with using the MCMI to test "normal" people as long as the evaluator is aware that the test was designed for and standardized with a psychiatric population. The user will have to make the appropriate adjustments. But this is seldom done. The computerized narrative must never be lifted verbatim into the report since it may find serious psychopathology and personality disorders in just about everyone. The attorney should vigorously cross-examine a psychologist who does this.

Multiphasic Sex Inventory

The Multiphasic Sex Inventory (MSI) (Nichols and Molinder, 1984) is a self-report questionnaire which consists of statements about sexual activities, problems, and experiences. It has scales which assess the level of openness about the deviant sexual behaviors. The authors state that it has been used by over 1400 clinicians, clinics, universities, and institutions. Although the authors report on the use of the MSI in studies of sex offenders, it has not been reviewed in Buros. It is intended to be used in assessing sex offenders to develop treatment plans and to be used during treatment to assess progress. However, it is also sometimes used to assess an individual who denies sexual abuse to determine whether the individual actually is an abuser.

This test is not intended for this purpose. It must never be used when the defendant is denying the offense. The manual accompanying the MSI states, "[I]t is important to remember that the MSI is not appropriate for use in the legal pursuit of guilt or innocence. The alleged offender must acknowledge culpability in order for the inventory to be used" (Nichols and Molinder, 1984, p. 39). It must never be used on an individual who denies being a sex offender or as part of an assessment to determine whether someone who denies an alleged sex offense is likely to have actually done it.

The Penile Plethysmograph

The penile plethysmograph is a technique which attempts to measure sexual arousal by recording the penile responses during the presentation of sexual stimuli. The stimuli consist of slides of nude male and female adults and children and the audiotapes portray a variety of sexual activities. During the presentation of the stimuli, the penile responses are recorded with a volumetric or a circumferential device. Supporters claim that this technique permits assessment of sexual arousal and hence, sexual preferences and deviancy.

This technique is controversial and should never be used with someone who denies sexual abuse in order to assess the veracity of the denial. Plethysmograph researchers claim that plethysmography can be useful in treatment, but is of limited use with known sex offenders in predicting future behavior, and is of no use in screening a normal population. It cannot be used to determine whether a person who has been accused of sexual abuse and is denying it is telling the truth. There are virtually no data related to the use of the plethysmograph with adolescents (Murphy et al., 1991). Despite these limitations, the plethysmograph is often used in evaluations of both adults and adolescents in sexual offense cases.

Problems with the penile plethysmograph include:

· There is a lack of standardization for training in the use of the plethysmograph (Murphy and Peters, 1992).

· There are no standards controlling the type of erotic stimuli used and the method of presentation (Barker and Howell, 1992; Murphy and Peters, 1992; Schouten and Simon, 1992; Simon and Schouten, 1991).

· There are no generally agreed-upon guidelines as to normal and deviant phallometric response ranges (Simon and Schouten, 1991).

· There is a lack of adequate normative data in which the sexually deviant population is compared to a normal population. Without standardized norms, interpretation is impossible (Barker and Howell, 1992).

· Studies with normal controls indicate that a high percentage of control subjects respond with deviant arousal patterns (Annon, 1993; Freund and Watson, 1991; Simon and Schouten, 1991). The high percentage of normal controls who show arousal to deviant stimuli on the plethysmograph means that arousal to deviant themes does not confirm sexual deviance.

· Subjects are readily able to manipulate their erectile responses. There is no completely adequate way or generally accepted procedures for detecting, preventing, or correcting for faking on the plethysmograph (Barker and Howell, 1992; Hall et al., 1988; Langevin, 1988; Murphy and Peters, 1992; Proulx et al., 1993; Quinsey and Laws, 1990; Schouten and Simon, 1992; Simon and Schouten, 1991; Travin et al., 1988).

· Although some research with adults has been able to separate offenders from nonoffenders on the group level, statistically significant differences between groups does not automatically translate into functionally significant differences for interpreting an individual's pattern of erectile responding (Marshall and Eccles,1991; Murphy and Peters, 1992).

· Incestuous offenders tend to show arousal patterns that are similar to nonoffenders (Murphy and Peters, 1992).

· Efforts to calculate a "pedophile index" and use a cutoff score or the use of discriminate analyses results in many misclassifications and produces a high rate of both false negatives and false positives (Murphy and Peters, 1992; Simon and Schouten, 1991).

· Although reliability is necessary for the plethysmograph to be valid, the reliability in studies is

influenced by variables such as the length of the test-retest interval, selection bias, stimulus content, and scoring methods. The research shows reliability coefficients ranging from .38 to .94 (Simon and Schouten, 1991).

· The research on the relationship between changes in arousal patterns after treatment and recidivism is limited and the evidence is that changes in erectile responding with treatment do not predict outcome (Blader and Marshall, 1989).

· Although the rationale for using the plethysmograph is that psychophysiological assessment is necessary because sex offenders cannot be taken at their word, one study (Day et al., 1989) found that the self-report measures (MSI scales) were superior to psychophysiological measures in discriminating between groups classified on the basis of their offenses.

· Although the rationale for using the plethysmograph is that it can detect deviant arousal in offenders who are not truthful concerning their erotic likes and dislikes, the plethysmograph is not very sensitive for offenders who do not admit to a corresponding erotic preference (Freund and Watson, 1991).

· The evidence does not provide adequate support for the hypothesized relationship between sexual arousal in the laboratory and overt sexual acts (Barker and Howell, 1992; Hall et al., 1988; Simon and Schouten, 1991).

· Not all sex offenders have deviant arousal patterns that correspond to their criminal sexual behavior (Hall et al., 1988; Marshall and Eccles, 1991).

Murphy and Peters (1992) conclude about the forensic use of the penile plethysmograph:

The results of the studies using erection data suggest that, although group differences are reliably found, the ability to classify an individual would produce error rates that would not be appropriate for the trial situation. In addition, in cases of incest or when patients deny charges, one would even expect to find either no responding in the laboratory or a normal response pattern. Further, it is clear that individuals can fake their responses and the absence of significant responding is basically meaningless in terms of a clinical interpretation. Like the MMPI literature, we find the conditions under which the test has been validated do not meet legal requirements. (pp. 32-33)

Simon and Schouten (1991) argue:

The use of phallometric findings for important clinical and legal decisions and scientific inquiry should reflect a full appreciation of the measurement technique and the assumptions underlying its use. This becomes possible given adequate empirical support and clear explication of general principles. The validity and clinical utility of plethysmography in the assessment and treatment of sexual deviance remain to be established. (p. 87)

Barker and Howell (1992) state:

Misuse of the plethysmograph is a major concern. Using the plethysmograph to predict innocence, guilt, or likelihood of reoffending is beyond the scope of the test's validity. In this application the plethysmograph has not "gained the general acceptance" required by *Frye vs. United States* to be acceptable in a court of law. (p. 22)

McConaghy (1989) observes:

Though never validated as a measure of individuals' sexual arousal, PVR measures of erection are currently widely recommended for assessment and determining treatment of individual sex offenders. If these assessments could affect or are believed by the offenders to affect the outcome of the legal processes in which they are involved, the procedure is not only scientifically unsupported, it is unethical. (p. 357)

Pithers (quoted in Annon, 1993), in a deposition, states:

I know of no psychometric procedure or psychophysiological procedures that can be used to demonstrate with psychological certainty that a person has committed a legal offense or engaged in child sexual abuse or is likely to do so in the future. That is the province of sorcerers and witches, not of a psychologist. It clearly asserts that the practitioner has special powers beyond which most psychologists would assert themselves to have; and therefore, I believe it is a highly inappropriate response and potentially one for consideration by an ethical board. (p. 40)

In conclusion, research does not support the use of the plethysmograph as a technique to determine whether an individual who denies abuse is, in fact, sexually deviant, to make sentencing recommendations, or to predict recidivism. It is not generally accepted in the scientific community and meets neither the *Frye* test nor *Daubert.*

Testimony About the Plaintiff in Personal Injury Cases

In personal injury cases involving sexual abuse, there may be admission of the abuse but dispute over the degree to which the abuse damaged the plaintiff. There may be dispute over whether the abuse occurred. There may be acknowledgment of the abuse but dispute as to its intrusiveness and extent. Therefore, the plaintiff's psychologist or psychiatrist should have addressed the following in the evaluation:

1. What are the personality characteristics and current psychological functioning of the plaintiff?
2. What is the probable cause of any emotional problems?
3. What is the probability that the alleged event occurred as claimed?
4. What are alternative explanations for the statements being made by the plaintiff?
5. (In recovered memory cases with adults) When did the plaintiff realize he or she had been sexually abused? (This goes to the statute of limitations.)

The major error we see in plaintiffs' experts is the assumption that sexual abuse inevitably causes alleged victims severe and long-lasting psychological problems. Children who may have been only fondled are diagnosed as having PTSD and needing years of therapy.

Not all victims of childhood abuse show later adjustment problems. Finkelhor (1990) reports, "Almost every study of the impact of sexual abuse has found a substantial group of victims with little or no symptomatology." (p. 327) Parker and Parker (1991) observe, "It is far from clear if the abusive experience itself plays a significant causal role in subsequent maladjustment." (p. 185) Berliner and Conte (1993) state, "Although common psychological characteristics may be present in many cases, there is no evidence for the assertion they are contained in all or even the majority of true cases of child sexual abuse." (p. 116)

All medical records and school records should be carefully reviewed. School records may contain information about behavior problems, health, or referrals for counseling in addition to

grades. This will help determine what problems may have predated the abuse incidents. With adults, there may be an MMPI or other evaluation records prior to the date the abuse was said to have occurred. In one repressed memory case, the young man claimed he began gaining significant weight in fifth grade, the year the alleged abuse took place, and that he then changed from a happy, normal boy into a fat and unhappy child who was miserable through the rest of school. However his medical and school records had weights noted at different ages so we were able to chart his weight from early childhood through high school and disprove his claim of a sudden weight gain in fifth grade.

A direct causal relationship between the behaviors of the defendant and the plaintiff's current problems is extremely difficult to establish. Although some victims of childhood sexual abuse are reported to have a number of symptoms, including depression, anxiety, low self-esteem, distrust, social isolation, sexual dysfunction, eating disorders, and difficulties in close interpersonal relationships, these problems are not specific to a history of sexual abuse. The base rates for these behaviors associated with other causal chains are higher than for any demonstrated link with sexual abuse. The behaviors frequently offered as behavioral indicators of sexual abuse are instead nonspecific stress responses which can be linked to any number of stressor experiences. Beitchman et al. (1991), in a review of the short-term effects of child sexual abuse, conclude that, with the exception of sexualized behavior, the majority of short-term effects noted in the literature are problems that characterize child clinical samples in general. Two recent review articles on the long-term effects come to similar conclusions. Beitchman et al. (1992) and Pope and Hudson (1992) report that empirical research has yet to establish a relationship between sexual abuse and the disorders frequently claimed to be caused by childhood sexual abuse.

The characteristics of actual sexual abuse generally associated with more negative outcomes must be considered. There appears to be greater trauma if the perpetrator is a father or stepfather, if coercion, force, or violence are present, and if the abuse consists of more physically assaultive, intrusive acts (Beitchman et a]., 1991, 1992; Finkelhor and Browne, 1986; Finkelhor, 1990).

An important factor associated with the effects of sexual abuse is family dysfunction. Although few of the studies on the effects of abuse have controlled for the contribution of family characteristics, those that have establish that it is extremely difficult to separate the effects of abuse from the effects of the accompanying family dysfunctions. This is because both extrafamilial and intrafamilial sexual abuse are closely associated with families that are dysfunctional and pathological (Alexander and Lupfer, 1987; Beitchman et al., 1991; Harter et al., 1988; Hoagwood and Stewart, 1989; Hulsey et al., 1989).

For example, Hulsey et al. (1989) found that, although women with a history of childhood abuse display greater pathology on the MMPI than do nonabused women, when childhood family variables (such as families that are chaotic, conflicted, and enmeshed) are considered, these differences are greatly reduced or eliminated. Therefore the pathology observed in an adult who was sexually abused as a child may be a function of a pathological home environment rather than an effect of the sexual abuse. Harter et al. (1988) report that family characteristics and perception of social isolation were more predictive of social maladjustment than abuse per se. When family characteristics were controlled, the presence of abuse was not related to social adjustment. Therefore, family characteristics must be carefully explored and considered.

Another factor to be considered is the the fact that many personality characteristics appear to have a high heritability (Lykken et al., 1992; Tesser, 1993). The University of Minnesota twin studies have produced powerful evidence that personality factors are strongly affected by genes. This must be considered when forming conclusions concerning the cause of an individual's emotional problems.

It is unlikely that all of a plaintiff's emotional problems and global dysfunctions will have any single cause. To claim a direct, specific and singular cause for anything human beings do goes far beyond any evidence in the science of psychology (Einhorn and Hogarth, 1982; Faust, 1989; Gambrill, 1990; Meehl, 1977)

In an example, the plaintiff, a withdrawn, inhibited, and depressed man in an unsatisfactory marriage, sued the minister of the church the family had attended when he was an adolescent. He described three incidents of abuse. The first occurred in the minister's car, when the boy was 13 or 14 years old. The minister put his hand on the boy's thigh and asked him if he were circumcised. The minister rubbed the boy's leg but there was no attempt to touch his genital area. In the second incident the minister again rubbed his leg but did not touch his genital area. He does not recall what they talked about but remembers feeling scared, selfconscious, and embarrassed. In the third incident, which occurred in a summer church camp, the minister brought the boy into an empty cabin, touched the boy's genital area over his clothing and asked him if he ever touched himself or played with himself. The plaintiff recalled being scared and upset over the experience, which he described as "strange."

After these incidents, the man kept in contact with the minister, whom he described as being generally helpful and reinforcing, despite these three incidents, since he was a shy boy with little self-confidence. He did not attribute his current problems to this relationship until he heard about this minister being sued, decided to sue also, and was told by the mental health professionals his attorney referred him to that the abuse was the cause of his problems.
The plaintiff's psychologist concluded that "it is inescapable and unequivocal that (the minister's) actions have had a pervasive, traumatic, and long-term impact on (the plaintiff)" and that the plaintiff's current distress was "an almost direct result of (the minister's) actions." He diagnosed the man as having Post-Traumatic Stress Disorder.

There is no empirical support on the effects of child sexual abuse for such a conclusion. To claim that the abuse was responsible for all of the plaintiff's current problems goes far beyond what can be responsibly asserted. The PTSD diagnosis is completely inappropriate. Neither the events described by the plaintiff, his reactions at the time, nor his current symptoms fit this diagnosis. The man's history contained many other troublesome factors, including a mean and cruel alcoholic father, his parents' divorce, a stern stepfather with whom he had a conflicted relationship, small stature and late maturity, and school difficulties that predated the abuse. But the psychologist claimed that all the plaintiff's troubles were caused by the abuse. Unfortunately, this is not an unusual example.

Here, the man had serious psychological problems and there was no evidence in the testing of malingering. But we have evaluated several plaintiffs where there has been strong evidence of significant malingering. As is discussed elsewhere in this book, malingering cannot be successfully detected in clinical interviews, but some objective tests, especially the F minus K

index on the MMPI-2, give useful information. The California Psychological Inventory also detects profiles that are invalid due to a fake-bad response set and the Millon Clinical Multiaxial Inventory-II also indicates when responses are exaggerated. The actual profiles for these tests should be examined when cross-examining the evaluating psychologist.

Allegations of Recovered Memories

This is discussed elsewhere in these volumes, but we will provide a few observations regarding recovered memory allegations in sexual abuse cases (also see Wakefield and Underwager, 1992, 1994b). In recovered memory cases, there are no memories for years because the abuse is said to have been completely "repressed" until, generally with a help of a therapist, it is then "recovered." These cases may lead to some type of litigation, most likely civil, but there have been criminal prosecutions as well. Several states have extended the statutory period of limitations in civil cases until several years after abuse is remembered and/or after it is understood there was damage done by the abuse.

Attorneys must understand the claims, the scientific basis for these claims, and the therapeutic techniques often used in recovered memory cases. Therapists specializing in recovered memory maintain that memory deficits, amnesia, and dissociation are characteristic of trauma. Many maintain that large numbers of women have been sexually abused but that up to half of all incest survivors do not remember their abuse. Many believe that abuse survivors must be helped to retrieve their memories in order to recover. They often retrieve memories with intrusive and unvalidated techniques including direct questioning, hypnosis, reading books, attending survivors' groups, age regression, dream analysis, and a variety of unorthodox procedures.

These "repressed" or "dissociated" memories are thought to differ from the simple forgetting or not thinking about an event that may have been unpleasant but was not particularly traumatic. No psychologist disagrees that many events are forgotten and that persons may be reminded of them years later. Also, the phenomenon of infant amnesia means that most people's earliest memories are not before the age of about three or four (Fivush and Hamond, 1990; Howe and Courage, 1993; Loftus, 1993; Nelson, 1993). But the assumption in recovered memory therapy is that the abuse was repressed or dissociated because it was too traumatic to be remembered.

The recovered memory therapists support their assumptions through concepts such as repression, dissociation, traumatic amnesia; body memories, and multiple personality disorder. However, there is no scientific support for the way these concepts are used, nor any credible evidence that it is common for children to undergo traumatic sexual abuse but, as adults, have no conscious memories of the abuse until it is uncovered by a therapist "skilled" in such matters.

Repression is not generally accepted in the scientific community except among analytically-oriented therapists, who base their beliefs on anecdotal reports and clinical case studies. Traumatic amnesia can occur for a single, traumatic event, such as a rape, but there is no support for the claim that it is common for individuals to be completely amnesiac for repeated episodes of sexual abuse. There is no support that such events will be completely repressed for years, only to be accurately remembered years later. Diagnoses of Multiple Personality Disorder often appear in recovered memory cases, especially when the alleged abuse is violent and sadistic, and many people claim most individuals diagnosed with MPD were abused as children. But MPD itself is controversial and, despite its inclusion in DSM-III-R and DSM-IV, cannot be said to be

generally accepted in the scientific community.

Court Rulings Relevant to Expert Testimony in Child Sexual Abuse Cases

Maryland vs. Craig

There has been a growing attempt to protect the child witness from the trauma of testifying in court by modifying court procedures, such as testifying behind a screen or on videotape in another room. This was the issue addressed in *Maryland* vs. *Craig* (110 S. Ct., 3157, 1990) where, according to the Supreme Court, if the prosecution moves to have the child witness testify behind a screen, they will have establish several things. The requisite necessity finding must be case specific. The trial court must hear evidence and determine whether the procedure's use is necessary to protect the particular child witness's welfare; find that the child would be traumatized, not by the courtroom generally, but by the defendant's presence; and find that the emotional distress suffered by the child in the defendant's presence is more than *de minimis.*

This Supreme Court ruling demands that there be an evidentiary hearing, prior to the trial, at which there will be testimony about the effect on the specific child of testifying in the presence of the person accused. The defense will object, since such a procedure gives the message the defendant has done something to terrify the child.

The prosecution is likely to use whatever experts have interviewed the child or provided therapy to offer testimony and opinions. This is despite the fact that there is no research separating out the single factor of the defendant's presence from all other factors in assessing the probable effects of courtroom testimony on a child.

However, if the prosecution makes such a motion, the defense should immediately move for an evaluation of the child by their own expert in order to counter the testimony of the prosecution's experts. Such an evaluation can produce useful information and may enhance the credibility of the defense expert if he or she has also evaluated the child. But the best and most accurate testimony may well be for the expert to testify that there is simply no way to tell whether the child will be traumatized in court other than to rely upon the baseline information that most children are not severely traumatized by testifying.

A mental health professional who testifies that the requirements of *Maryland vs. Craig* are met and therefore a screen can be used has exceeded the competency and ability of the mental health professions. There are no empirical data to support such a claim. There is no way any competent mental health professional can testify that emotional distress would be caused solely and alone by the presence of the defendant (Underwager and Wakefield, 1992). There are no techniques that can measure emotional distress with the precision required by the Supreme Court. Mental health experts should be confronted with the fact that this requirement exceeds what is possible to do. To attempt to do so violates the code of ethics for psychologists.

Idaho vs. Wright

In *Idaho vs. Wright* (110 S. Ct., 3139, 1990), the court addressed the issue of what kinds of hearsay are admissible in terms of the Confrontation Clause. The Court set forth a two part test for determining whether hearsay evidence may be admitted against a defendant in a sexual abuse case. First, hearsay may be admitted if it falls under a "firmly rooted" exception to the hearsay rule. Second, if the statement falls under a hearsay exception that is not "firmly rooted," then the

statement is presumptively unreliable and inadmissible, and will only meet Confrontation Clause standards of admissibility if it is supported by a showing of "particularized guarantees of trustworthine

Mental health professionals who offer hearsay testimony concerning statements child witnesses have allegedly made about abuse should be cross-examined on the reliability of these statements. It is difficult to meet the standard of "particularized guarantees of trustworthiness" without a tape of the interview, since without a tape, there is no way to establish just what transpired in the interview. Taped interviews that are leading and suggestive can be challenged that any statements resulting from such techniques are unreliable.

New Jersey vs. Michaels

New Jersey vs. Michaels (642 A.2d 1372, N.J. 1994) is a decision from the New Jersey Supreme Court. Kelly Michaels had been convicted of sexually abusing children in a day care center and was imprisoned for 5 years before her case was overturned on appeal. The children had been subjected to highly leading, suggestive, and coercive interviews. The New Jersey Supreme Court ruled that the interrogations of the children were improper, and given substantial likelihood the evidence derived from them was unreliable, a pretrial hearing was required at which the state would be required to prove by clear and convincing evidence that the statements and testimony retained sufficient degree of reliability to warrant admission at trial.

What this ruling means is that, in situations where the interviews of the child witnesses were leading and suggestive, the attorney can move for a taint hearing where the state must prove that the interviews were not leading and coercive and that the testimony of the child witness(es) would be reliable. In the taint hearing, the state is entitled to call experts to offer testimony with regard to the suggestive capacity of the suspect investigative procedures; and the defendant may offer expert testimony of the issue of the suggestiveness to counter the state's evidence. Attorneys must be knowledgeable about the information above on memory, suggestibility, and interviewing techniques.

Daubert vs. Merrell, Dow Pharmaceuticals

The recent unanimous United States Supreme Court decision in *Daubert vs. Merrell, Dow Pharmaceuticals* (61 U.S.L.W. 4805, 113 S Ct 2786, 1993) in June, 1993 dramatically changes the criteria by which scientific testimony will be admitted as evidence in court. The ruling states that the major criterion of the scientific status of a theory is its falsifiability, refutability, or testability. This, in effect, replaces the *Frye* test *(Frye vs. United States,* 293 F. 1013) with the Popperian principle of falsification as the determinant of scientific knowledge.

Justice Blackmun identified four factors that the court should consider in determining whether an expert's opinion is valid under rule 702:

1. Whether the expert's theory or technique has been or can be tested or falsified.
2. Whether the theory or technique has been subjected to peer review or publication.
3. What the known or potential rate of error is for any test or scientific technique that has been employ
4. Whether the technique is generally accepted in the scientific community.

Therefore, although general acceptance in the scientific community (the *Frye* test) is one consideration, the lack of such by itself does not preclude the proposed testimony. This will

make admissible new scientific evidence that was excluded under *Frye.* At the same time, if properly understood and followed, this ruling is likely to render inadmissible testimony based on such concepts and theories as the child sexual abuse accommodation syndrome and claims that childhood sexual abuse has been "repressed."

Although the decision is limited to federal court, it will be applicable wherever federal rules of evidence apply. (See Underwager and Wakefield, 1993 and Stewart, 1993 for discussions of the *Daubert* decision.)

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Footnote 1

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