Expert Testimony in Child Sexual Abuse Litigation: Consensus and Confusion

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I. Introduction

Sexual abuse of children is sadly common.[1] The true prevalence of sexual abuse is unknown because the crime is shrouded in secrecy. Research suggests that approximately twenty percent of girls experience some form of sexual abuse during childhood.[2] Boys appear to be sexually abused at a lower rate of five to fifteen percent.[3] Abusive experiences range in severity from brutal rapes to relatively minor events like witnessing a single episode of indecent exposure at a park.

Not all victims of sexual abuse suffer psychological damage from the experience. Most victims go on to lead productive, happy lives. Yet, there is no gainsaying that every year thousands of children are damaged by sexual abuse.[4] For the lucky ones, the trauma passes quickly. For others, the hurt lasts a lifetime. Psychologist Anna Salter put it well when she wrote that sexual abuse leaves "footprints on the heart."[5]

Because sexual abuse occurs in secret and because most of the time the only witnesses are the child and the perpetrator, sexual abuse is often difficult to prove. The U.S. Supreme Court observed, "Child abuse is one of the most

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[1] In 2007, the year of most recent data, child protective services (CPS) received 3.2 million referrals regarding possible child abuse or neglect, involving 5.8 million children. Of the referrals, CPS substantiated 794,000 children as victims of maltreatment. As has always been the case, neglect was the most common form of maltreatment (59%). Sexual abuse amounted to 7.6% of substantiated cases. Using these numbers, there were 60,344 substantiated cases of sexual abuse in 2007. U.S. Department of Health & Human Services, Administration for Children & Families, *Children's Bureau Express*, Online Digest, vol. 10(3) April 1, 2009.

As mentioned previously, neglect has always been the most common form of maltreatment. *See generally* John E.B. Myers, *Child Protection in America: Past, Present and Future* (2006) (Oxford University Press).

[2] *See* Lucy Berliner & Benjamin E. Saunders, *Child Sexual Abuse*. in John E.B. Myers (Ed.), THE APSAC HANDBOOK ON CHILD MALTREATMENT (3d ed. 2010)(Sage).

[3] *Id.*

[4] *Id.*

[5] Anna C. Salter, *Transforming Trauma: A Guide to Understanding and Treating Adult Survivors of Child Sexual Abuse* 159 (1995)(Sage).

difficult crimes to detect and prosecute, in large part because there often are no witnesses except the victim."[6] In a similar vein, the California Supreme Court remarked, "There are particular difficulties with proving child sexual abuse: the frequent lack of physical evidence, the limited verbal and cognitive abilities of child victims, the fact that children are often unable or unwilling to act as witnesses because of the intimidation of the court room setting and the reluctance to testify against their parents."[7]

Every effort must be made to improve the legal system's ability to protect children and punish offenders. At the same time, great care must be taken to safeguard the innocent against false accusation.[8] In the hope of contributing to this effort, this article will focus on one important aspect of child sexual abuse litigation—expert testimony from medical and mental health professionals. First, this article describes the most up to date information on medical and psychological evidence of sexual abuse. The article cites recent court decisions; but more importantly, the article reports on the latest medical and psychological research relevant to expert testimony. Armed with this research, judges and attorneys are in a better position to evaluate the worth of expert testimony. Part II discusses medical evidence of sexual abuse and describes recent research on laboratory evidence, sexually transmitted infection, injuries due to sexual abuse, and proof of penetration. Part III shifts the focus to psychological evidence of sexual abuse. Part III is divided into three sections. Section A discusses the complex and controversial subject of psychological expert testimony offered as substantive evidence of sexual abuse. Section B addresses the much less controversial subject of expert testimony to rehabilitate a child's credibility following impeachment.

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[6] Pennsylvania v. Ritchie, 480 U.S. 39, 60 (1987).
[7] In re Cindy L., 17 Cal. 4th 15, 28 (1997).
[8] Deliberately false accusations of sexual abuse are rare, but they do occur. For a review of the small body of research on false accusations *see* John E.B. Myers, *Myers on Evidence in Child, Domestic, and Elder Abuse Cases* § 6.05 (2005, 2010 Supp.) (Aspen Law and Business).

Finally, section C discusses expert testimony offered to critique how children were interviewed about sexual abuse.

II. Medical Evidence of Child Sexual Abuse

Most forms of sexual abuse do not cause physical injury.[9] If injury occurs, it is typically minor and heals rapidly. Pediatrician Martin Finkel explains:

> Physical findings that reflect acute or chronic residua to sexual contact are infrequent. For the most part, this is the result of 2 dynamics: (a) The individual engaging the child does not intend to hurt the child physically, and (b) most children do not disclose immediately following their last contact for fear of harm. The lack of physical evidence alone should not lead to the conclusion that inappropriate sexual contact did not occur. . . . If the child incurred an injury that was superficial, and the time interval since the last contact is more than 72 hours, it is unlikely that any residua will be identified. . . . Healed diagnostic genital and anal findings that can stand alone to confirm sexual contact are present in approximately 5% of cases.[10]

The investigation typically includes an examination despite the fact that medical examination seldom finds evidence of sexual abuse. When medical evidence is discovered, courts agree that expert testimony describing the

[9] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. pp. 53-103, 77 (3rd ed. 2009) (American Academy of Pediatrics).

[10] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103, 77 (3rd ed. 2009) (American Academy of Pediatrics).

evidence is admissible.[11] Even if the medical examination finds nothing, the examination is an opportunity to provide psychological support for the child and reassure both the child and the parents that the child is physically unharmed.[12]

[11] *See, e.g.*, King v. Evans, 621 F. Supp. 2d 850 (N.D. Cal. 2009)(defense counsel failed to perform effectively when counsel failed to hire a medical expert to evaluate prosecution's medical evidence); Gersten v. Senkowski, 426 F.3d 588 (2d Cir. 2005), *cert. denied*, 547 U.S. 1191 (2006) (sexual abuse case; defense counsel's performance was constitutionally defective because counsel did not make any effort to determine whether state's medical evidence was reliable); People v. Benavides, 35 Cal. 4th 69, 105 P.3d 1099, 24 Cal. Rptr. 3d 507 (2005) (defendant anally raped 21-month-old causing fatal internal injuries); Poynor v. State, 962 So. 2d 68 (Miss. Ct. App. 2006) (proper for pediatrician who examined child to testify that child's hymen had multiple notches that were consistent with penetration); State v. Price, 165 S.W.3d 568 (Mo. Ct. App. 2005) (rectal scarring was consistent with abuse); In re Tristan R., 63 A.D.3d 1075, 883 N.Y.S.2d 229 (2009); State v. Hammett, 361 N.C. 92, 637 S.E.2d 518, 519 (2006) ("In this case, we consider whether the trial court committed error in admitting a medical expert's opinion that a child had been sexually abused, based on the child's statements and physical evidence found during an examination.… [W]e conclude that the interlocking facts of the victim's history combined with the physical findings constituted a sufficient basis for the expert opinion that sexual abuse had occurred."); Warner v. State, 144 P.3d 838 (Okla. Crim. App. 2006).

[12] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Johathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION at 2779-92 (2008) ("a genital examination may be viewed by some children as therapeutic" at 2784. "While identifying trauma and infectious diseases is extremely important and may require specific treatment, it also is important to reassure a child and her family that she is healthy and that her genital examination is normal. A clinician's assurance of a genital examination without evidence of trauma, and hence normal findings helps begin a process of healing." at 2790-91); Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE, 53-103,at 92 (3rd ed. 2009) (American Academy of Pediatrics) ("The physical examination should be therapeutic for the child, confirming his or her sense of physical intactness and normality.").

A. Sperm, Seminal Fluid, and DNA

The presence of spermatozoa on a child is powerful evidence of sexual contact.[13] Motile sperm are capable of movement.[14] The duration of motility depends in part on where sperm lands.[15] This motility decreases quickly following ejaculation.[16] Inside the vagina or rectum, sperm can remain motile for a number of hours.[17] Nonmotile sperm is detectible for long periods. Indeed, nonmotile sperm can be isolated on cloth for months.[18]

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[13] Kathi Makoroff, Melissa Desai & Elizabeth Benzinger, *The Role of Forensic Materials in Sexual Abuse and Assault.* In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 377-87 (3rd ed. 2009) (American Academy of Pediatrics) ("In the appropriate context, the identification of sperm is sufficient for diagnosis of sexual abuse." at 383);Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. at 171-92,176 (3rd ed. 2009) (American Academy of Pediatrics) ("The identification of spermatozoa by microscopy is considered diagnostic of sexual contact when identified by trained personnel.").

[14] Motility is defined as "spontaneous movement." Motile is defined as "having spontaneous but not conscious or volitional movement." Dorland's Illustrated Medical Dictionary p. 1175(30th ed. 2003).

[15] Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE at 177-78 (3rd ed. 2009)(American Academy of Pediatrics).

[16] Vincent J. Palusci & Cindy W. Christian, Forensic *Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. at 171-92 (3rd ed. 2009) (American Academy of Pediatrics) ("Sperm motility decreases rapidly, and the detection of motile sperm is the best indicator of recent ejaculation." at 176. "The presence of motile sperm in the vagina decreases rapidly." at 177. "The average time for loss of sperm motility in half of adult cases is 2 to 3 hours . . ." at 178.)

[17] Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE at 177 (3rd ed. 2009) (American Academy of Pediatrics).

[18] Kathi Makoroff, Melissa Desai & Elizabeth Benzinger, *The Role of Forensic Materials in Sexual Abuse and Assault.* In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 377-87 (3rd ed. 2009) (American Academy of Pediatrics)

Seminal fluids that do not contain sperm nevertheless provide evidence of sexual contact.[19] Acid phosphatase, for example, is produced by the prostate gland and indicates ejaculation.[20] Acid phosphatase is detectable on cloth for many months.[21] Men who have had a vasectomy still produce normal levels of this enzyme.[22]

("Sperm may also be found on dried secretions from clothing or bedding for months." at 383); Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. at 171-92 (3rd ed. 2009) (American Academy of Pediatrics) ("Sperm is stable in dried secretions and can be detected in clothing stains or on bedding for many months or even years." at 178).

[19] In addition to acid phosphatase, P-30 anitgen is found in seminal fluid. "The detection of P-30 by enzyme-linked immunosorbent assay (ELISA) is a more specific and sensitive marker for ejaculate than is acid phosphatse, but it is not universally assayed in forensic laboratories." Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE at 171-92 (3rd ed. 2009) (American Academy of Pediatrics).

[20] Kathi Makoroff, Melissa Desai & Elizabeth Benzinger, *The Role of Forensic Materials in Sexual Abuse and Assault.* In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 377-87 (3rd ed. 2009) (American Academy of Pediatrics) ("Acid phosphatase is an enzyme found in low concentrations (<50 IU/L) in vaginal fluid and is also secreted by the prostate gland, achieving high concentrations (130-1,800 IU/L) within seminal fluid. The presence of AP is not affected by vasectomy. Acid phosphatase persists longer than sperm after sexual assault, and levels typically return to normal between 18 and 24 hours after ejaculation. Acid phosphatase is usually undetectable in the vagina after 48 hours. The enzyme is stable in dried secretions and clothing and, in some instances, it can be detected after months or even years." at 383); Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. at 171-92 (3rd ed. 2009) (American Academy of Pediatrics) ("Although acid phosphatase is also found in vaginal fluid and urine of women, it is found in much higher concentrations in semen (130-1,800 IU/L) than in vaginal fluid (<50 IU/L) . . .The presence of acid phosphatase is a less specific and less sensitive marker of ejaculate than is sperm, but acid phosphatase has been noted to persist longer than sperm after sexual assault." at 178).

[21] Kathi Makoroff, Melissa Desai & Elizabeth Benzinger, *The Role of Forensic Materials in Sexual Abuse and Assault.* In Robert M. Reece &

DNA is a reliable method of placing an individual at a crime scene.[23] DNA can be isolated from sperm, saliva, blood, skin, and hair root.[24]

B. Sexually Transmitted Infection[25]

Sexually transmitted infections (STI)[26] are documented in 1% to 5% of prepubertal victims of sexual abuse.[27] In

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Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 377-87 (3rd ed. 2009) (American Academy of Pediatrics) ("The enzyme is stable in dried secretions and clothing and, in some instances, it can be detected after months or even years." at 383); Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. at 171-92 (3rd ed. 2009)(American Academy of Pediatrics) ("Although acid phosphatase is also found in vaginal fluid and urine of women, it is found in much higher concentrations in semen (130-1,800 IU/L) than in vaginal fluid (<50 IU/L). Acid phosphatase is found in normal levels in vasectomized men. The presence of acid phosphatase is a less specific and less sensitive marker of ejaculate than is sperm, but acid phosphatase has been noted to persist longer than sperm after sexual assault." at 178.).

[22] Kathi Makoroff, Melissa Desai & Elizabeth Benzinger, *The Role of Forensic Materials in Sexual Abuse and Assault*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 377-87 (3rd ed. 2009) (American Academy of Pediatrics) ("The presence of AP is not affected by vasectomy." at 383); Vincent J. Palusci & Cindy W. Christian, *Forensic Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE at 171-92 (3rd ed. 2009) (American Academy of Pediatrics) ("Acid phosphatase is found in normal levels in vasectomized men." at 178).

[23] Vincent J. Palusci & Cindy W. Christian, FORENSIC *Evidence in Child Sexual Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. 171-92, 179 (3rd ed. 2009) (American Academy of Pediatrics).

[24] *Id*.

[25] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Johathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* at 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION at 2779-92, 2784 (2008) ("The US Centers for Disease Control and Prevention has guidelines for STI testing in cases of suspected sexual abuse . . .In addition, the American Academy of Pediatrics has recommendations for when to test prepubertal children for STIs.").

sexually active adolescents, it can be difficult to determine whether an STI is the result of abuse.[28] The fact that the suspected perpetrator does not have an STI does not rule out the suspect because he may have had medical attention. [29]

The presence of certain sexually transmitted infections in prepubertal children provides strong evidence of sexual abuse.[30] The following STIs are persuasive evidence of sexual

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[26] The term sexually transmitted infection (STI) is replacing the older term sexually transmitted disease (STD).

[27] Deborah C. Stewart, *Sexually Transmitted Infections in Child and Adolescent Sexual Assault and Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE.147-69, at 147 (3rd ed. 2009) (American Academy of Pediatrics).

See also Allan R. DeJong, Sexually *Transmitted Infections in Child Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 343-76 (3rd ed. 2009) (American Academy of Pediatrics) ("Sexually transmitted infections have been detected in approximately 1% to 30% of children and adolescents examined for sexual abuse. The actual risk of acquiring STIs by child sexual abuse victims is unknown. Several studies suggest approximately 5% of prepubertal children evaluated for sexual abuse have an STI." at 343).

[28] Allan R. DeJong, Sexually *Transmitted Infections in Child Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 343-76 (3rd ed. 2009)(American Academy of Pediatrics) ("The presence of an STI in the pubertal adolescent may represent an infection acquired through abuse or prior sexual activity." at 343); Deborah C. Stewart, *Sexually Transmitted Infections in Child and Adolescent Sexual Assault and Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. at 147-69 (3rd ed. 2009) (American Academy of Pediatrics).

[29] Allan R. DeJong, Sexually *Transmitted Infections in Child Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 343-76 (3rd ed. 2009) (American Academy of Pediatrics) ("The inability to document a specific STI in a possible suspected perpetrator does not exclude the possibility that this individual was the source of the child's infection." at 345. "Perpetrators who have taken commonly prescribed antibiotics for another infection may eradicate the gonococci and have negative cultures when they are subsequently screened as possible sources of the child's infection." at 348).

[30] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* at 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92 (2008) ("The presence of an

contact if transmission from mother to baby at birth (perinatal transmission) is ruled out: gonorrhea,[31] syphilis,[32] human immunodeficiency virus,[33] and Chlamydia trachomatis.[34]

Transmission of gonorrhea requires bodily contact with infected material.[35] Gonorrhea can be found in the

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STI does not always mean a child was sexually abused." at 2785); Allan R. DeJong, S*exually Transmitted Infections in Child Sexual Abuse.* In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 343-76 (3rd ed. 2009) (American Academy of Pediatrics) ("Sexually transmitted infections (STIs) are not commonly identified in prepubertal children. Therefore, the presence of an STI in a child should raise concerns of sexual abuse." p. 343.); Deborah C. Stewart, *Sexually Transmitted Infections in Child and Adolescent Sexual Assault and Abuse*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. at 147-69 (3rd ed. 2009) (American Academy of Pediatrics).

[31] Deborah C. Stewart, Sexually *Transmitted Infections in Child and Adolescent Sexual Assault and Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE. 147-69, 149 (3rd ed. 2009) (American Academy of Pediatrics) ("In all prepubertal children beyond the newborn period and in all non-sexually active adolescents, a gonococcal infection is usually diagnostic of sexual abuse.")

[32] Allan R. DeJong, *Sexually Transmitted Infections in Child Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 343-76 (3rd ed. 2009) (American Academy of Pediatrics) ("Syphilis is detected in 0.0% to 1.8% of reported victims of sexual abuse." at 353. "Prepubertal children with primary or secondary stages of syphilis occurring beyond early infancy should be presumed to be victims of sexual abuse." at 354).

[33] Allan R. DeJong, Sexually *Transmitted Infections in Child Sexual Abuse.* In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT: A PRACTICAL GUIDE 343-76, at 344 (3rd ed. 2009) (American Academy of Pediatrics).

[34] *Id.*

[35] Allan R. DeJong, *Sexually Transmitted Infections in Child Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT 5346, at 345 (3rd ed. 2009) (American Academy of Pediatrics) (the incubation period for gonorrhea is 2 to 7 days. "Reported rates of gonococcal infection range from 1% to 30% among sexually abused children. The prevalence in prepubertal children is probably less than 2%, and probably less than 7% among pubertal children routinely cultured because of suspected sexual abuse." at 346. "Gonococci can survive up to 24 hours on fomites (toilet seats, towels) in moist purulent secretions. This fact raises the possibility of nonsexual

genitals, rectum, and mouth of sexually abused girls and boys.[36] Similarly, chlamydia trachomatis is transmitted by contact with infected tissue and is found in the vagina, rectum, and mouth of a child who contracted the infection from the abuser.[37]

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transmission in some cases, although clear documentation of cases of nonsexual transmission is not available." at 349); Deborah C. Stewart, *Sexually Transmitted Infections in Child and Adolescent Sexual Assault and Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE at 149 (3rd ed. 2009) (American Academy of Pediatrics) ("In all prepubertal children beyond the newborn period and in all non-sexually active adolescents, a gonococcal infection is usually diagnostic of sexual abuse.").

See Steadman v. State, 280 S.W. 3d 242,244 (Tex. Crim. App. 2009) (four-year-old had gonorrhea; so did defendant).

[36] Allan R. DeJong, Sexually *Transmitted Infections in Child Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT 345-376, at 345 (3rd ed. 2009) (American Academy of Pediatrics) (The incubation period for gonorrhea is 2 to 7 days. "Reported rates of gonococcal infection range from 1% to 30% among sexually abused children. The prevalence in prepubertal children is probably less than 2%, and probably less than 7% among pubertal children routinely cultured because of suspected sexual abuse." at 345 "Gonococci can survive up to 24 hours on fomites (toilet seats, towels) in moist purulent secretions. This fact raises the possibility of nonsexual transmission in some cases, although clear documentation of cases of nonsexual transmission is not available." p. 349); Deborah C. Stewart, *Sexually Transmitted Infections in Child and Adolescent Sexual Assault and Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), *Medical* EVALUATIONS OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 147-52 (3rd ed. 2009) (American Academy of Pediatrics). *See* Steadman v. State, 280 S.W.3d 242 (Tex. Crim. App. 2009) (four-year-old had gonorrhea; so did defendant).

[37] Allan R. DeJong, *Sexually Transmitted Infections in Child Sexual Abuse.* In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT at 343-76 (3rd ed. 2009) (American Academy of Pediatrics) ("Chlamydial vaginal infections beyond the first year of life are strongly associated with sexual contact when proper methods are used for detecting the infection and sexual abuse." at 351); Deborah C. Stewart, *Sexually Transmitted Infections in Child and Adolescent Sexual Assault and Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 153, 155 (3rd ed. 2009) (American Academy of Pediatrics).

The following STIs raise suspicion of sexual abuse, but are not diagnostic: Trichomonas vaginalis, Condylomata acuminata (warts),[38] and genital herpes simplex.[39]

C. Pregnancy

Pregnancy of a child is unequivocal proof of sexual intercourse.[40] Genetic testing is admissible to help establish paternity.

D. Findings on Physical Examination

As previously mentioned, sexual touching often causes no injury.[41] When injury does occur, it is often superficial and heals quickly leaving no residua detectable on physical examination.[42] Rubbing a penis or finger back and

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See Kelley v. State, 292 S.W.3d 297, 300 (Ark. 2009) (9-year-old had Chlamydia; "Dr. Esquival testified that Chlamydia is spread either 'by active intercourse or by very close genital to genital contact.'").

[38] *See* State v. Smallwood, 2009 WL 2243644 (La. Ct. App. 2009) (child and defendant had genital warts; expert testified the warts were consistent with sexual abuse*)*; State v. Johnson, 652 So.2d 1069 (La. Ct. App. 1995) (11-year-old boy "had venereal warts ringing his anus.").

[39]*See* Deborah C. Stewart, *Sexually Transmitted Infections in Child and Adolescent Sexual Assault and Abuse.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATIONS OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 147 (3rd ed. 2009) (American Academy of Pediatrics).

[40] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103, at 81 (3rd ed. 2009) (American Academy of Pediatrics).

[41] *See* United States v. Charley, 189 F.3d 1251, 1256 (10th Cir. 1999) (10- and 13-year-old victims described repeated genital and anal contact by defendant with his finger and penis; "A physical examination showed no evidence of abuse. Both girls had intact hymens, and the anal and genital areas appeared normal with no visible bleeding, bruising, scarring, tears, tags or discharge. According to Dr. Junkins, this circumstance was not inconsistent with sexual abuse since children's tissues heal quickly, although there may be residual scarring.").

[42] *See* Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92 (2008) ("the hymen and surrounding tissues heal rapidly, often leaving no signs of healed trauma." at 2780); Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P.

forth across a child's genitals can cause irritation and redness (erythema), but the irritation soon disappears.[43] Following digital-genital or genital-genital contact, some children report painful urination (dysuria). This symptom can corroborate a child's disclosure.[44] The odds of finding injury increase when a child is examined within seventy-two hours after abuse.[45] In most instances, the examination takes place long after abuse and the result is a "normal" physical examination.[46]

Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103 (3rd ed. 2009) (American Academy of Pediatrics) ("Most injuries that do occur are superficial and heal without residual findings because most children disclose long after the last contact and are well beyond the 2 to 96 hours necessary for superficial trauma to resolve."); John McCann, Sheridan Miyamoto, Cathy Boyle & Kristen Rogers, *Healing of Hymenal Injuries in Prepubertal and Adolescent Girls: A Descriptive Study*, 119 PEDIATRICS e1094-e1106 (2007) ("As a hymenal laceration heals, it may or may not leave evidence of the previous injury." at e1095).

See also People v. Vang, 171 Cal. App. 4th 1120, 90 Cal. Rptr. 3d 328 (2009) (expert testified that child had very little hymen from 5:00 to 7:00, and this was consistent with penetration. The expert could not date the injury "because even injuries as significant as this heal within three weeks." 90 Cal. Rptr. 3d at 331).

[43] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103, at 82 (3rd ed. 2009) (American Academy of Pediatrics).

[44] *See* Cynthia DeLago, Esther Deblinger, Christine Schroeder & Martin A. Finkel, *Girls Who Disclose Sexual Abuse: Urogenital Symptoms and Signs After Genital Contact*, 122 PEDIATRICS e281-e286 (2008).

[45] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* at 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92, at 2780 (2008) ("Among children who recently have been sexually abused ($\leq$ 72 hours) and have had forensic evidence collected, up to 25% may have evidence of acute anogenital injury . . . When looking at the prevalence of significant findings in non-acute examinations, case-series reports note that 95% of children with a history of sexual abuse will have unremarkable physical examinations." at 2780).

[46] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* at 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92 (2008) ("A completely normal

Except in the rare circumstance of congenital anomalies of the genital urinary tract, girls have a hymen. The hymen is a mucous membrane separating the external from the internal genital structures.[47] Prior to puberty, the hymen is quite sensitive to touch.[48] As girls reach puberty, it alters due to estrogen and becomes less sensitive to touch.[49] The hymen

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examination does not exclude abuse and is the most frequent examination finding in children who have been sexually abused."); Cynthia DeLago, Esther Deblinger, Christine Schroeder & Martin A. Finkel, *Girls Who Disclose Sexual Abuse: Urogenital Symptoms and Signs After Genital Contact*, 122 PEDIATRICS e281-e281 (2008) ("Girls who experience sexual abuse rarely exhibit abnormal genital findings. In fact, absence of genital findings is the rule rather than the exception."); Howard Dubowitz, *Healing of Hymenal Injuries: Implications for Child Health Care Professionals*, 119 PEDIATRICS 997, 999 (2007) ("relatively few girls evaluated for sexual abuse have abnormal findings on physical examination. Fortunately, most sexually abused girls do not experience serious physical trauma, primarily because of the nature of the abuse.").

[47] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53- 61 (3rd ed. 2009) (American Academy of Pediatrics); Martin A. Finkel, *Medical Aspects of Prepubertal Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT (3rd ed. 2009) (American Academy of Pediatrics) ("If the genitourinary track is normally developed, the hymen is present." 269-91 at 291).

[48] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92 (2008) ("Avoiding direct contact with the hymenal tissue is important because this is an area very sensitive to touch in most prepubertal girls." at 2784); Martin A. Finkel, *Medical Aspects of Prepubertal Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT pp. 269-91 (3rd ed. 2009) (American Academy of Pediatrics) ("The membrane is innervated and, in the prepubertal child, the hymen can be exquisitely sensitive to touch." at 291).

[49] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53, 90 (3rd ed. 2009) (American Academy of Pediatrics) ("In puberty, the hymenal membrane undergoes significant changes that are secondary to estrogen. Estrogen results in thickening of the hymenal membrane, increased elasticity, and decreased pain sensitivity.").

does not completely cover the vagina.[50] In actuality, the hymen contains an orifice.[51] The shape of the hymen varies among children.[52]

It was once thought that the size of the hymenal orifice could provide evidence of penetration, but it is now understood that the size of the opening varies from child to child.[53] In the same child the size of the orifice can change as the child changes position.[54] Although the size of the hymenal

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[50] Martin A. Finkel, *Medical Aspects of Prepubertal Sexual Abuse.* In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT (3rd ed. 2009)(American Academy of Pediatrics) ("Many nonmedical professionals have the perception that the hymen is an impermeable membrane, and any opening is abnormal. An imperforate hymen is the only anatomical variant of hymenal configurations in which no opening is present.").

[51] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. pp. 53-77, at 61 (3rd ed. 2009) (American Academy of Pediatrics).

[52] Martin A. Finkel, *Medical Aspects of Prepubertal Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT (3rd ed. 2009) (American Academy of Pediatrics) ("The appearance of the hymenal membrane is quite variable.").

[53] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?*, 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92 (2008) ("We caution that the findings for the diameter of the hymenal opening may lack precision and therefore are not clinically useful." at 2790); Howard Dubowitz, *Healing of Hymenal Injuries: Implications for Child Health Care Professionals*, 119 PEDIATRICS 997-99 (2007) ("We have learned that the size of the hymenal opening is mostly meaningless." at 998); Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-90 (3rd ed. 2009) (American Academy of Pediatrics) ("The diameter of the hymenal orifice alone should not be used as a screening test for the presence of sexual abuse.").

[54] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103 (3rd ed. 2009) (American Academy of Pediatrics) ("The 'normal' size of the hymenal orifice varies with age, body habitus, and pubertal development. The size of the orifice may vary during the examination depending on positioning (supine frog-leg vs. knee-chest), the state of relaxation of the patient, and examination technique.

orifice is not by itself diagnostic, the presence of acute or chronic trauma to the hymen and other genital structures can provide evidence of sexual abuse.[55] It is a misconception that all females bleed when they first have sexual intercourse.[56]

When medical professionals describe injury to the hymen, they locate the injury by reference to the hands of a clock.[57] With the child lying on her back (supine position), and viewing the hymen from the child's feet, 12 o'clock is at the top; 6 at the bottom (posterior). Thus, an injury at the 2 o'clock position is near the top of the hymen, slightly to the right (child's left).

Clearly, there is a range of normal variability. The transverse diameter of the hymenal orifice alone cannot be relied on as a sole diagnostic finding of vaginal penetration." at 62. "The orifice diameter may vary considerably, depending on the age of the child, the position in which the child is examined, the degree of relaxation, and the amount of traction on the labia during the examination. The transverse diameter alone is rarely sufficient to determine whether a child has or has not been sexually abused and should not be used as the sole criterion for such a determination." at 75); Martin A. Finkel, *Medical Aspects of Prepubertal Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT 269 (3rd ed. 2009) (American Academy of Pediatrics) ("When a child is examined in the knee-chest position, the appearance of the hymen may be quite different." at 281. "Other variables that may account for a changing appearance of the hymenal orifice are the state of relaxation and degree of labial traction and separation." at 282).

[55] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-78 (3rd ed. 2009) (American Academy of Pediatrics) (Finkel describes factors that can cause injury, including amount of force used, size of object inserted in child, use of lubrication, and child's position during the act).

[56] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-86 (3rd ed. 2009) (American Academy of Pediatrics) ("The common perception that women bleed during their first coitus, thus confirming their virginal status, is incorrect." at 86. Some women bleed and some don't).

[57] *See* People v. Vang, 171 Cal. App. 4th 1120, 1125 (2009) (expert testified that child had very little hymen from 5:00 to 7:00, and this was consistent with penetration).

Penetration of a child's vagina by a finger, penis, or object may cause serious injury or no damage at all.[58] The type of injury caused depends on the amount of force, use of lubricant, the child's age,[59] and the size of the penetrating object.[60] If the child is prepubertal, penile penetration is likely to injure tissue and, in some cases, damage the hymen and/or leave scar tissue.[61] Some sexually abused girls have a transection (tear) through the entire width of the hymen.[62] A complete transection between 4 and 8 o'clock in a prepubertal child is fairly strong evidence of penetration.[63] Some

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[58] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-80 (2008) ("penetration may have occurred without causing physical injury." at 2780).

[59] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53, 86 (3rd ed. 2009) (American Academy of Pediatrics) ("In the pubertal patient who experiences vaginal penetration, the potential to identify diagnostic findings is limited . . .").

[60] *Id.* ("Depending on the child's age, penetration of the vagina by a penis may or may not lead to significant findings." at 85. "The elasticity of the membrane in the pubertal child may afford the intromission of a penis with surprisingly little residua." at 86).

[61] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-103 (3rd ed. 2009) (American Academy of Pediatrics)("It is expected that the introduction of an adult penis into a prepubertal child's vagina should produce acute and obvious signs of trauma and result in chronic residua such as transections and healing scar tissue. This is true if the contact is acute and forceful." at 85); John McCann, Sheridan Miyamoto, Cathy Boyle & Kristen Rogers, *Healing of Hymenal Injuries in Prepubertal and Adolescent Girls: A Descriptive Study*, 119 PEDIATRICS e1094-e1106 (2007) ("As a hymenal laceration heals, it may or may not leave evidence of the previous injury." at e1095).

[62] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-103 (3rd ed. 2009) (American Academy of Pediatrics) ("However, rather dramatic acute non-transection injuries may heal with surprisingly little residua." at 86).

[63] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused?* 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92 (2008) ("A transaction of the posterior

prepubertal children have a notch that does not extend the entire width of the hymen.[64] A deep notch is probative, albeit not diagnostic, of penetration.[65]

Fellatio typically causes no injury. If force is used, however, there may be tiny red dots called petechiae on the roof and back of the child's mouth.[66] This injury results when capillaries are ruptured.[67] Inside the upper and lower lip is a sliver of tissue called the frenulum that connects the lip to the

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hymen between 4 and 8 o'clock in prepubertal girls indicating genital penetrating trauma; however, the presence of this finding is not confirmatory of sexual abuse. Posterior hymenal findings including transections between 4 and 8 o'clock, deep notches, and perforations were not seen in studies of prepubertal girls without a history genital trauma . . ." at 2790).

[64] *See* State v. Streater, 673 S.E.2d 365 (N.C. Ct. App. 2009) (deep hymenal notches at 10:00 and 2:00). Opinion withdrawn by order of the court.

[65] Molly Curtin Berkoff, Adam J. Zolotor, Kathi L. Makoroff, Jonathan D. Thackeray, Robert A. Shapiro & Desmond K. Runyan, *Has This Prepubertal Girl Been Sexually Abused*? 300 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2779-92 (2008) ("Posterior hymenal findings including transections between 4 and 8 o'clock, deep notches, and perforations were not seen in studies of prepubertal girls without a history of genital trauma from sexual abuse included in this systematic review. Therefore, one can conclude that the posterior hymenal findings of transections, deep notches, and perforations are extremely infrequent findings among children without a history of genital trauma from sexual abuse or other means. Current guidelines suggest deep notches are supportive of a disclosure of sexual abuse. Without a disclosure of sexual abuse, interpretation of deep notches is considered an indeterminate finding that may require further evaluation. While deep notches of the posterior hymen were not found in prepubertal girls without a history of sexual abuse, the finding also is uncommon among sexually abused children. " at 2790).

[66] Martin A. Finkel, *Physical Examination.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103, at 84 (3rd ed. 2009) (American Academy of Pediatrics).

[67] *See* Dorland's Illustrated Medical Dictionary (30th ed. 2003), defining "petecia" as "a pinpoint, nonraised, perfectly round, purplish red spot caused by intradermal or submucous hemorrhage." p. 1411. Certain medical conditions can cause petechiae.

gum.[68] You can feel your frenulum by sticking your tongue up in front of your upper teeth. If a child's lip is forced away from the child's mouth, the frenulum can tear.[69]

Penetration of the anus may or may not cause injury.[70] The anal sphincter is elastic and is designed to open wide enough to pass stool that is as large as the average penis.[71] A finger or a penis can penetrate the anus without causing injury, particularly when lubrication is used.[72] Rubbing a finger or penis between the buttocks cheeks may cause temporary erythema, but erythema alone is not probative of sexual abuse.[73]

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[68] A "frenulum" is "a small fold of integument or mucous membrane that checks, curbs, or limits the movements of an organ or part." Dorland's Illustrated Medical Dictionary 739 (30th ed. 2003). There are numerous frenula in the human body, including the ones attaching the lips to the gums.

[69] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103, 84 (3rd ed. 2009) (American Academy of Pediatrics).

[70] *Id. (*"Controversy exists concerning the significance of anal dilation in response to traction. Rectal dilation should be interpreted cautiously when observed in isolation." at 76).

[71] Martin A. Finkel, *Medical Aspects of Prepubertal Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT (3rd ed. 2009) (American Academy of Pediatrics) ("The anal sphincter is anatomically designed to contract and pass stool on a routine basis. Children can pass, by parental description, surprisingly large-diameter stools without problems. Anal fissures can be seen following passage of a large-diameter stool, as commonly associated with constipation. Fissures can also be the result of the introduction of a foreign body, such as a finger, penis, or other object. Anal fissures are a non-specific finding of superficial mucosal trauma. The specificity of a fissure increases with a corroborative history." at 285).

[72] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-103, at 87 (3rd ed. 2009) (American Academy of Pediatrics).

[73] Martin A. Finkel, *Medical Aspects of Prepubertal Sexual Abuse*. In Robert M. Reece & Cindy W. Christian (Eds.), CHILD ABUSE: MEDICAL DIAGNOSIS & MANAGEMENT (3rd ed. 2009) (American Academy of Pediatrics) ("The anal and perianal tissues are carefully examined for both acute and healed signs of trauma. Acute signs of trauma may be evident as

When a child has acute lacerating or impaling injury to the genitals or rectum, accident must be ruled out.[74] In girls, accidental straddle injury can occur when the child falls onto an object like the horizontal bar of a bicycle or playground equipment.[75] Accidental injury is unlikely to affect the hymen, though, which is recessed inside the child's body.[76] Similarly, an accident is unlikely to lacerate the rectum, which is protected by the buttocks.[77]

E. Proof of Penetration

Penetration is an element of the crime of rape as well as certain other sex offenses.[78] Ejaculation is not required.[79] Any penetration of the female genitals—including the genital lips (labia majora and labia minora)—constitutes

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superficial abrasions and chafing of the anal verge and the tissues that form the gluteal cleft. Perianal redness is frequently observed in non-abused and abused children and, thus, it is a nonspecific finding." at 284-85).

[74] Martin A. Finkel, *Physical Examination.* In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE. 53-103, at 91 (3rd ed. 2009) (American Academy of Pediatrics).

[75] *Id.* ("The leading cause was straddle injury on such objects as bicycle bars, beds, fences, concrete walls, and playground equipment. Other causes of accidental perianal injury were impalement, motor vehicle crashes, zipper injuries, and animal bites." at 398-99).

[76] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-103, at 91 (3rd ed. 2009) (American Academy of Pediatrics).

See People v. Vang, 171 Cal. App. 4th 1120, 90 Cal. Rptr. 3d. 328 (2009) (expert testified that child had very little hymen from 5:00 to 7:00, and this was consistent with penetration; expert testified this injury "could not have been caused by an injury from a bicycle accident." 90 Cal. Rptr. 3d at 331).

[77] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-103, at 91 (3rd ed. 2009) (American Academy of Pediatrics).

[78] *See, e.g.*, Cal. Penal Code §§ 261 (rape); 286 (sodomy); 289 (unlawful sexual penetration).

See also, In re E.H., 967 A.2d 1270 (D.C. 2009).

[79] *See, e.g.*, State v. Shaw, 987 So.2d 398, 409 (La. Ct. App. 2008) ("For a rape to occur, emission is not necessary . . .").

penetration.[80] Similarly, any anal or oral penetration is sufficient.[81] Penetration may be established with expert testimony.[82] On rare occasions, an eyewitness observes penetration.[83] Finally, penetration can be established by testimony from the victim.[84] Not surprisingly, young children have a limited understanding of penetration.[85] When a young child says, "He put it in me," does this mean he put "it" inside the vagina, between the genital lips, or in the vicinity of the genitals? Penetration has occurred if the child is describing the vagina or between the genital lips. However, the young child may not be aware of this occurrence.[86] When a child's description of "in me" is accompanied by testimony that "it

[80] *See, e.g.*, State v. Shaw, 987 So.2d 398, 409 (La. Ct App. 2008) ("For a rape to occur, emission is not necessary, and any penetration, however, slight, of the aperture of the female genitalia, even its external feature, is sufficient.").

[81] *See, e.g.*, Commonwealth v. King, 445 Mass. 217, 834 N.E.2d 1175 (2005) (oral penetration).

[82] *See, e.g.*, State v. Galloway, 304 N.C. 485, 284 S.E.2d 509 (1981); Warner v. State, 144 P.3d 838 (Okla. Crim. App. 2006).

[83] Singleton v. State, 16 So.3d 742 (Miss. Ct. App. 2009).

[84] *See, e.g.*, Johnson v. State, 328 Ark. 526, 944 S.W.2d 115, 116 (1997); State v. Hawkins, 968 So.2d 1082, 1088 (La. Ct. App. 2007) ("The testimony of the victim can be sufficient to establish sexual penetration, even though there is an absence of scientific evidence of sexual intercourse.").

[85] Martin A. Finkel, *Physical Examination*. In Martin A. Finkel & Angelo P. Giardino (Eds.), MEDICAL EVALUATION OF CHILD SEXUAL ABUSE: A PRACTICAL GUIDE 53-103 (3rd ed. 2009) (American Academy of Pediatrics)(referring to the genitalia, Dr. Finkel writes, "Children will frequently state that an object has been placed 'inside' of them, and yet no confirmatory physical findings are present." at 85. With reference to anal penetration, Finkel writes, "Just as children who provide histories of vaginal penetration commonly have examination findings to suggest otherwise, genital-anal contact can be perceived as entering the anorectal canal when, in fact, pressure over the external sphincter dilated the anus, creating the sensation of an object entering the canal without actual penetration." at 88).

See In re E.H., 967 A.2d 1270 (D.C. 2009) (young child's reluctant testimony was not sufficient to establish penetration).

[86] After years of reading penetration cases, I get the impression appellate courts are fairly generous when it comes to upholding jury findings of penetration.

hurt," the inference of penetration is strengthened.[87] Similarly, if "in me" testimony is corroborated by injury or irritation of the child's genitals, confidence in the child's description grows. In some instances, perpetrators admit penetration.[88]

F. Summary

Medical evidence can provide convincing proof of child sexual abuse and courts are comfortable with expert testimony describing medical evidence. However, more often than not, sexual abuse leaves no physical residua. When there is no medical evidence, courts sometimes allow expert testimony to help the jury understand that absence of physical findings is consistent with sexual abuse. Such testimony is appropriate when the defense argues that absence of medical evidence points away from abuse.

III. Psychological Expertise in Child Sexual Abuse Litigation

Part III addresses expert testimony in sexual abuse litigation provided by mental health professionals including psychologists, psychiatrists, and clinical social workers. Pediatricians and nurses who specialize in child abuse are also familiar with the psychological dimensions of abuse and provide expert psychological testimony.[89]

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[87] As stated elsewhere the prepubertal hymen is typically very sensitive to touch. Certainly an adult penis, and even a finger, entering a young child's genitals could cause considerable pain.

[88] *See, e.g.*, United States v. Wilcox, 487 F.3d 1163 (8th Cir. 2007)(victim described penetration; defendant admitted penetration); Stulb v. State, 279 Ga. App. 547, 631 S.E.2d 765, 767 (2006) (at trial Stulb admitted that 'my penis was out' and he 'attempted to place [his] penis in the vagina of [A.L.]' Moreover, A.L. testified that 'it hurt' when Stulb attempted to have intercourse with her . . . In light of Stulb's admission that he attempted to have intercourse with A.L., and A.L.'s statement that 'it hurt,' there was sufficient evidence for the jury to conclude that slight penetration occurred").

[89] *See* United States v. Charley, 189 F.3d 1251 (10th Cir. 1999); State v. Streater, 673 S.E.2d 365 (N.C. Ct. App. 2009)(physician's testimony that his findings were consistent with sexual abuse was an impermissible

Three types of psychological testimony are discussed in this section. First, I examine expert testimony offered as substantive evidence of child sexual abuse. Such testimony is complex and controversial. Part III.A. delves into the subject by describing the types of testimony offered as substantive evidence, reviewing relevant psychological research and commentary, and working toward the conclusion that at this stage of knowledge, it may be wise to exclude at least some forms of such testimony. In particular, Part III.A.7.b. makes the case for restrictions on the most common form of expert psychological testimony offered as substantive evidence—testimony that a child's symptoms are consistent with sexual abuse. Finally, Part III.A.9. attempts to correct the misguided practice of allowing forensic interviewers to offer "expert" testimony amounting to an opinion of abuse.

Part III.B. briefly discusses expert psychological testimony designed to rehabilitate a child's credibility following certain types of impeachment. Such testimony is not controversial. Part III.C. addresses expert testimony offered to critique the way in which children were interviewed following an allegation of child abuse. This is the most recent addition to psychological testimony in child sexual abuse litigation. The introduction of such testimony is warranted when the facts are correct. In a small number of cases, prosecutors have offered expert testimony during the prosecution's case-in-chief and prior to any attack on the interviews. Part III.C.2. discusses these cases and argues that such testimony should be excluded as a violation of the rule against bolstering one's own witnesses.

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opinion regarding the child's credibility; there was no physical evidence of sexual abuse).

A. Psychological Testimony Offered as Substantive Evidence of Child Sexual Abuse

1. *Psychological Sequelae of Child Sexual Abuse*

At its core, sexual abuse is psychological abuse because it is a fundamental betrayal of trust. Adults are supposed to protect children, not exploit them. Some sexually abused children feel the abuse is their fault and that they are unworthy, unlovable, damaged goods. Sexual abuse causes stress-related symptoms including nightmares,[90] regression to earlier stages of development (*e.g.*, bedwetting or soiling[91] in toilet trained children), depression, poor self esteem, misbehavior at home and at school, somatic problems such as headaches and stomachaches, anxiety, hypervigilance, and fear.[92] Many sexually abused children have some of the

[90] *See* Debra A. Poole & Michele A. Wolfe, *Child Development: Normative Sexual and Nonsexual Behaviors That May Be Confused with Symptoms of Sexual Abuse*, in Kathryn Kuehnle & Mary Connell, THE EVALUATION of CHILD SEXUAL ABUSE ALLEGATIONS 101-28 (2009) (Wiley)(sleep problems are not a strong indicator of sexual abuse).

[91] *See* Michael W. Mellon, Stephen P. Whiteside & William N. Friedrich, *The Relevance of Fecal Soiling as an Indicator of Child Sexual Abuse: A Preliminary Analysis*, 27 JOURNAL OF DEVELOPMENTAL BEHAVIORAL PEDIATRICS 25-32 (2006) (occasional soiling not enough to diagnose child sexual abuse); Debra A. Poole & Michele A. Wolfe, *Child Development*: *Normative Sexual and Nonsexual Behaviors That May Be Confused with Symptoms of Sexual Abuse*, in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 101-28 (2009) (Wiley) (soiling not a useful symptom to differentiate abused from non-abused children).

[92] For information on the psychological impact of child sexual abuse, *see* Jennifer J. Freyd, Frank W. Putnam, Thomas D. Lyon, Kathryn A. Becker-Blease, Ross E. Cheit, Nancy B. Siegel, & Kathy Pezdek, *The Science of Child Sexual Abuse*, 308 SCIENCE 501 (22 April 2005) (CSA is associated with serious mental and physical health problems, substance abuse, victimization, and criminality in adulthood. Mental health problems include posttraumatic stress disorder, depression, and suicide. CSA may interfere with attachment, emotional regulation, and major stress response systems."); Kathleen A. Kendall-Tackett, Linda Meyer Williams & David Finkelhor, *Impact of Sexual Abuse on Children: A Review and Synthesis of Recent Empirical Findings*, 113 PSYCHOLOGICAL BULLETIN 164-80 (1993); John E.B. Myers, *Myers on Evidence in Child, Domestic and Elder*

symptoms of Post Traumatic Stress Disorder (PTSD). In fact, roughly a third of sexually abused children meet the full diagnostic criteria for PTSD.[93]

For perpetrators, disclosure spells disaster and offenders are keen to maintain silence.[94] Many children are threatened,[95] some with death or death of family members or pets.[96] Perpetrators often saddle children with responsibility for maintaining silence—"If you tell, I'll go to jail and your mom and your brothers and sisters won't have a place to live"; "If you tell, social workers will take you away"; "No one will believe you."[97] Some offenders maintain silence by distorting

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Abuse Cases § 6.03 (2005, 2010 Supp.) (Aspen) (collecting psychological research on impact of sexual abuse).

See also People v. Weiss, 133 P.3d 1180, 1185 (Colo. 2006) ("Sexual assault is among the most intimate and personally-devastating invasions a person may experience in his or her lifetime. It typically produces emotionally-destructive reverberations for the victim long after its occurrence. This can be particularly true when the victim is a child.").

[93] Lucy Berliner & Diana M. Elliott, *Sexual Abuse of Children*, in John E.B. Myers, Lucy Berliner, John Briere, C. Terry Hendrix, Carole Jenny & Theresa A. Reid (Eds.), THE APSAC HANDBOOK ON CHILD MALTREATMENT 55-78, at 60 (2002) (Sage).

[94] *See* State v. Arroyo, 284 Conn. 597, 935 A.2d 975, 982 n. 8 (2007); State v. Bruna, 12 Neb. App. 798, 686 N.W.2d 590, 612 (2004) (perpetrator used threats of violence and shame).

For information on disclosure of child sexual abuse, *see* Thomas D. Lyon, Abuse Disclosure: *What Adults Can Tell*, in Bette L. Bottoms, Gail S. Goodman & C.J. Najdowski (Eds.), CHILD VICTIMS, CHILD OFFENDERS: PSYCHOLOGY AND LAW (2009) (Guilford); Margarte-Ellen Pipe, Michael E. Lamb, Yael Orbach & Ann-Christin Cederborg (Eds.), CHILD SEXUAL ABUSE: DISCLOSURE, DELAY & DENIAL (2007) (Lawrence Erlbaum).

[95] *See, e.g.*, State v. Streater, 673 S.E.2d 365 (N.C. Ct. App. 2009) (defendant threatened to "ground" victim if she disclosed).

[96] *See, e.g.*, State v. Thomas, 290 So.3d 129, 132 (Mo. Ct. App. 2009) ("He later began telling M.M. that he would kill her mother, her sisters or her friend if M.M. said anything about what was happening."); State v. Giddens, 681 S.E.2d 504, 505 (N.C. Ct. App. 2009) ("Defendant told J.B. that if he told anyone what happened, Defendant would kill Amanda."); In re C.C., 2005 WL 2388262 (Ohio Ct. App. 2005)(not reported) (victim would be shot if abuse disclosed).

[97] *See* State v. Thomas, 290 S.W.3d 129, 131 (Mo. Ct. App. 2009) ("Defendant warned A.P. not to tell anyone because her mother or

the adult-child relationship—"This is our secret, and we can't tell anyone." Indeed, "our little secret" is a mantra among perpetrators.[98] The coercion required to prevent disclosure is stressful and amounts to additional psychological abuse.[99]

2. *Stress-Related Psychological Symptoms are Seen in Non-Abused as Well as Abused Children*

Stress-related symptoms are not unique to sexual abuse. For instance, witnessing domestic violence causes stress-related symptoms in children.[100] Children who are neglected but not sexually abused often have mental health issues.[101] Family disorganization, poverty, and substance/alcohol abuse are stressful for children and adults. Even children growing up in "normal" homes can be anxious, and some psychological symptoms (e.g., nightmares) are so common among non-maltreated children that they are considered a normal part of growing up.

3. *Psychological Symptoms Seen in Sexually Abused Children and Non-Abused Children as Evidence of Sexual Abuse*

It is undisputed that sexual abuse causes stress-related psychological symptoms in some children. Difficulties arise, however, when evaluating the presence of psychological symptoms seen in sexually abused children. If a symptom were seen *only* in sexually abused children, that symptom would be diagnostic of sexual abuse or, as some say,

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grandfather might kill him, or he might go to jail for a very long time. A.P. did not tell anyone because she still loved Defendant and was scared for his safety.").

[98] A Westlaw search employing the term "our little secret" reveals numerous cases. *See, e.g.*, State v. Morgan, 2009 WL 306188 (Neb. Ct. App. 2009) (not reported).

[99] *See* Daniel v. State, 675 S.E.2d 472 (Ga. Ct. App. 2009) (child was coerced by her family and a defense investigator to recant).

[100] Sandra A. Graham-Bermann & Kathryn H. Howell, *Child Abuse in the Context of Intimate Partner Violence*, in John E.B. Myers (Ed.), THE APSAC HANDBOOK ON CHILD MALTREATMENT (3d ed. 2010) (Sage).

[101] Howard Dubowitz (Ed.), NEGLECTED CHILDREN: RESEARCH, PRACTICE AND POLICY (1999) (Sage).

pathognomic for sexual abuse.[102] Unfortunately, there is no psychological symptom or group of symptoms that are found only among sexually abused children.[103] Moreover, there is no psychological syndrome that diagnoses sexual abuse.[104] Finally, there is no psychological test that can tell whether a child was sexually abused.[105]

All of the stress-related symptoms observed in sexually abused children are seen to a greater or lesser extent in non-abused children. To rephrase the issue from the preceding paragraph: Does presence of psychological symptoms observed in sexually abused *and* non-abused children provide evidence of sexual abuse? In some cases the answer is yes, but arriving at that answer requires an understanding of two issues: (a) How often is the symptom observed in sexually

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[102] *See* David Faust, Ana J. Bridges & David C. Ahern, *Methods for the Identification of Sexually Abused Children: Issues and Needed Features for Abuse Indicators*, in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 3-19, at 7 (2009) (Wiley) ("A perfectly differentiating indicator would be uniquely associated with child sexual abuse—it would occur only if a child has been sexually abused and would never occur for other reasons—but such indicators are extremely rare in psychology.").

[103] *See* Sonja N. Brilleslijper-Kater, William N. Friedrich & David L. Corwin, *Sexual Knowledge and Emotional Reaction as Indicators of Sexual Abuse in Young Children: Theory and Research Challenges*, 28 CHILD ABUSE & NEGLECT 1007-17 (2004); Kamala London, Maggie Bruck, Stephen J. Ceci & Daniel W. Shuman, *Disclosure of Child Sexual Abuse: A Review of the Contemporary Empirical Literature*, in Margaret-Ellen Pipe, Michael E. Lamb, Yael Orbach & Ann-Christin Cederborg (Eds.), CHILD SEXUAL ABUSE: DISCLOSURE, DELAY & DENIAL 11-40, at 11 (2007) (Lawrence Erlbaum) ("[T]here are no unique psychological symptoms specific to sexual abuse.").

[104] *See* Kathleen A. Kendall-Tackett, Linda Meyer Williams & David Finkelhor, *Impact of Sexual Abuse on Children: A Review and Synthesis of Recent Empirical Findings*, 113 PSYCHOLOGICAL BULLETIN 164-80 (1993).

[105] Gail S. Goodman, R.E. Emery & J.J. Haugaard, *Developmental Psychology and Law. The Cases of Divorce, Child Maltreatment, Foster Care, and Adoption, in* I.E. Sigel & K.A. Renninger (Eds.), HANDBOOK OF CHILD PSYCHOLOGY: VOLUME 4. CHILD PSYCHOLOGY IN PRACTICE 775-874 (1998).

abused *and* non-abused children?; and (b) What are the populations of sexually abused and non-abused children?

a. *Frequency of symptoms seen in sexually abused and non-abused children*

The more often the symptom is observed in abused children and the less often in non-abused children, the greater the potential probative value. However this conclusion is immediately complicated by the fact that little comparative data is available on the prevalence of various symptoms among abused and non-abused children. Moreover, quite a few sexually abused children have no detectable symptoms.

b. *The populations of sexually abused and non-abused children*

The fact that a symptom is seen more often in sexually abused than non-abused children is not enough to conclude that the symptom is indicative of abuse. One must also consider the fact that the population of non-abused children is much larger than the population of abused children. Even though a symptom is observed more often in sexually abused children, the fact that there are many more non-abused than abused children means that most children with the symptom will be non-abused.[106]

[106] *See* Ana J. Bridges, David Faust & David C. Ahern, *Methods for the Identification of Sexually Abused Children: Reframing the Clinician's Task and Recognizing Its Disparity with Research on Indicators,* in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 21-47 (2009) (Wiley); David Faust, Ana J. Bridges & David C. Ahern, *Methods for the Identification of Sexually Abused Children: Issues and Needed Features for Abuse Indicators,* in Kathryn Kuehnle & Mary Connell (Eds.), *The* EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 3-19 (2009)(Wiley); David Faust, Ana J. Bridges & David C. Ahern, *Methods for Identification of Sexually Abused Children: Suggestions for Clinical Work and Research,* in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 29-66 (2009) (Wiley); Thomas D. Lyon & Jonathan J. Koehler, *The Relevance Ratio: Evaluating the Probative Value of Expert Testimony in Child Sexual Abuse Cases*, 82 CORNELL LAW REVIEW 43-78 (1996); Jonathan J. Koehler, *The Normative Status of Base Rates at Trial*, in J.

Consider the imaginary city of Dillville. Ten thousand female children between 3 and 10 years of age live in Dillville. Twenty percent of Dillville's girls are sexually abused. Thus, there are 2,000 sexually abused 3- to 10-year-old girls in Dillville, and 8,000 non-abused girls. A five-year-old Dillville girl started wetting the bed at night, and medical reasons for the bedwetting have been ruled out. Sexual abuse causes some potty trained children to wet the bed. Does this child's bedwetting tend to prove sexual abuse? Assume bedwetting in toilet trained children is observed in 20% of sexually abused children and 5% of non-abused children. We would expect to find 400 sexually abused bed-wetters among Dillville girls. Yet, because 5% of non-abused children wet the bed, and because there are many more non-abused than abused children, we find an equal number of bedwetters—400—among the non-abused Dillvillers. If all we know about a child is that she wets the bed, she is as likely to be non-abused as abused.

Altering the figures reinforces the conclusion that psychological symptoms seen in abused as well as non-abused children are indeterminative of sexual abuse.[107] Suppose 10% of the sexually abused and 5% of the non-abused girls wet the bed; now 200 sexually abused girls and 400 non-abused girls wet the bed. A bed-wetter is twice as likely to be non-abused as abused.

Castellan, Jr. (Ed.), INDIVIDUAL AND GROUP DECISION MAKING: CURRENT ISSUES 137-49 (2003) (Lawrence Erlbaum).

[107] *See* Debra A. Poole & Michele A. Wolfe, *Child Development: Normative Sexual and Nonsexual Behaviors That May Be Confused with Symptoms of Sexual Abuse*, Kathryn Kuehnle & Mary Connell, THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 101-28, at 117 (2009) (Wiley) ("One reason short-lived complaints fail to differentiate between abused and nonabused children is that physical complaints are so common among children in general.").

4. *The Effect of the Number of Symptoms on Probative Value*

The more stress-related symptoms a child has, the more likely the child experienced some stress-inducing event. However, sexual abuse is not the only possibility. The statistical impact of population sizes remains.

5. *Post Traumatic Stress Disorder*

As mentioned earlier, up to a third of sexually abused children meet the diagnostic criteria for PTSD.[108] In examining whether a diagnosis of PTSD is probative of sexual abuse two issues arise: first, is the frequency of PTSD in non sexually abused children; and second, the diagnosis of PTSD presupposes that something traumatic happened.[109] The issue in child sexual abuse litigation is *whether* abuse occurred. If a diagnosis of PTSD *assumes* trauma occurred, the diagnosis cannot prove the trauma.[110] It is circular reasoning.[111] Perhaps the best approach is to eschew the label of PTSD and focus on the child's symptoms. Of course, if these symptoms are also observed in non-abused children—they are—we are back to

[108] The diagnostic criteria for PTSD are contained in AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. Text Revision) (2000).
[109] *See id.* at 468 ("The person has been exposed to a traumatic event . . .").
[110] *See* State v. Chauvin, 846 So.2d 697, 704 (La. 2003) ("PTSD assumes the presence of a stressor and then attaches a diagnosis to the child's reactions to it.").
[111] *See* David L. Faigman, David H. Kaye, Michael J. Saks & Joseph Sanders, MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY § 13-1.2.1 at 107 (2002)(West) ("Some courts have expressed concern with the self-referential aspects of PTSD. In particular, a necessary prerequisite to a finding of PTSD, by definition, is the experiencing of 'an event that is outside the range of normal human experience that would be distressing to almost anyone.' That the alleged victim suffered such an experience, of course, is what the criminal prosecution is intended to determine. Hence, there is a circularity to reasoning from a diagnosis of PTSD, which accepts that the traumatic experience occurred if the individual says it did, to the judgment that the traumatic experience occurred.").

the twin issues of symptom frequency in abused and non-abused children and population sizes.

Given the fact that a diagnosis of PTSD assumes trauma occurred, one can argue that expert testimony using PTSD terminology is inherently misleading. It is likely to exaggerate the probative value of symptoms in the eyes of the jury and is unfairly prejudicial to the defendant.

6. *Symptoms That Have a Relatively Strong Nexus with Sexual Abuse*

Stress-related symptoms seen in sexually abused and non-abused children say little about sexual abuse. With children younger than ten or so, however, symptoms of a sexual nature have a strong connection to sexual knowledge. Sexual knowledge is sometimes rooted in sexual abuse. Particularly concerning symptoms are: (1) aggressive sexuality in young children, (2) imitation by young children of adult sexual acts, and (3) sexual knowledge that is unusual for a child of that age.[112]

Children are not asexual.[113] Yet, developmentally inappropriate sexual knowledge or behavior in a young child indicates sexual knowledge.[114] Consider a four-year-old who says, "Joey's pee pee was big and hard, and he made me lick it and white stuff popped out and tasted really yucky." This child

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[112] *See* William N Friedrich, P. Grambsch, D. Broughton, J. Kuipers & W.L. Beilke, *Normative Sexual Behavior in Children*, 88 PEDIATRICS 456-64, 462 (1991) (Friedrich and his colleagues found that unusual sexual behaviors in non-abused children are those "that are either more aggressive or more imitative of adult sexual behavior.").

[113] *See* Debra A. Poole & Michele A. Wolfe, *Child Development: Normative Sexual and Nonsexual Behaviors That May Be Confused with Symptoms of Sexual Abuse*, in Kathryn Kuehnle & Mary Connell, THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 101-28 (2009) (Wiley).

[114] *See* C.L.S. v. G.J.S., 953 So.2d 1025, 1042 (La. Ct. App. 2007) ("Some of the strongest evidence that the Daughter was sexually abused was the testimony regarding the sexualized behavior that was exhibited by this young child. It would have been almost impossible for the Daughter at her tender age to simulate male masturbation and to describe ejaculation in the way that she did without her having been exposed to sexual abuse.").

has seen a pornographic video, has been coached, or has been sexually abused. Pornography is unlikely to be the explanation when a child describes the taste and feel of seminal fluid, leaving coaching or abuse as the only possible explanations.[115] It is unlikely that a four-year-old could be coached to provide such a graphic description of abuse and ejaculation. That leaves abuse. Of course, Joey may not be the abuser. The child might have named the wrong person. But even if Joey is innocent, sexual abuse remains. In sum, graphic descriptions of sexual abuse from young children often provide strong evidence of sexual abuse.[116]

In addition to graphic verbal descriptions, behaviors can indicate developmentally unusual sexual knowledge. Such behaviors include: attempting to engage in explicit sex acts, inserting objects in the child's or someone else's vagina or anus,[117] initiating French kissing, excessive masturbation,[118] masturbating with an object, and imitating sexual intercourse.[119] Again, one must rule out benign explanations

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[115] *See* Cynthia DeLago, Esther Deblinger, Christine Schroeder & Martin A. Finkel, *Girls Who Disclose Sexual Abuse: Urogenital Symptoms and Signs After Genital Contact*, 122 PEDIATRICS e281-e286, at e281 (2008) ("In most cases, the final diagnosis of sexual abuse is based on the girl's history, especially if she provides idiosyncratic details unique to her situation.").

[116] *See* C.L.S. v. G.J.S., 953 So.2d 1025, 1042 (La. Ct. App. 2007) ("Some of the strongest evidence that the Daughter was sexually abused was the testimony regarding the sexualized behavior that was exhibited by this young child. It would have been almost impossible for the Daughter at her tender age to simulate male masturbation and to describe ejaculation in the way that she did without her having been exposed to sexual abuse."); State v. Smith, 768 N.W.2d 62 (Wis. Ct. App. 2009) (child said defendant's penis felt like a "hard banana").

[117] *See* State v. Shelton, 218 Or. App. 652, 180 P.3d 155, 157 (2008) ("Between August and October 2004, Deborah noticed T engaging in unusual and inappropriate behavior. On one occasion, Deborah observed T pull her underwear aside and attempt to insert rocks in herself.")

[118] Masturbation is normal. It is excessive masturbation that is worrisome. Obviously, it can be difficult to determine when normal masturbation cross the line into excessive masturbation.

[119] *See* Sonja N. Brilleslijper-Kater, William N. Friedrich & David L. Corwin, *Sexual Knowledge and Emotional Reaction as Indicators of Sexual Abuse in Young Children: Theory and Research Challenges*, 28

before attributing such behavior to sexual abuse. Although hyper sexualized behavior is uncommon in non-abused children, it does occur.[120] Again this revives the conundrum of population sizes.[121] The fact that sexual behavior is much more frequent in sexually abused than non-abused young children does not eliminate the fact that the population of non-abused children is much larger than the population of abused children.[122] Giving proper respect to population sizes and

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CHILD ABUSE & NEGLECT 1007-17, at 1013 (2004) ("Preschool children have only limited knowledge of sexuality. They possess a basic knowledge of genital differences, one's gender identity, sexual body parts, and their nonsexual functions. Children do not think sexually about the functions of sexual body parts."); William N Friedrich, P. Grambsch, D. Broughton, J. Kuipers & W.L. Beilke, *Normative Sexual Behavior in Children*, 88 PEDIATRICS 456-64 (1991).

[120] *See* Debra A. Poole & Michele A. Wolfe, *Child Development: Normative Sexual and Nonsexual Behaviors That May Be Confused with Symptoms of Sexual Abuse.* In Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS: A COMPREHENSIVE GUIDE TO ASSESSMENT AND TESTIMONY 101-128 (2009) (Wiley).

[121] *See* Sonja N. Brilleslijper-Kater, William N. Friedrich & David L. Corwin, *Sexual Knowledge and Emotional Reaction as Indicators of Sexual Abuse in Young Children: Theory and Research Challenges*, 28 CHILD ABUSE & NEGLECT 1007-17 (2004); Debra A. Poole & Michele A. Wolfe, *Child Development: Normative Sexual and Nonsexual Behaviors That May Be Confused with Symptoms of Sexual Abuse*, in Kathryn Kuehnle & Mary Connell, THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS. 101-28, 112 (2009) (Wiley) ("It is an error, though, to assume that most children who show inappropriate sexual behavior were sexually abused. The majority of sexual behavior occurs among nonabused children simply because sexual behavior is common and there are more nonabused than abused children.").

[122] *See* Gary B. Melton, John Petrila, Norman G. Poythress & Christopher Slobogin, PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 874 n.211 (3rd ed.) (2007) (Guilford) ("Because a large proportion of a small population [sexually abused children] still may be smaller than a small proportion of a large population [non-abused children] and because sexualized behavior is exhibited by only a minority of the sexually abused population, the [population size] problem still applies.").

benign alternatives, developmentally unusual sexual knowledge often provides evidence of sexual abuse.[123]

7. *Mental Health Testimony as Substantive Evidence*

To provide substantive evidence of sexual abuse, a mental health professional must be able to: (a) determine with reasonable certainty that sexual abuse occurred or, (b) opine that a child's symptoms, behavior, and statements are consistent with sexual abuse.

a. *The role of mental health professionals in determining whether sexual abuse occurred*

Mental health professionals who provide treatment routinely consider the symptoms described above to make treatment decisions. After all, it is hardly appropriate to treat a

[123] The evidentiary value of developmental unusual sexual knowledge is not without controversy. *See* Kerry M. Drach, Joyce Wientzen, & Lawrence R. Ricci, *The Diagnostic Utility of Sexual Behavior Problems in Diagnosing Sexual Abuse in a Forensic Child Abuse Evaluation Clinic*, 25 CHILD ABUSE & NEGLECT 489-503 (2001). In the Abstract of this article the authors wrote, "This study found no significant relationship between a diagnosis of sexual abuse and the presence or absence of sexual behavior problems in a sample of children referred for sexual abuse evaluation. The finding suggests that community professionals should use caution in relying on sexual behavior problems as a diagnostic indicator of abuse." The article by Drach, Wientzen and Ricci is criticized in William N. Friedrich, Sarah T. Trane, & Kevin J. Gully, *Letter to the Editor, It Is a Mistake to Conclude that Sexual Abuse and Sexualized Behavior Are Not Related: A Reply to Drach, Wientzen, and Ricci* (2001), 29 CHILD ABUSE & NEGLECT 297-302, 297 (2005). Friedrich and his colleagues wrote, "Their findings reiterate the fact that sexual behavior is not just a function of sexual abuse, but in fact can reflect normative processes, family variables, and child variables. However, we believe that their conclusion that a history of sexual abuse does not correlate with sexualized behavior is a mistake on three counts: circular logic, overgeneralization of null results, and an invalid criterion." In a reply letter to the Friedrich, Trane and Gully letter to the editor, Ricci, Drach, & Wientzen take issue with Friedrich's critique. Lawrence R. Ricci, Kerry M. Drach, & Joyce Wientzen, *Further Comment on the Lack of Utility of Sexual Behavior Problems as Measured by the Child Sexual Behavior Inventory in Diagnosing Sexual Abuse: A Reply to Friedrich, Gully, and Trane* (2004), 29 CHILD ABUSE & NEGLECT 303-306 (2005).

child for the effects of sexual abuse if there is no reason to think the child was abused. However, the degree of certainty required to diagnose sexual abuse in the clinical setting may not be enough to provide expert testimony in court.[124] This presents the issue of whether mental health professionals can diagnose sexual abuse with sufficient reliability to make their testimony useful in litigation.

This question divides experts on child sexual abuse. Some experts, notably psychologist Gary Melton, argue that mental health professionals cannot reliably detect sexual abuse.[125] Melton asserts that evaluating symptoms observed in abused and non-abused children is a matter of common sense, and mental health professionals have little to add.[126] Moreover, Melton argues mental health professionals rely heavily on the child's words when forming their decisions about sexual abuse. A diagnosis of sexual abuse is, therefore, little more than a thinly veiled opinion about whether the child told the truth.[127] Courts agree that experts are not permitted to

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[124] *See* Gary B. Melton, John Petrila, Norman G. Poythress & Christopher Slobogin, PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 516 (3d ed.)(2007) (Guilford) ("Although clinical intuition may be useful in guiding treatment planning, it is insufficient as a basis for determining whether maltreatment may have occurred.").

[125] *See id.*at 516 ("There is no reason to believe that clinicians' skill in determining whether a child has been abused is the product of specialized knowledge.").

[126] *Id.*at 508 ("The determination of whether abuse or neglect occurred is a judgment requiring common sense and legal acumen, but it is outside the specialized knowledge of mental health professionals."). *See also id*. at 516.

[127] *Id*. at 515 ("Some commentators distinguish the admissibility of an opinion about whether a purportedly abused child is believable from that of a 'diagnosis' of a child as abused. In our view (and that of most appellate courts), this is a distinction without a difference.").

Melton is not alone in believing that an opinion abuse occurred is essentially an opinion on credibility. *See, e.g.*, State v. Streater, 673 S.E.2d 365 (N.C. Ct. App. 2009) (physician's testimony that his findings were consistent with sexual abuse was an impermissible opinion regarding the child's credibility; there was no physical evidence of sexual abuse); Bell v. Commonwealth, 245 S.W.3d 738 (Ky. 2008); State v. Kirkman, 126 Wash. App. 97, 107 P. 3d 134 (2005).

opine that a child was truthful.[128] Melton concludes that courts should not permit mental health professionals to testify whether a child was sexually abused.[129] Indeed, Melton argues such testimony is unethical.[130]

Steve Herman, also a psychologist, reviewed the small body of empirical research discussing the accuracy of clinical judgments about sexual abuse and concluded, along with Melton, that such judgments lack reliability.[131] Psychologists

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[128] *See* John E.B. Myers, *Myers on Evidence in Child, Domestic and Elder Abuse Cases* § 6.25 (2005, 2010 supp.) (Aspen) (collecting cases).

[129] Gary B. Melton & Susan Limber, *Psychologists' Involvement in Cases of Child Maltreatment*, 44 AMERICAN PSYCHOLOGIST 1225-33, at 1230 (1989)("Under no circumstances should a court admit the opinion of an expert about whether a particular child has been abused."); Gary B. Melton, John Petrila, Norman G. Poythress & Christopher Slobogin, PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS at 516 (3rd ed.)(2007) (Guilford) ("Because testimony as an expert involves an implicit representation that the opinions presented are grounded in specialized knowledge, a mental health professional should decline on ethical grounds to offer an opinion about whether a child told the truth or has been 'abused.' By the same token, under the rules of evidence, such an opinion should never be admitted.").

[130] Gary B. Melton, John Petrila, Norman G. Poythress & Christopher Slobogin, *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* at 516 (3rd ed.) (2007) (Guilford).

[131] Steve Herman, *Forensic Child Sexual Abuse Evaluations*, in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 247-66 (2009) (Wiley) ("There have been only a handful of empirical studies that shed some light on the probable accuracy of informal clinical judgments about the validity of allegations of CSA. There are also a number of relevant theoretical analyses and commentaries. Taken together, these empirical studies and theoretical analyses indicate that the reliability, validity, and accuracy of evaluators' clinical judgments about the validity of uncorroborated allegations of CSA are low." at 251. "This analysis indicates that, in the absence of corroborative evidence, forensic evaluators (a) are unable to discriminate between true and false reports of sexual abuse based on children's reports during unstructured investigative interviews at greater than expected chance accuracy (the level of accuracy that could be achieved by making judgments based on flipping a coin) and (b) have a limited ability to discriminate between true and false reports based on children's reports

David Faust, Ana Bridges and David Ahern, who conclude that clinical judgments about sexual abuse are based on unverified methods and speculation, express similar skepticism.[132] Other experts agree.[133]

Psychologist Howard Garb is an authority on the accuracy of clinical judgments by mental health professionals.[134] Garb's research indicates that when it comes to evaluating causation, such as whether a child was abused, mental health professionals fare poorly.[135]

On the other hand, many mental health professionals believe it is possible for experts to conclude that sexual abuse is the most likely explanation for a child's symptoms and

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during NICHD protocol interviews." at 259); Steve Herman, *Improving Decision Making in Forensic Child Sexual Abuse Evaluations*, 29 LAW AND HUMAN BEHAVIOR 87-120 (2005).

[132] David Faust, Ana J. Bridges & David C. Ahern, *Methods for the Identification of Sexually Abused Children: Issues and Needed Features for Abuse Indicators,* in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 3-19, at 4 (2009) (Wiley).

[133] *See, e.g.*, Thomas M. Horner, Melvin J. Guyer & Neil M. Kalter, *The Biases of Child Sexual Abuse Experts. Believing Is Seeing*, 21 BULLETIN OF THE AMERICAN ACADEMY OF PSYCHIATRY AND LAW 281-92 (1993); Thomas M. Horner, Melvin J. Guyer & Neil M. Kalter, *Clinical Expertise and the Assessment of Child Sexual Abuse*, 32 JOURNAL OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY 925-31 (1993).

[134] Howard N. Garb, STUDYING THE CLINICIAN: JUDGMENT RESEARCH AND PSYCHOLOGICAL ASSESSMENT 100-101 (1998) (American Psychological Association) ("A review of the validity of causal judgments did not reveal any task for which validity was good or excellent . . . Clinicians should be very careful about making causal judgments. Because case formulations are frequently made on the basis of clinical experience and clinical intuition, and because reliability and validity have often been poor for case formulations, clinicians may frequently want to defer from making judgments about the causes of a client's problems or they may want to use empirical methods to derive causal inferences.").

[135] *Id.*

statements.[136] Social worker Kathleen Faller concludes this is the majority position in the United States.[137]

Given the controversy over the reliability of mental health diagnoses of child sexual abuse, the burden should be on the proponent of such testimony to establish reliability. The most appropriate forum in which to address the issue is an evidentiary hearing under the microscope of *Daubert v. Dow Pharmaceuticals*[138] or *Frye v. United States*.[139]

Most appellate courts reject mental health testimony stating that a particular child was sexually abused.[140] Some courts worry the opinion comes too close to the ultimate issue and usurps the function of the jury.[141] Other courts are concerned about the scientific/clinical controversy over the reliability of such testimony.[142]

b. *Expert testimony that a child's symptoms are consistent with sexual abuse*

Although most appellate decisions reject mental health testimony that a child was sexually abused, many courts

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[136] *See* S.M. Sgroi, F.S. Porter & L.C. Blick, *Validation of Child Sexual Abuse*, in S.M. Sgroi (Ed.), HANDBOOK OF CLINICAL INTERVENTION IN CHILD SEXUAL ABUSE 39-79 (1983) (Lexington Books).

[137] Kathleen C. Faller, *Understanding and Assessing Child Sexual Maltreatment* (2nd ed.) (2002) (Sage).

[138] 509 U.S. 579 (1993).
See United States v. Sanchez, 65 M.J. 145 (C.A.A.F. 2007) (court applied *Daubert* to expert medical testimony).

[139] 293 F.1013 (D.C. App. 1923).

[140] *See, e.g.*, Peterson v. State, 450 Mich. 349, 537 N.W.2d 857 (1995) (particularly thorough discussion); State v. Streater, 673 S.E.2d 365 (N.C. Ct. App. 2009); State v. Cressey, 628 A.2d 696 (N.H. 1993)(very useful discussion).

[141] *See* State v. Florczak, 76 Wash. App. 55, 882 P.2d 19 (1994) (opinion child had PTSD secondary to child sexual abuse was improper opinion on ultimate issue).

[142] *See* Steward v. State, 652 N.E.2d 490 (Ind. 1995) (court recognized population size problem with generalized "syndrome" testimony); State v. Cressey, 137 N.H. 402, 628 A.2d 969 (1993) (court understood population size issue); State v. Johnson, 652 So.2d 1069 (La. Ct. App. 1995) (expert's testimony was undermined because expert did not understand population size issue).

approve testimony that a child's symptoms are consistent with sexual abuse.[143] Courts are comfortable admitting "consistent with" testimony because it is a step away from the ultimate issue. The expert simply informs the jury that the child's symptoms are consistent with sexual abuse and lets the jury reach its own conclusion.

Despite the tendency of courts to admit "consistent with" testimony, there are three problems with such testimony. First, although testimony that a child's symptoms are consistent with sexual abuse is not an opinion in so many words that a child was sexually abused, the testimony is offered precisely for that purpose. The testimony invites the following reasoning: because the child has symptoms consistent with sexual abuse, the child was sexually abused. Thus, "consistent with" testimony is really an opinion regarding whether the child was abused.

"Consistent with" testimony is the functional equivalent of a direct opinion on abuse. As mentioned previously, there is considerable controversy surrounding "direct opinion" testimony. "Consistent with" testimony masks the controversy behind the innocuous term "consistent with." If testimony in the form of a direct opinion on sexual abuse is excluded because of doubts about reliability, the same should be true for testimony that a child's symptoms are "consistent with" sexual abuse.[144]

A second concern about "consistent with" testimony is that many symptoms consistent with sexual abuse are also

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[143] *See, e.g.*, United States v. Charley, 189 F.3d 1251 (10th Cir. 1999); State v. Crespo, 292 Conn. 917 (Conn. Ct. App. 2009); Hubert v. State, 676 S.E.2d 436 (Ga. Ct. App. 2009); Bishop v. State, 982 So.2d 371, 381 (Miss. 2008); Hobgood v. State, 926 So.2d 847 (Miss. 2006); State v. Spann, 2009 WL 2751079 (N.C. Ct. App. 2009) (unpublished).

But see State v. Streater, 673 S.E.2d 365 (N.C. Ct. App. 2009) ("consistent with" testimony too close to an opinion the child was telling the truth).

[144] Expert testimony that a child's symptoms are consistent with sexual abuse should be subjected to analysis under *Daubert* or *Frye*. *See* Hadden v. State, 690 So.2d 573 (Fla. 1997) (consistent with testimony subject to *Frye*).

consistent with non-abuse.[145] Nightmares are consistent with sexual abuse, but also with a host of issues that have nothing to do with abuse. In fact, nightmares are consistent with *normal* child development. Expert testimony that a child's symptoms are consistent with sexual abuse is likely to inflate the probative value of the symptoms and consequently mislead the jury.

Finally, "consistent with" testimony masks the twin issues of symptom frequency and population size as previously discussed. When an expert testifies that a child's symptoms are consistent with sexual abuse, the jury takes the testimony as proof the child was sexually abused. The jury is unlikely to appreciate the complexity of symptom frequencies in abused and non-abused children, along with population sizes. Unfortunately, jurors are not the only ones struggling with this issue. Many attorneys fail to appreciate these issues. This results in a failure to conduct the probing cross-examination needed to expose the weaknesses of "consistent with" testimony.

Given the shortcomings of "consistent with" testimony, such testimony should be excluded unless the proponent addresses two issues during the expert's direct examination. First, the expert should explain *why* the symptoms tend to *prove* sexual abuse. It is simply not enough for the expert to state that a child's symptoms are consistent with sexual abuse. Second, the expert should explain the impact of symptom frequency and population size on probative value. Only when explanations of symptom frequency and population size are added to "consistent with" testimony is the jury equipped with the information it needs to give "consistent with" testimony its proper weight. Absent this information, "consistent with" testimony is inherently misleading.

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[145] *See* Daniels v. State, 4 So. 3d 745 (Fla. Ct. App. 2009) (nurse testified she had never seen a child react as the victim did to the physical examination; there was no basis to conclude that the child's reaction suggested sexual abuse).

This analysis is also relevant to medical evidence of child sexual abuse. Medical experts often testify that the findings of a physical examination are consistent with sexual abuse. The concerns about "consistent with" testimony from mental health experts apply with equal vigor to "consistent with" testimony from medical experts.

8. *Qualifications of Experts Offering Testimony as Substantive Evidence*

Mental health testimony offered as substantive evidence of child sexual abuse is complex and controversial. If such testimony is admissible at all—a point of contention—it should be offered only by the most highly qualified experts. The professional must have a thorough grasp of child development, memory and suggestibility, normal sexual development, the impact of sexual abuse, normal and abnormal psychology, medical evidence of sexual abuse, the process by which children disclose sexual abuse, proper and improper interview methods, prevalence rates of various symptoms in abused and non-abused children, the impact of population size, and the strengths and weaknesses of clinical judgment. The professional should be conversant with the debate regarding the reliability of expert testimony offered as substantive evidence. Only a handful of mental health professionals working with sexually abused children possess this depth of knowledge. Professionals who lack this expertise should not provide expert testimony that a child was sexually abused or has symptoms consistent with sexual abuse.

9. *A Disturbing Trend: Expert Testimony from Forensic Interviewers Offered as Substantive Evidence*

Interviewing children about possible sexual abuse is a challenging task requiring skill and patience. Today there are more than seven hundred specialized centers called child advocacy centers (CAC) that interview children in abuse cases.[146] The forensic interviewers working in CACs are predominantly social workers and, to a lesser extent, police

[146] *See* National Children's Alliance website.

officers. These professionals are fully equipped to conduct forensic interviews. In a disturbing development, however, appellate decisions from Mississippi and South Carolina allowed forensic interviewers to offer what amounts to expert testimony that a child was sexually abused. With all due respect for forensic interviewers and these courts, forensic interviewers are experts on interviewing, not psychological assessment of child sexual abuse. This is a task for which most psychiatrists, psychologists, and clinical social workers lack competence.

In *Williams v. State*,[147] the Mississippi Court of Appeals approved expert testimony from a forensic interviewer that a child's interview was consistent with sexual abuse. This testimony was offered as substantive evidence. There was no showing that the interviewer possessed the expertise required to provide "consistent with" testimony.

The South Carolina Supreme Court in *State v. Douglas*[148] considered testimony from a Victim Assistance Officer who regularly interviewed children. The interviewer attended forty hours of training on forensic interviewing as well as a follow up training session. She did not have a college degree. The interviewer testified that based on her interview she concluded that the child needed a medical evaluation. Although the interviewer did not opine that the child was telling the truth or was abused, the import of her testimony could not have been lost on the jury. For all intents and purposes the interviewer said, "I believed the child was abused, therefore I referred the child for a medical examination." This is substantive evidence. The Supreme Court disagreed. The court emphasized that the interviewer

[147] 970 So.2d 727 (Miss. Ct. App. 2007).

See also Hubert v. State, 297 Ga.App. 71 (Ga. Ct. App. 2009) (court approves expert testimony from police officer/forensic interviewer who interviewed child that child appeared traumatized); Parramore v. State, 5 So.3d 1074 (Miss. 2009) (forensic interviewer testified that child's behavior and demeanor were consistent with other sexually abused children; Supreme Court did not address the issue of the interviewer's testimony, and affirmed the defendant's conviction).

[148] 380 S.C. 499, 671 S.E.2d 606 (2009).

did not say she believed the child. The court was convinced the interviewer's testimony—which the court did not consider to be expert testimony—was helpful to the jury. Respectfully, the court was misguided. To reiterate: the interviewer's testimony was substantive evidence. As in the Mississippi case, there was no showing that the interviewer was competent to provide such evidence. A forensic interviewer's hunch about abuse should not be paraded before the jury as substantive evidence.

B. Psychological Testimony to Rehabilitate a Child's Credibility

If the complexity of mental health testimony offered as substantive evidence is on a par with calculus, then testimony offered to rehabilitate a child's credibility is 2 + 2 = 4. A common defense strategy in child sexual abuse cases is to undermine the child's credibility by pointing out that the child delayed reporting, gave inconsistent versions of the abuse over time, or recanted. Of course, this is entirely legitimate impeachment. When the defense adopts this strategy, however, it is fair for the prosecution to rehabilitate the child's credibility with expert testimony. An expert may testify that it is not uncommon for sexually abused children to delay reporting, be inconsistent, or recant.[149]

Psychological research demonstrates that delayed reporting is common among sexually abused children.[150]

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[149] *See* Peterson v. Smith, 450 Mich. 349, 537 N.W.2d 857 (1995); State v. R.E.B., 385 N.J. Super. 72, 895 A.2d 1224, 1233 (2006) (case deals with fresh complaint of rape; "The victim's delay in reporting or silence may be considered by the jury in assessing the victim's credibility, but the jury must also be told that the 'silence or delay, in and of itself, is not inconsistent with a claim of abuse.'"); State v. Shomberg, 709 N.W.2d 370, 382 (Wis. 2006) ("Recantation is a subject clearly beyond the common knowledge or understanding of a jury or other fact finder. As such, it is an example of an area of 'specialized knowledge that will assist the trier of fact to understand the evidence or to determine a fact in …").

[150] *See* Cynthia DeLago, Esther Deblinger, Christine Schroeder & Martin A. Finkel, *Girls Who Disclose Sexual Abuse: Urogenital Symptoms and Signs After Genital Contact*, 122 PEDIATRICS e281-e286, at e285 (2008)

("Similar to others, we observed that girls frequently wait to disclose inappropriate sexual experiences . . . ."); Irit Hershkowitz, Yael Orabch, Michael E. Lamb, Kathleen J. Sternberg & Dvora Horowtiz, *Dynamics of Forensic Interviews with Suspected Abuse Victims Who Do Not Disclose*, 30 CHILD ABUSE & NEGLECT 753-69, at 754 (2006) ("there is consensus that many abuse victims cannot be protected or helped because they never disclose their experience or do so belatedly."); John E.B. Myers, *Myers on Evidence in Child, Domestic and Elder Abuse Cases* § 6.04 (2005, 2010 Supp Aspen); Margaret-Ellen Pipe, Michael E. Lamb, Yael Orbach & Ann-Christin Cederborg (Eds.), CHILD SEXUAL ABUSE: DISCLOSURE, DELAY AND DENIAL 11-40 (2007) (Lawrence Erlbaum).
See also Thomas D. Lyon, *False Denials: Overcoming Methodological Biases in Abuse Disclosure Research*, in Margaret-Ellen Pipe, Michael E. Lamb, Yael Orbach, & Ann-Christin Cederborg (Eds.), CHILD SEXUAL ABUSE: DISCLOSURE, DELAY AND DENIAL 11-39 (2007) (Lawrence Erlbaum), Lyon wrote:

> Contemporary reviews of the literature have acknowledged that child victims usually delay reporting abuse, and most often never tell anyone. (p. 42).
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> In sum, the studies examining nondisclosure among children with gonorrhea present convincing evidence that a large percentage of sexually abused children do not disclose abuse, even when questioned, and that high rates of disclosure in some studies can be attributed to suspicion bias, substantiation bias, and differences both in what constitutes appropriate interviewing and in what equals disclosure. Furthermore, the studies support the proposition that although abused children may initially deny abuse, repeated interviewing may eventually elicit disclosures. (p. 54).
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> I have argued in this chapter that nondisclosure of sexual abuse among truly abused children is a real and serious phenomenon. When suspicion bias and substantiation bias are minimized, only about half of abused children questioned about abuse disclosed. Because rates of denial are substantially higher than zero, denial is neither conclusive nor particularly compelling evidence that a child was not abused. This does not mean that a child's denial is irrelevant. As long as non-abused children are more likely to deny abuse than abused children, a denial of abuse is some evidence that abuse did not occur. But to the extent that denial rates are surprisingly high, an expert can justifiably testify that denials are surprisingly weak evidence against abuse.

Frequently when children finally disclose, they give slightly different versions of the abuse to different interviewers.[151] Finally, although there is debate about how many sexually abused children recant, it is undisputed that some children recant and some recant their recantation.[152] Thus, from a psychological point of view, expert testimony about delay, inconsistency, and recantation is not controversial. From the legal perspective, such testimony is not worrisome. The expert ventures no opinion on whether the child was abused. Indeed, the expert need never have met the child. The expert remains a safe distance from the ultimate issue. All the expert needs to do is summarize the literature on delay, inconsistency, or recantation. Moreover, the defendant invites the expert testimony by attacking the child's credibility.

When discussing expert testimony to rehabilitate credibility, it is appropriate to mention Child Sexual Abuse Accommodation Syndrome (CSAAS).[153] This maligned and misunderstood "syndrome" was described by psychiatrist Roland Summit in 1983.[154] Summit's goal was to help mental

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(pp. 57-58).

[151] *See* Erna Olafson & Condy S. Lederman, *The State of the Debate About Children's Disclosure Patterns in Child Sexual Abuse Cases*, 57 JUVENILE AND FAMILY COURT JOURNAL 27-40, at 30 (2006) ("when questioned during formal interviews, children may only partially disclose during the initial interview.").

[152] There is debate about the rate of recantation. *See* Kamala London, Maggie Bruck, Stephen J. Ceci, & Daniel W. Shuman, *Disclosure of Child Sexual Abuse: A Review of the Contemporary Empirical Literature*, in Margaret-Ellen Pipe, Michael E. Lamb, Yael Orbach, & Ann-Christin Cederborg (Eds.), CHILD SEXUAL ABUSE: DISCLOSURE, DELAY AND DENIAL 11-39 (2007) (Lawrence Erlbaum); Thomas D. Lyon, *False Denials*: *Overcoming Methodological Biases in Abuse Disclosure Research*, *in* Margaret-Ellen Pipe, Michael E. Lamb, Yael Orbach, & Ann-Christin Cederborg (Eds.), CHILD SEXUAL ABUSE: DISCLOSURE, DELAY AND DENIAL 41-62 (2007 Lawrence Erlbaum).

See also Daniel v. State, 675 S.E.2d 472 (Ga. Ct. App. 2009) (child was coerced by her family and a defense investigator to recant).

[153] Roland C. Summit, *The Child Sexual Abuse Accommodation Syndrome*, 7 CHILD ABUSE & NEGLECT 177-193 (1983).

[154] *Id.*

health professionals understand the psychological dynamics of sexual abuse, particularly incest.[155] Summit explained that many sexually abused children delay reporting. The child feels trapped and struggles to make the best of a bad situation. When the disclosure finally does come, it may be halting and piecemeal. Following disclosure, some children feel compelled to recant.

Summit never intended CSAAS as a test for sexual abuse. The syndrome neither detects nor diagnoses sexual abuse.[156] Thus, CSAAS does not provide substantive evidence of sexual abuse. Rather, CSAAS assumes abuse occurred and explains how children respond. Although CSAAS must not be offered as substantive evidence of sexual abuse, the syndrome plays a useful role in rehabilitating children's credibility. CSAAS helps the jury come to grips with delayed reporting, halting and inconsistent disclosure, and recantation. Limited to this rehabilitative purpose, CSAAS serves a useful role in court.[157]

For discussion of CSAAS *see* John E.B. Myers, *Myers, Evidence in Child, Domestic and Elder Abuse Cases* §§ 6.20[B]; 6.22 (2005, 2010 supp.) (Aspen).

[155] For cases recognizing that CSAAS does not diagnose sexual abuse *see* People v. Bowker, 203 Cal. App. 3d 385, 249 Cal. Rptr. 886 (1988); People v. Gray, 187 Cal. App. 3d 213, 231 Cal. Rptr. 658 (1986); Newkirk v. Commonwealth, 937 S.W.2d 690 (Ky. 1996); State v. Sargent, 738 A.2d 351 (N.H. 1999).

[156] *See* Mary B. Meinig, *Profile of Roland Summit*, 1 VIOLENCE UPDATE 6 (May, 1992) (This monthly newsletter is no longer published.)

To this day there is no syndrome that detects or diagnoses child sexual abuse. Nor is there a psychological test that detects or diagnoses sexual abuse.

[157] *See* State v. R.B., 183 N.J. 308, 873 A.2d 511, 520 (2005) ("expert testimony concerning the [CSAAS] syndrome is permitted on a circumscribed basis to explain what may well be counter-intuitive to a jury: that a child victim of sexual assault is often loathe to press an accusation. Testimony concerning this syndrome is not admissible as substantive proof of child abuse. Because '[t]he expert should not be asked to give an opinion about whether a particular child was abused[,] … care should be taken to avoid giving the jury an impression that the expert believes based on CSAAS … that a particular child has been abused.'" p. 520. "In a proper CSAAS case, '[t]he expert [is] not[] asked to give an

C. Expert Testimony Attacking and Defending Interviews

Children testify in most child sexual abuse trials. In addition, the child's hearsay is often admitted. Thus, the child's credibility is the centerpiece of the prosecution's case and the bulls-eye for the defense.[158] Somehow the defense must shake the jury's confidence in the child.

1. *Expert Testimony Attacking Interviews of the Child*

In order to undermine the child's credibility, a common defense strategy is to offer expert testimony critiquing interviews of the child.[159] Courts are receptive to such testimony, and for good reason. When an interview is defective, the defense *should* attack. Expert testimony is generally needed to help the jury understand the imperfections

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opinion about whether a particular child was abused.' For that reason, the CSAAS expert should not describe the attributes exhibited as part of that syndrome due to the risk that the jury may track the attributes of the syndrome to the particular child in the case." p. 523.); State v. L.A.G., 2009 WL 1256904 (N.J. Super. A.D. 2009); People v. Weber, 807 N.Y.S.2d 222 (App. Div. 2006)(trial court did not err in allowing expert testimony on CSAAS).

[158] *See* State v. Dylan, 204 P.3d 44 (N.M. Ct. App. 2009) (children's credibility was central issue).

[159] *See, e.g.*, People v. Cardamone, 381 Ill. App. 3d 462, 885 N.E.2d 1159 (2008)(defense expert testimony on interviewing should have been admitted; conviction reversed; "It is highly doubtful that psychological concepts such as reconstructive retrieval, infantile amnesia, mass suggestion, and even forensic interviewing techniques for child victims of sexual abuse are within common knowledge. The trial court asserted that defendant could cross-examine the complainants about what they heard and knew before they complained and what questions were asked by the investigators. In our opinion, cross-examination was not a substitute for the experts' testimony, because it merely elicited facts without helping the jury understand how those facts impacted the reliability of memory and, therefore, the complainants' statements." 885 N.E.2d at 1193-94. "The testimony here was relevant to whether the investigative techniques and the circumstances surrounding the allegations created distorted memories or misconceptions." *Id*. at 1194.); State v. Huntley, 177 P.3d 1001, 1008 (Kan. Ct. App. 2008)("This seems to be in step with an emerging trend to recognize and permit expert testimony on the impact of suggestive interviewing techniques on child witnesses.").

of the interview. Indeed, a defense attorney who fails even to consider attacking the interviews may render ineffective assistance to the defendant.[160] The Vermont Supreme Court in *State v. Wigg*[161] described the types of expert testimony allowed by courts. *Wigg* approved expert testimony on proper and improper methods of interviewing. The court held that experts may comment on whether particular interviews comply with accepted practice.[162] The court rejected expert testimony that interviewing impacted a particular child's credibility, reasoning that such testimony comes too close to a direct opinion on a child's credibility.

This article is not the venue for detailed analysis of the voluminous literature on interviewing practices. Suffice it to say that consensus exists on many points.[163] First, forensic

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[160] *See* People v. Settanni, 2009 WL 206533 (Cal. Ct. App. 2009) (nonpublished) (conviction reversed; "we conclude counsel's failure to conduct even a modicum of investigation into the retention of such an expert amounts to professional performance below a reasonable standard of care."); Mullins v. State, 30 Kan. App. 2d 711, 46 P.3d 1222 (2002) (defense attorney rendered ineffective assistance by failing to retain an expert to evaluate interviews of child); Stott v. State, 182 S.W.3d 728 (Mo. Ct. App. 2006) (defendant sought unsuccessfully to convince appellate court that trial attorney was ineffective because attorney did not retain an expert to challenge interviews).

[161] 179 Vt. 65, 889 A.2d 233 (2005).

[162] 889 A.2d at 238.

[163] *See* Michael E. Lamb, Yael Orbach, Irit Hershkowitz, Phillip W. Esplin & Dvora Horowitz, *A Structured Forensic Interview Protocol Improves the Quality and Informativeness of Investigative Interviews with Children: A Review of Research Using the NICHD Investigative Interview Protocol*, 31 CHILD ABUSE & NEGLECT 1201-31, at 1202-03 (2007) (reviewing the literature, the authors conclude, "these books and articles reveal a substantial degree of consensus regarding the ways in which investigative interviews should be conducted. . . . Expert professional groups agree that children should be interviewed as soon as possible after the alleged offenses by interviewers who themselves introduce as little information as possible while encouraging children to provide as much information as possible in the form of narratives elicited using open-ended prompts . . . The universal emphasis on the value of narrative responses elicited using open-ended prompts is rooted in the oft-replicated results of laboratory analogue studies demonstrating that information elicited using such prompts is much more likely to be accurate than information elicited using more focused recognition prompts . . .").

interviews should be conducted by trained interviewers who receive regular peer review of their work.[164] Second, children should be interviewed as soon as possible.[165] Third, the number of interviews should be minimized, although more than one interview is sometimes necessary.[166] The concern

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[164] *See* Michael E. Lamb, Irit Hershkowitz, Yael Orbach & Phillip W. Esplin, *Tell Me What Happened: Structured Investigative Interviews of Child Victims and Witnesses* (2008) (Wiley).

[165] *See* Michael E. Lamb, Yael Orbach, Irit Hershkowitz, Phillip W. Esplin & Dvora Horowitz, *A Structured Forensic Interview Protocol Improves the Quality and Informativeness of Investigative Interviews with Children: A Review of Research Using the NICHD Investigative Interview Protocol*, 31 CHILD ABUSE & NEGLECT 1201-31, at 1202-03 (2007) (reviewing the literature, the authors conclude, "these books and articles reveal a substantial degree of consensus regarding the ways in which investigative interviews should be conducted. . . . Expert professional groups agree that children should be interviewed as soon as possible after the alleged offenses by interviewers who themselves introduce as little information as possible while encouraging children to provide as much information as possible in the form of narratives elicited using open-ended prompts.").

[166] David La Rooy, Michael E. Lamb & Margaret-Ellen Pipe, *Repeated Interviewing: A Critical Evaluation of the Risks and Potential Benefits*, in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 327-61 (2009) (Wiley) ("it is clear that outright skepticism about repeated interviewing is unjustified because there were some conditions in which repeated interviews seemed advantageous." at 352. "Repeated interviews are not inherently suggestive but can maximize the effects of suggestive interviewing." at 355); Gail S. Goodman & Jodi A. Quas, *Repeated Interviews and Children's Memory: It's More Than Just How Many*, 17 CURRENT DIRECTIONS IN PSYCHOLOGICAL SCIENCE 386-90 (2008); Jodi A. Quas, Lindsay C. Mallow, Annika Melinder, Gail S. Goodman, Michelle D'Mello, & Jennifer Schaaf, *Developmental Differences in the Effects of Repeated Interviews and Interviewer Bias on Young Children's Event Memory and False Reports*, 43 DEVELOPMENTAL PSYCHOLOGY 823-37 (2007) ("studies of children's memory for experienced events generally suggest that repeated interviews can improve performance by facilitating recall and reducing forgetting. Yet, in a second line of research, specifically when children are suggestively questioned about false events, adverse effects of repeated interviews appear to emerge." at 823. "There are several reasons why repeated interviews may benefit memory. As indicated earlier, repetition may reduce forgetting because original event details are rehearsed during intervening interviews, a phenomenon sometimes termed an *inoculation effect.* Similarly, when questions repeatedly probe for particular event details, children learn what is important to recount and can

focus on this information. Finally, because intervening interviews serve as reminder cues and may activate additional information stored in memory, repeated interviews could lead to reminiscence (remembering new information across interviews) or hypermnesia (an increase in the total amount of details remembered across interviews. Although studies have not found evidence for hypermnesia in children following repeated interviews, especially when interviews occur following a delay, studies have revealed benefits of repetition in terms of greater reminiscence, decreased forgetting, and often increased resistance to misleading suggestions. For instance, following repeated interviews, young children can provide detailed and accurate accounts of a range of events, even highly stressful experiences . . . As mentioned, repeated interviews appear to adversely affect performance when children are questioned about never-experienced (i.e., false) events. Theoretically, the repeated interviews increase the familiarity of false events. Because familiarity is often taken as evidence that an event occurred, children may confuse the source of their knowledge about false events as being due to actual experience, a pattern consistent with source-monitoring perspectives concerning memory and suggestibility . . . If children are exposed to misinformation during repeated interviews, young children in particular may incorporate the false verbatim information into their immediate memory accounts, thereby increasing inaccuracies. Finally, when interviews are repeated, children may assume that their earlier responses were incorrect, leading to inaccuracies over time due to social pressure. Several studies confirm these possibilities and reveal remarkably high error rates among children exposed to repeated interviews about fictitious events." at 824. Describing the results of the present study the authors write, "Interview repetition did not increase children's errors, even though each interview contained misleading questions and, for half of the children, began with an interviewer providing highly biased statements . . . Our findings reveal that an inoculation effect is likely when children are asked direct questions about an event that occurred relatively recently." at 833. The authors found that a biased interviewer can distort children's recollections. The authors concluded, "Nonetheless, our findings do underscore two important conclusions: First, repeated interviews do not necessarily increase inaccuracies and cause false reports, even in preschool children. Instead, an inoculation effect may apply to some situations in which children are repeatedly interviewed about false events, even by biased interviewers. Second, when long delays have passed, the effects of interviewer bias are particularly deleterious, leading at times to higher numbers of older rather than younger preschoolers alleging false events occurred. Given that many forensic interviews with children occur after long delays, it is thus critical that interviewers try to adhere to appropriate interviewing techniques and best-practice guidelines." at 835.); Lindsay C. Malloy & Jodi A. Quas, *Children's Suggestibility: Areas of Consensus and Controversy*, in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL

about multiple interviews is not so much the number of interviews as it is the deleterious impact of repeated *suggestive* questioning. When children are interviewed non-suggestively more than once, they generally do quite well.[167] Fourth, forensic interviews should be videotaped.[168] Fifth, and most importantly, interviewers should maximize the use of open-

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ABUSE ALLEGATIONS 267-97 (2009) (Wiley) ("There are several reasons why repeated interviews may lead to increased errors. With repetition, children may gradually confuse information learned about in interviews and information from their original memory representation or incorporate information gleaned from prior questions into their subsequent reports. Also, when interviews are repeated, children may assume that their earlier responses were incorrect, especially given that they tend to trust adults as sources of knowledge, leading to changes in their responses, and increased inaccuracy over time. . . In contrast to the aforementioned studies' findings, results of other studies indicate that repeated interviews may benefit children's memory because the interviews allow children to rehearse event details and become familiar with interviewers' questions and style, decreased forgetting, and increased resistance to misleading suggestions." at 279-80. "In sum, repeated interviews in isolation do not inherently cause false reports or lead to dramatic inaccuracies. In other words, despite former studies' results commonly (but inappropriately) leading to broad, generalized statements about the harmful effects of repeated interviews, research now clarifies that the effects of repeated interviews on children's memory are quite complex." at 282.).

[167] *See* J. Zoe Klemfuss & Stephen J. Ceci, *Normative Memory Development and the Child Witness*, in Kathryn Kuehnle & Mary Connell, THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 153-80 (2009) (Wiley) ("In summary, while repeatedly asking children closed-ended questions about past events has been shown to decrease their accuracy for past events, repeatedly asking children open-ended questions will at worst, have no effect, and at best, may improve their memories for those past events. Therefore, repeatedly asking children open-ended questions is unlikely to produce false claims of sexual abuse." at 169-70).

[168] *See* Commonwealth v. Niels, 73 Mass. App. Ct. 689, 901 N.E.2d 166, 177 (2009) ("On appeal, the juvenile argues that Federal and State due process principles required the Commonwealth to videotape the MIT interview of Norma, and that it was error to deny his motion to dismiss. We disagree. Although we have acknowledged that the electronic recording of Sexual Abuse Intervention Network (SAIN) interviews (comparable to MIT interviews) is 'good practice,' neither we nor the Supreme Judicial Court has 'required that such records b made.'").

See also John E.B. Myers, *Myers on Evidence in Child, Domestic and Elder Abuse Cases* § 1.16 (2005, 2010 supp.) (Aspen) (discussing the pros and cons of videotaping).

ended, non-suggestive questions.[169] Sixth, "yes-no" questions should be kept to a minimum, especially with young

[169] *See* Lindsay C. Malloy & Jodi A. Quas, *Children's Suggestibility: Areas of Consensus and Controversy*, in Kathryn Kuehnle & Mary Connell (Eds.), THE EVALUATION OF CHILD SEXUAL ABUSE ALLEGATIONS 267-97, 274 (2009) (Wiley) ("Regardless of the type of direct question, children err more often when asked direct than free-recall questions . . . When children are asked questions that pressure them to respond in particular ways, contain false embedded clauses, or are nonsensical, they often respond rather than say they do not know or ask for clarification."); Kamala London, Maggie Bruck & Laura Melnyk, *Post-Event Information Affects Children's Autobiographical Memory After One Year*, LAW AND HUMAN BEHAVIOR (2008) (emphasizing the importance of maximizing open-ended questions at all interviews); Yael Orbach & Michael Lamb, *Young Children's References to Temporal Attributes of Allegedly Experienced Events in the Course of Forensic Interviews*, 78 CHILD DEVELOPMENT 1100-20, 1104 (2007) ("In forensic contexts, responses to individual free-recall prompts are typically 3 to 5 times more informative than responses to more focused prompts.… Research in laboratory analog contexts has shown that freely recalled information is more likely to be accurate than information retrieved in response to recognition memory prompts, including those presented in yes-no and forced-choice formats. Although it is typically impossible to assess the accuracy of information disclosed in forensic cases, close examinations of individual cases in which accuracy could be assessed have yielded findings consistent with those obtained in the laboratory."); Michael E. Lamb, Yael Orbach, Irit Hershkowitz, Dvora Horowitz & Craig B. Abbott, *Does the Type of Prompt Affect the Accuracy of Information Provided by Alleged Victims of Abuse in Forensic Interviews?*, 21 APPLIED COGNITIVE PSYCHOLOGY 1117-30, at 1117-18 (2007) ("In the last 2 decades, researchers have repeatedly documented that information retrieved from memory using free-recall processes is more likely to be accurate than information retrieved using recognition processes, including yes/no and 'forced-choice' prompts. This fact has major implications when accuracy is very important such as in the course of forensic interviews. Young children, especially preschoolers, are more likely than older children to respond erroneously to suggestive questions about their experiences and to select erroneous options when responding to yes/no and forced-choice questions. Regardless of age, furthermore, responses to free-recall open-ended questions are more likely to be accurate than responses to more focused questions. Although young children tend to remember less information and provide briefer accounts of their experiences than older children do, their recall reports are not less accurate. Such findings have helped foster a remarkable consensus concerning the ways in which investigative interviews should be conducted. Professional and expert guidelines recommend that forensic interviewers should rely as much as possible on free-recall open-ended

children.[170] Seventh, when suggestive questions are asked—and such questions are sometimes necessary—the interviewer should follow up with open-ended questions such as, "Tell me more about that."[171] Eighth, children should never be coerced into answering questions. Ninth, a number of interview protocols are used around the country. The only interview protocol that has been empirically studied and validated is the National Institute of Child Health and Development (NICHD) Investigative Interview Protocol.[172] This is not to suggest that the NICHD protocol is the only acceptable protocol, but to

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questions when obtaining information from an alleged victim of child sexual abuse and take special care to avoid risky questions when interviewing young children.").

[170] *See* Michael E. Lamb, Yael Orbach, Irit Hershkowitz, Dvora Horowitz & Craig B. Abbott, *Does the Type of Prompt Affect the Accuracy of Information Provided by Alleged Victims of Abuse in Forensic Interviews?*, 21 APPLIED COGNITIVE PSYCHOLOGY 1117-30, at 1117-18 (2007) ("In the last 2 decades, researchers have repeatedly documented that information retrieved from memory using free-recall processes is more likely to be accurate than information retrieved using recognition processes, including yes/no and 'forced-choice' prompts.").

See also United States v. Cano, 61 M.J. 74, 78 (C.A.A.F. 2005) ("There is a good deal of scholarly debate in the area of child suggestibility and its effect on the reliability of the testimony of a child victim. However, scholars agree that the danger of false testimony from a child is greater when the child is subjected to highly suggestive interviewing techniques such as 'closed' (yes/no) questions and 'multiple interviews with multiple interviewers.'").

[171] *See* Alison R. Perona, Bette L. Bottoms & Erin Sorenson, *Research-Based Guidelines for Child Forensic Interviews*, 12 JOURNAL OF AGGRESSION, MALTREATMENT & TRAUMA 81-130, at 87 (2006) ("Directed or specific questions are sometimes necessary, however, because children—especially young children—have difficulty reporting experiences because they lack 'metamemory' skills such as how to search for knowledge stored in memory and how to report knowledge in a structured manner.").

[172] For discussion of the NICHD protocol and a summary of research on the protocol *see* Michael E. Lamb, Irit Hershkowitz, Yael Orbach & Phillip W. Esplin, *Tell Me What Happened: Structured Investigative Interviews of Child Victims and Witnesses* (2008) (Wiley).

point out the need to subject other protocols to empirical validation.[173]

When the defense offers expert testimony attacking interviews of the child, the prosecution can cross-examine the expert and offer rebuttal expert testimony. In the final analysis, the best defense against the attack on the interviewer is to ensure that professionals who interview children are competent. Competent interviewing defends itself.

2. *Another Disturbing Trend: Expert Testimony on Interviewing Offered by the Prosecution During the Government's Case-in-Chief*

Part III.9. describes a disturbing trend in some courts to allow forensic interviewers to provide what amounts to substantive evidence of child sexual abuse. This subsection discusses another worrisome development regarding forensic interviewers: prosecutors sometimes offer forensic interviewers as expert witnesses to describe proper interviewing methods and to state that they—the interviewer—used proper methods in the case on trial.[174] If such testimony were offered after the defense attacked the interview, there would be no problem. The concern, however, is that the prosecutor offers the interviewer's testimony during the state's case-in-chief and *before* any attack by the defense. The purpose of the testimony is to convince the jury that the interview was done properly, thus bolstering the child's credibility. However, allowing the prosecution to offer expert testimony during the state's case-in-chief violates the rule that a party may not bolster the credibility of its own witnesses

[173] Thomas D. Lyon, Michael E. Lamb & John Myers, *Letter to the Editor, Authors' Response to Vieth* (2008), 33 CHILD ABUSE & NEGLECT 71-74, at 71 (2009) ("Lamb and colleagues did not suggest that the NICHD Protocol was the only valid and reliable method for interviewing children.").

[174] *See* State v. Hakala, 763 N.W.2d 346 (Minn. Ct. App. 2009); Williams v. State, 970 So.2d 727 (Miss. Ct. App. 2007); Mooneyham v. State, 915 So.2d 1102 (Miss. Ct. App. 2005); State v. Thomas, 290 S.W.3d 129 (Mo. Ct. App. 2009); State v. Douglas, 380 S.C. 499, 671 S.E.2d 606 (2009).

unless credibility is attacked.[175] The only proper role for a forensic interviewer during the state's case-in-chief is to lay the foundation for admission of the videotaped interview into evidence. Any testimony beyond that, especially expert testimony, is improper bolstering and is unfair to the defendant.

IV. Conclusion

Child sexual abuse is difficult to prove. Usually there is no medical evidence, although when such evidence does exist it is admissible. These cases rise and fall on the child's shoulders. In an effort to bolster or undermine the child, prosecution and defense sometimes turn to expert testimony. Some forms of expert testimony are straightforward and uncontroversial, other forms are complex, controversial, and of dubious reliability.

As a student of child abuse litigation, I read hundreds of appellate court decisions every year. Most of the time, the courts perform admirably. Sometimes, however, unreliable expert testimony slips past trial court judges and is not caught on appeal. Trial judges may admit suspect expert testimony because counsel fails to object. In these cases, the appellate court is powerless to act absent plain error. In other cases, trial counsel objects but the trial court fails to exercise its duty as gatekeeper of expert evidence. Sadly, appellate judges sometimes do little better. Worse, appellate courts occasionally craft rules that authorize dubious expert testimony.

The integrity of criminal litigation depends on the bar and the bench. For attorneys locked in pitched battle it is tempting to offer any expert testimony—even dubious testimony—that helps win the case. This is not a criticism of lawyers; it is reality. Of course, one can argue that the check on unreliable expert testimony is cross-examination, and many prosecutors and defenders are fully capable of dismantling

[175] *See* Michael H. Graham, HANDBOOK OF FEDERAL EVIDENCE § 607:1 at 429, 431 (6th ed. 2006) (Thompson) ("The credibility of a witness may not be bolstered in the absence of an attack.").

unreliable expert testimony. The fear, however, is that many attorneys have only a superficial understanding of the complexity of expert testimony regarding child sexual abuse. Effective cross-examination is more the exception than the rule.

In the final analysis, it is up to judges to scrutinize expert testimony and separate the wheat from the chaff. It is time for trial and appellate judges to recommit to exacting scrutiny of expert testimony offered in child sexual abuse litigation. The stakes are too high to expose jurors to unreliable expert testimony. It will not do to avoid the judicial gatekeeping responsibility by deferring to cross-examination. Unreliable expert testimony should not be subjected to cross-examination because it should not have been admitted in the first place.