Association of Family and Conciliation Courts, Arizona Chapter

2014-2017 Summit Project

CHILD SEXUAL ABUSE:

ASSESSMENT AND EARLY INTERVENTION FOR ALLEGED ABUSERS, PROTECTIVE PARENTS, AND THE CHILD WHO ALLEGES SEXUAL ABUSE

Summit Project

The Arizona Chapter of the Association of Family and Conciliation Courts (AZAFCC), is a multidisciplinary organization comprised of behavioral health professionals, judicial officers, attorneys, mediators, and others engaged in the family law process. In meeting one of the Mission Statement objectives for the organization, the 2009-2010 Board of Directors of AZAFCC endorsed proceeding with an annual project designed to address a core issue in the family law arena. Hence, the Summit Project was inaugurated. Each Summit Project's goal is to create a product for professionals who confront the identified issue to use as a resource. The AZAFCC Summit Project Committee is made up of a diverse group, including interests groups, policy makers, behavioral health practitioners, attorneys, and judicial officers.

The 2014-2017 Summit Project is "Child Sexual Abuse: Assessment and Early Intervention for Alleged Abusers, Protective Parents, and the Child Who Alleges Sexual Abuse." The focus of this project is to provide a framework and flowchart for how family court, criminal court, and law enforcement can assess, coordinate, intervene, investigate, and manage allegations of child sexual abuse. Additionally, the Project provides recommendations and guidelines for assessment, early intervention, and options for immediate responses for the entire family embroiled in child sexual abuse situations. The Project also provides judicial officers proposed forms of Order for the assessment and management of interventions for alleged abusers, protective parents/grandparents/other caretakers, and children.

This report is meant to be used as a resource; the recommendations and guidelines are not comprehensive or meant as authoritative works, do not carry legal weight, and are not endorsed by any organization, entity, or institution, including the Association of Family and Conciliation Courts (AFCC), or the individual members of the AZAFCC Summit Project Committee. This report does not reflect the views of any particular individual, organization, entity, or organization.

Guidelines and recommendations herein may communicate expectations that exceed those established by law or regulation. Where conflicts exist, applicable law, court rules, regulations, and agency requirements supersede any guidelines or recommendations within this resource.

In the area of sexual abuse and family law, many other issues deserve attention and improvement. At the end of this report, the AZAFCC Summit Project Committee suggests areas for further exploration and evaluation. The scope of this report is limited to child sexual abuse and does not report on other types of child abuse.

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Attorney at Law
Phoenix, Arizona

Wendy Dutton, Ph.D.
AZAFCC Member
Forensic Interviewer
Phoenix, Arizona

Rebecca Stahl, J.D., L.L.M.
AZAFCC Board Member
Attorney at Law
Los Angeles, California

Tracey Westerhausen, J.D.
Attorney at Law
Tempe, Arizona

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Introduction

Issues in child sexual abuse cases include assessment and evaluation of child sexual abuse, evidence-based treatments, best practice standards, victim and offender dynamics, sequela (short and long-term effects) of child sexual abuse, and the likelihood of child sexual abuse during low-conflict divorce versus high conflict divorce. This Project reviews these issues in order to assist the Family Court in understanding the issues, identify how the court works as a team with behavioral health professionals, medical professionals, law enforcement professionals, and attorneys.

In cases involving allegations of child sexual abuse, one consideration is whether each family member should be evaluated to inform the Family Court about the family dynamics and the context in which the allegations have been raised. Early intervention in sexual abuse allegation cases is critical to assure the child's safety, preserve the physical evidence, prevent unnecessary or unskillful forensic child interviews, and stabilize the family. A review of the components of a sound evaluation and the qualifications and forensically-informed stance of competent behavioral health professionals assists the court in appointing professionals and forming the intervention team.

Definitions of Child Sexual Abuse (CSA)

The American Psychological Association defines sexual abuse as:

> Unwanted sexual activity, with offenders using force, making threats or taking advantage of victims not able to give consent.

The DSM V, the guide that behavioral health practitioners utilize in defining and diagnosing mental health conditions, provides the following clinical definition/diagnosis of CSA:

> Child sexual abuse encompasses any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver, or other individual who has responsibility for the child. Sexual abuse includes activities such as fondling a child's genitals, penetration, incest, rape, sodomy, and indecent exposure. Sexual abuse also includes noncontact exploitation of a child by a parent or caregiver – for example, forcing, tricking, enticing, threatening, or pressuring a child to participate in acts for the sexual gratification of others, without direct physical contact between child and abuser.

(APA, 2013).

The Arizona Revised Statutes provide the following statutory definitions:

> 'Abuse' means the infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody and control of a child. Abuse includes:
>
> (a) Inflicting or allowing sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-1406, molestation of a child pursuant to section 13-1410, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553, incest pursuant to section 13-3608 or child prostitution pursuant to section 13-3212.
>
> (b) Physical injury that results from permitting a child to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or

equipment is possessed by any person for the purpose of manufacturing a dangerous drug as defined in section 13-3401.

(c) Unreasonable confinement of a child.

A.R.S. § 8-201(2).

A person commits sexual abuse by intentionally or knowingly engaging in sexual contact with any person who is fifteen or more years of age without consent of that person or with any person who is under fifteen years of age if the sexual contact involves only the female breast.

A.R.S. § 13-1404(A).

A person commits sexual conduct with a minor by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person who is under eighteen years of age.

A.R.S. § 13-1405(A).

A person commits sexual assault by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person without consent of such person.

A.R.S. § 13-1406(A).

A person commits molestation of a child by intentionally or knowingly engaging in or causing a person to engage in sexual contact, except sexual contact with the female breast, with a child who is under fifteen years of age.

A.R.S. § 13-1410(A).

A person who over a period of three months or more in duration engages in three or more acts in violation of section 13-1405, 13-1406 or 13-1410 with a child who is under fourteen years of age is guilty of continuous sexual abuse of a child.

A.R.S. § 13-1417(A).

A person commits commercial sexual exploitation of a minor by knowingly:

1. Using, employing, persuading, enticing, inducing or coercing a minor to engage in or assist others to engage in exploitive exhibition or other sexual conduct for the purpose of

producing any visual depiction or live act depicting such conduct.

2. Using, employing, persuading, enticing, inducing or coercing a minor to expose the genitals or anus or the areola or nipple of the female breast for financial or commercial gain.
3. Permitting a minor under the person's custody or control to engage in or assist others to engage in exploitive exhibition or other sexual conduct for the purpose of producing any visual depiction or live act depicting such conduct.
4. Transporting or financing the transportation of any minor through or across this state with the intent that the minor engage in prostitution, exploitive exhibition or other sexual conduct for the purpose of producing a visual depiction or live act depicting such conduct.
5. Using an advertisement for prostitution as defined in section 13-3211 that contains a visual depiction of a minor.

A.R.S. § 13-3552(A).

A person commits sexual exploitation of a minor by knowingly:

1. Recording, filming, photographing, developing or duplicating any visual depiction in which a minor is engaged in exploitive exhibition or other sexual conduct.
2. Distributing, transporting, exhibiting, receiving, selling, purchasing, electronically transmitting, possessing or exchanging any visual depiction in which a minor is engaged in exploitive exhibition or other sexual conduct.

A.R.S. § 13-3553(A).

A person commits child prostitution by knowingly:

1. Causing any minor to engage in prostitution.
2. Using any minor for the purposes of prostitution.
3. Permitting a minor who is under the person's custody or control to engage in prostitution.
4. Receiving any benefit for or on account of procuring or placing a minor in any place or in the charge or custody of any person for the purpose of prostitution.
5. Receiving any benefit pursuant to an agreement to participate in the proceeds of prostitution of a minor.
6. Financing, managing, supervising, controlling or owning, either alone or in association with others, prostitution activity involving a minor.

7. Transporting or financing the transportation of any minor with the intent that the minor engage in prostitution.
8. Providing a means by which a minor engages in prostitution.

A.R.S. § 13-3212(A).

At the Federal level, the Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as:

> Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

The CAPTA definition of sexual abuse includes:

(A) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or

(B) the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Process of Responding to Child Sexual Abuse Allegations

Initial Contact with the (Suspected) Sexually Abused Child

Typically, a Family Court judge will not be the first person to encounter the abused child. However, the Family Court judge may be the first to hear about the protective parent's concerns about child abuse in the other parent's home. When the protective parent presents in Family Court, the judge must determine if the child is safe. If the allegations have not been reported to law enforcement and/or the Department of Child Safety (DCS), the protective parent or the court must do so immediately. After the suspected sexual abuse has been reported to law enforcement and/or DCS, the Family Court should determine if a criminal investigation has begun, and if so, must determine the status of the current criminal proceedings. At this point, the Family Court may appoint a Behavioral Health Provider (BHP), obtain DCS records, and/or schedule a return hearing. When appointing a BHP, the court should determine if the BHP is forensically-informed.[1] A forensically-informed professional will have experience in Family Court cases with high conflict divorce.

If the protective parent informs the Court that the child has had a forensic interview and did not disclose abuse but the parent continues to be worried about the child's behavior and statements, the Court has the following options:

(1) Appoint a Court-Appointed Advisor (CAA) to gather relevant investigative documents and/or interview relevant persons; and/or
(2) Appoint a Therapeutic Interventionist/BHP to provide child therapy, crisis intervention, family therapy, and/or to conduct an evaluation.

No matter who is tasked with gathering information about the family, the following are the relevant documents the Court needs to proceed. Therefore, Judge should enter orders for the release of all records on the family including:

- Complete, unredacted DCS records;
- Law enforcement records;
- Forensic interviews (DVD and records);
- Therapy/counseling records;
- Hospital records;
- Medical records;
- Psychological evaluations;
- Criminal justice records; and
- Juvenile detention records.

[1] "Forensically-informed" means a BHP has at least the following: familiarity with the AFCC Guidelines for Court-Involved Therapy (AFCC, 2010); familiarity with the goals of the Family Court; and training as required by A.R.S. § 25-406(C).

Law Enforcement

This section outlines the typical procedure that law enforcement personnel follow upon receipt of a child abuse report. If a parent raises a concern of CSA in Family Court, the court needs to immediately make a law enforcement report if one has not already been made.

The following protocol outlines the typical response process of law enforcement agencies. Procedures are generally consistent across agencies. Each agency will start with a patrol officer response prior to a detective (criminal investigator) becoming involved. A typical investigation will likely include the following steps:

(1) The initial response by the patrol officer will comply with the Multidisciplinary Protocol for the Investigation of Child Abuse (http://www.maricopacountyattorney.org/pdfs/protocols/Multidisciplinary-Protocol-on-Investigation-of-Child-Abuse-2008.pdf; the goal of the Multidisciplinary protocol is for only one forensic interview to be completed of the alleged victim);
(2) The initial law enforcement report will be taken by the patrol officer who responds to the location of the reporting party; the report may be taken telephonically when appropriate.

Patrol officers will then determine if the elements of the crime and jurisdiction rise to the level of statutory definitions for CSA. The officer may use the following techniques/questioning protocols in making that determination:

(a) Patrol officers may interview[2] the reporting source, away from the victim, witnesses, or other reporting sources utilizing the "W" questions, in order to:
    (1) Obtain the facts of the reported crime (What happened?)
    (2) Determine if the child is in imminent danger (Who did this?)
    (3) Determine if the victim may require medical attention (When did this happen?)
    (4) Determine jurisdiction (Where did this happen?)

(b) A.R.S. § 13-3620 requires "[a]ny person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature or who reasonably believes there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant

[2] This is not considered a forensic interview and should be very limited.

who is protected under section 36-2281 shall immediately report or cause reports to be made of this information to a peace officer or to the department of child safety, except if the report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only."

The next steps in law enforcement protocol are dictated by the initial findings of the patrol officer during his/her response to the report. If certain criteria are met during the initial response, the patrol officer will be directed to coordinate immediate transport to a local child/family advocacy center. Some of the criteria that may require an immediate response by a detective are:

- When the "suspect" and the "victim" reside together or when the "suspect" is known and there is immediate danger of the victim being re-contacted or re-victimized by the "suspect;" or
- There are multiple victims with the potential for additional victims if not immediately acted upon. –should we use quotation marks around victim here for consistency?

If a detective is assigned, a search warrant may be required to obtain evidence (pornography, videos, computers, biological evidence, *etc.*).

The Office of Child Welfare Investigations (OCWI) and Department of Child Safety (DCS) will be included in any immediate response situation. OCWI/DCS is concerned for the welfare of the alleged victim while law enforcement is concerned with the criminal investigation. In accordance with the law and law enforcement procedures, a joint investigation will be conducted with law enforcement as the lead agency. A joint investigation means that OCWI/DCS are included in each investigative step completed by law enforcement. For example, if the responding officer coordinates family transportation to an advocacy center for a forensic interview, OCWI/DCS will meet them at the advocacy center and be present for the investigation.

If the allegations/disclosures do not meet the criteria for an immediate investigative response by a detective, a patrol officer will take the information and document the information in a law enforcement report. The reporting party should request a report number from the patrol officer. It will then be assigned to a detective within a few days who will become the point of contact for the parents/court. The detective will communicate with the parents/caregiver to arrange for a forensic interview to be completed of the child. The criminal investigation could proceed in a variety of ways based on the information obtained during the forensic interview(s). The Family Court may want to review the section on Temporary Orders below to determine its next steps after law enforcement becomes involved.

Child Forensic Interviews[3]

When a child's report of maltreatment is reported and responded to by a law enforcement or child protection agency, the child enters an unfamiliar social sphere governed by legal discourse (Cooper, Wallin, Quas, & Lyon, 2010). Children enter into conversations with investigators or interviewers. It is the investigator's task to ask questions and receive answers to determine whether a crime occurred, and if so, establish the elements of that crime. These elements include not only the acts that occurred, but also the context surrounding the acts, such as the location and time frame of the incidents. Children may also be asked questions concerning the intent of the offender. In order to establish the elements of the crime, a child must provide detailed information about individual abusive incidents. Investigators are obligated to question children to obtain information to prove that the crime occurred. These types of interviews can be challenging for young children given the limitations of language and attention, and motivation to protect loved ones (Dutton, 2011). Young children have been shown to be unaware of the requirements of legal charges, evidence, and processes (Cooper et al, 2010; Saywitz, Jaenicke, & Comparo, 1990). They may not provide necessary information in spontaneous statements or narratives to establish the elements, context, or corroboration of the crime unless directly asked by an interviewer (Orbach & Lamb, 2000). Law enforcement and child protection investigators should seek corroborating or exonerating evidence for the allegation. If the child's allegation does not meet the necessary standard of evidence for criminal charging or dependency, Family Court judges and professionals are often left to render judgment on the merits of the allegation. This decision can be especially challenging when the only available evidence is the child's statements.

Investigation of Child Maltreatment Reports in Maricopa County

Patrol officers are typically the first responders to child maltreatment reports to law enforcement agencies in Maricopa County. Based on the case facts, patrol officers and their supervisors may triage initial reports into two categories. The first category involves emergent situations, which require immediate investigation by detectives in order to protect the health and safety of the child or children involved. The second category involves no immediate risk of harm to the child, and can be referred by electronic or paper submission to detectives for additional investigation. Cases involving an offender who resides with the child are also jointly-investigated with the law enforcement agency by DCS. The OCWI will also become involved if the case involves criminal conduct against a child under the age of five. Detectives who investigate crimes against children will typically conduct an interview with the reporting party and arrange for an interview with child victim or witness at a children's advocacy center.

[3] References located at Appendix F.

Investigative case managers typically initiate investigations when reports of maltreatment are initially made to the DCS Child Abuse Hotline. Response time is determined by the level of priority assigned to the report. DCS investigators are required to notify law enforcement immediately in the allegations involve serious physical abuse or neglect, or sexual abuse. A joint investigation is required in these cases, and the law enforcement detective usually assumes the leadership role in the investigation.

In Maricopa County, law enforcement detectives who investigate crimes against children are required to complete 64 hours of training in forensic interviewing and abuse dynamics before they conduct interviews of child victims or witnesses. Highly trained and skilled Designated Forensic Interviewers (DFIs) are available to conduct forensic interviews at the five children's advocacy centers[4] in the Phoenix Metro area at the request of law enforcement and DCS or OCWI investigators. Use of DFIs by law enforcement and child protection workers is strongly recommended in cases involving the following factors:

1. Children with developmental disabilities.
2. Children under the age of seven.
3. Cases where there is an indication of lengthy, chronic abuse.
4. Children with significant emotional and/or behavioral symptoms.
5. Multiple victim cases if additional interviewers are needed.
6. Children sexually abused by persons unknown to the child.
7. Complex cases in which the detective or DCS investigator deems it necessary to refer a child to a Designated Forensic Interviewer.

These interviews are video and audio recorded to preserve the child's statements. The recording is then impounded into evidence. DFIs may maintain copies of the recorded forensic interviews separate from law enforcement records. Records of the child witness interviews may be obtained from the investigating law enforcement agency, or from the DFIs.[5]

Investigators will attempt to limit the number of interviews children undergo. Typically, children are forensically interviewed one time. Minimizing the number of times children are interviewed reduces the likelihood that children will be adversely affected by the investigation process (Henry, 1997). However, some children may require additional interviews, especially if they are severely

[4] Childhelp of Phoenix, Glendale Family Advocacy Center, Mesa Family Advocacy Center, Scottsdale Family Advocacy Center, and Southwest Family Advocacy Center.

[5] DFIs in Maricopa County are employed by several agencies including Phoenix Children's Hospital (Wendy Dutton and Amy Heil), Childhelp (Jennifer Ingalls and Sarah Ford), Southwest Advocacy Center (Ann Baker), City of Mesa (Lauren Glazer), and independent contractors of the City of Avondale (Sandy Corral) and the Maricopa County Attorney's Office (Christina Schopen, Adriana Frias, and Joy Lucero). Records requests should be directed to the agencies or to the independent contractors directly.

traumatized by the abuse, or if they are reluctant to discuss the allegations due to fear, embarrassment, or coaching by the abuser or other family members. Additional interviews have been shown to increase the amount of information children can provide, as long as they are conducted using appropriate non-suggestive techniques (La Rooy, Katz, Malloy, & Lamb, 2010).

Each of the children's advocacy centers has medical exam rooms. Forensic medical services are provided at each of the advocacy centers by the forensic medical staff of Child Protection Team Clinic of Phoenix Children's Hospital. Children over the age of 12 years may be medically examined by Sexual Assault Nurse Examiners (SANE) of Honor Healthcare. These health care professionals are highly trained in conducting forensic examinations and evidence collection. Medical examinations of children are conducted upon the request of the investigating detectives or DCS and OCWI investigators. The examinations are typically conducted shortly after the forensic interview of the child is completed.

Children's Disclosures of Maltreatment

Researchers have studied children who presented for assessment, investigation, or treatment of maltreatment, especially CSA. These studies examined children's disclosures to mental health professionals (Elliott & Briere, 1994; Sorenson & Snow, 1991), medical professionals (Lawson & Chaffin, 1992), law enforcement or CPS investigators (Bradley & Wood, 1996; Faller & Henry, 2000; Hershkowitz, Horowitz, & Lamb, 2007), or child abuse assessment teams (Carnes, Nelson-Gardell, Wilson, & Orgassa, 2001; Keary & Fitzpatrick, 1994). Meta-analysis of the results of many studies in this body of research indicated that it was common for children to delay months or years before they disclose maltreatment, especially of CSA (London et al., 2005).

Researchers have identified several factors associated with delays in disclosure of child maltreatment. The relationship between the victim and the offender was significant. Children who were abused by immediate family members were more likely to delay longer than those molested by extended family, acquaintances, or strangers (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003). Hershkowitz, Horowitz, and Lamb (2007) evaluated a sample of 26,325 children, ages 3-14, interviewed during investigations of maltreatment in Israel over a 12-year period. Results indicated that children were less likely to disclose allegations against parents or parent figures than other victim/offender relationships, especially when the allegations involved sexual abuse.

Children disclosed maltreatment, especially CSA, in a variety of ways. Disclosure has been described as a process by some researchers (Sorenson & Snow, 1991). For example, children have denied sexual abuse when questioned by medical professionals, even when definitive medical evidence was present (Lawson & Chaffin, 1992; Lyon, 2007). Some children made tentative or vague

disclosures initially, but discussed the abuse in more detail over time and when provided with social support (Alaggia, 2004; DeVoe & Faller, 1999; Gordon & Jaudes, 1996). Other researchers have described disclosure as an event, and that most children made a clear disclosure initially and remained consistent in their accounts over time (Bradley & Wood, 1996). However, these authors conducted chart reviews of closed DCS cases, which may not have reported children's disclosures of additional acts of abuse to parents, counselors, or other confidants.

Children's disclosures occur in three ways—accidental, prompted, and purposeful (Alaggia, 2004). Accidental disclosures occurred when the victim had no intention to disclose, but the abuse is discovered through medical diagnosis, witness observation, or offender confession. Prompted disclosures occurred when children disclosed after they received abuse prevention education, counseling, watched a television program concerning abuse, or when questioned directly. A purposeful disclosure was defined as a verbal statement to a trusted individual initiated by the victim. Children disclose in a purposeful manner in an attempt to end the abuse or seek emotional support in dealing with the abuse.

Children typically disclosed abuse to individuals whom they believed would protect and support them (Goodman-Brown, et al., 2003). Children's choices as to whom they disclosed varied with age and gender (Dutton, 2011; Faller & Henry, 2000). Younger children were more likely to disclose to primary caretakers, especially mothers. Older children, particularly adolescents, were more likely to disclose to friends or intimate partners (Faller & Henry, 2000; Fontanella, Harrington, & Zuravin, 2000).

Recantation

Children have been known to recant allegations of abuse. Researchers have studied the characteristics of cases in which children retract valid allegations of sexual abuse. There are several factors that have been associated with recantation. The most common reason reported is lack of maternal support. Children whose mothers did not believe the allegation or chose to support the alleged offender rather than their children were shown to have an increased risk of recantation (Bradley & Wood, 1996; Elliott & Briere, 1994; Malloy, Lyon, & Quas, 2007). Pressure from other family members or the offender to recant has also been shown to increase the risk of children retracting an allegation. Other factors such as involvement of law enforcement, child protection services, and facing judicial proceedings have been shown to be influential in recantation (Elliott & Briere, 1994).

Results of various studies revealed a variable recantation rates, ranging from 4% (Bradley & Wood, 1996) to 23% of cases (Malloy, et al, 2007). This variability in recantation frequency was due to the different research methodologies employed by researchers. For example, Bradley & Wood (1996)

reviewed closed case files of child protection investigations, revealing a 4% recantation rate. Malloy et al, (2007) studied children who were removed from their parents' custody in juvenile dependency cases, indicating a 23% recantation rate. The higher rate of recantation found in this study was due to the fact that the children included in the study were involved in juvenile dependencies, reflecting a lack of familial support.

Some researchers have expressed concern that children recant because the allegations were false or erroneous (London et al, 2005). It may be difficult for fact finders to evaluate whether the child is recanting a true allegation of abuse or retracting a false allegation. Horowitz et al (1996) suggested that several factors must be taken into consideration when evaluating the veracity of a child's retraction. Evaluators must consider whether or not the child has been pressured to recant by caretakers or family members. The degree to which the child's life has been disrupted as a result of the disclosure of the allegation must be taken into account. The amount and richness of detail children provided in both the original allegation and the reason offered for the retraction must also be analyzed.

Children's Memory and Suggestibility

Researchers have studied children's abilities to recall and relate past events. Children as young as 3 years of age are capable of providing accurate detailed accounts of events they experienced many times, as well as distinctive one-time events (Fivush, 1998). Children between the ages of 4- and 6-years old were able to recall details of family vacations that took place as long as 18 months in the past (Hammond & Fivush, 1990). Fivush & Schwarzmueller (1998) demonstrated that 8-year-old children were able to accurately recall events that occurred between 2 and 5 years in the past. Fivush (1993) found that older children provided more information in response to narrative invitations than younger children did. However, younger children provided as much information when asked specific questions by the interviewer.

Researchers have also examined the effects of stress and trauma on children's recall. Goodman, Hirschman, Hepps, & Rudy (1991) and Merritt, Ornstein, & Spiker (1994) studied children who underwent painful medical procedures involving urinary catheterization. These studies indicated that children have accurate recall of the procedures, and that accuracy improves with age and discussion with parents. Ornstein (1995) found that children recalled more detail about painful medical procedures than did another group of children who recalled a routine visit to the doctor. Peterson and Bell (1996) found that children who received treatment for traumatic injuries were able to give clear detailed accounts of the event that led to their emergency room visits, even after a period of two years (Peterson, 1999).

Memory researchers have also focused on the accuracy of children's memories for past events, and the degree to which their recollections or accounts can be altered by suggested information. Several studies have illustrated the strength of children's recall for events, in spite of the use of suggestive or leading questions (Goodman, Sharma, Thomas, & Considine, 1995: Rudy & Goodman, 1991). Laboratory studies have also indicated that given the right conditions (multiple suggestive interviews about non-events), inaccurate reports or false memories are relatively easy to create in young children, especially children under the age of 5 (Ceci, Crotteau-Huffman, Smith, & Loftus, 1994; Ceci, Loftus, Leichtman, & Bruck, 1994; Leichtman & Ceci, 1995).

Rudy and Goodman (1991) studied 4- and 7-year old children's recall of their interaction with an unfamiliar male. Pairs of children were sent into a trailer and interacted with a male research assistant who was dressed as a clown. The children were interviewed, and were asked specific and misleading questions about their interactions. Some of these questions falsely suggested abuse, such as, "He took your clothes off, didn't he?" Both age groups of children were highly resistant to suggestions of abuse. However, they were more likely to make errors in response to suggestive questions unrelated to abuse.

Goodman and her colleagues (1995) studied the effect of interviewer status and preconceived bias on the accuracy of recall by 4-year-old children about a staged event. In this laboratory study, 40 children engaged in play activities with an unfamiliar female adult. The children were randomly assigned to 1 of 4 interview conditions. The children were interviewed about the activities by either their mothers or by an unfamiliar female interviewer. The mothers and the unfamiliar interviewer conducted the interviews in 1 of 2 conditions—either uninformed, or they were given misleading or biased information by the researcher about what occurred during the play activities. Children provided less accurate information when questioned by misinformed strangers. Children were found to be more accurate, resistant to misleading suggestive questions about abuse-related topics when asked by their mothers. Overall, children's free-recall accuracy was diminished by biased interviewers. Children provided less information, or made more errors with regard to the order of events when questioned by misinformed interviewers.

In 1994, Stephen Ceci and his colleagues published germinal studies in which they demonstrated how repeated suggestive interviews compromised the accuracy of preschool-aged children when questioned about fictitious events (Ceci, Crotteau-Huffman et al, 1994; Ceci, Loftus, et al, 1994). These studies have come to be known as the "Mousetrap Studies," both in the research community and popular media. In the first study (Ceci & Crotteau-Huffman, et al., 1994), the researchers asked children's parents about events that had actually occurred in their children's lives. The researchers then instructed the children that they were going to read a list of events that may have happened to them, based on

conversations that the interviewer had with their parents. The interviewer warned that not all of the events really happened. Two fictitious events were included on the list, including descriptions of a hot-air balloon ride and the child getting his or her finger caught in a mousetrap and having to go to the hospital for treatment. During the first session, children were told to think about the fictitious events, and were asked if they could remember them. Over a 10-week period, the children were interviewed 7-10 times with a several day interval in between interviews. Results indicated that by the final interview, 34% of the children assented to the fictitious events and some provided elaborate narrative accounts of the false events. Ceci & Loftus et al. (1994), repeated this experiment with some key differences. The children were told that the fictitious events had actually occurred, and the time span of the study was increased to 12 weeks, with children undergoing 7-10 interviews. Results indicated that false assents increased from an initial 34% to 45% among the 3- and 4-year old participants subjects and from 25% to 40% for the 5-and 6-year old participants over the course of the study.

Forensic Interview Protocols

In short, young children have been demonstrated to be resistant to suggestion when questioned about abusive acts in laboratory settings. However, researchers have also demonstrated that children can adopt suggested information when questioned multiple times using suggestive techniques. As a result of this body of knowledge on children's memory and suggestibility, several interview protocols have been designed in an effort to enhance the accuracy of children's statements. These protocols include the Cognitive Interview (Fisher and McCauley, 1995), the Step-wise Interview (Yuille, Hunter, Joffe, & Zaparniuk, 1993), and the National Institute of Child Health and Human Development (NICHD) Protocol (Lamb, Sternberg, & Esplin, 1998). There are many similarities among these protocols. For example, all of them stress the importance of obtaining as much information as possible through requests for narrative and use of open-ended questions, and restricting the use of leading and suggestive questions. Use of coercive techniques is strongly discouraged.

The NICHD Protocol has been the most thoroughly researched protocol and has received the most empirical support. It is the only protocol that has been evaluated in actual abuse investigations (Orbach, Hershkowitz, Lamb, Sternberg, Esplin, & Horowitz, 2000; Pipe, Lamb, Orbach, & Esplin, 2004). The NICHD Protocol has been field-tested in Salt Lake City, Utah, and in Israel. In these studies, investigators were trained in the use of the NICHD Protocol and provided with scripts to follow during interviews with alleged child victims. Transcripts and video recordings of these interviews were compared to interviews the investigators conducted prior to their training. The interviews were matched for children's age, developmental level, and abuse characteristics. Researchers reported that use of this protocol can significantly increase the amount of information and forensically relevant details provided by children in their initial narratives. A modified form of

the NICHD Protocol, also known as the Semi-structured Cognitive Interview, has been endorsed as the preferred method for interviewing children in Maricopa County (Maricopa County Multidisciplinary Protocol on the Investigation of Child Abuse, 2008).

Semi-structured Cognitive Interview/Modified NICHD Protocol

The following is a brief discussion of the sequence and elements of this protocol:

- Rapport building and narrative practice: The interviewer asks the child open-ended questions about neutral topics, encouraging the child to provide narrative information. For example, the interviewer may ask the child to describe what she did on her last birthday and ask her to elaborate on various details.

- Interviewer expectations: The interviewer instructs the child to inform the interviewer if she does not understand or know an answer to a question and encourages the child to correct the interviewer. In addition, children are asked to promise to tell the truth during the interview. These instructions may be modified with pre-school aged children.

- Narrative invitation: The interviewer asks a broad open-ended invitation such as, "Tell me why you are here to talk to me today," or "I heard something happened to you, tell me everything about that." The interviewer encourages the child to provide as much information in a free-recall narrative way, without interruption. The interviewer should encourage the child to elaborate by using open-ended prompts such as, "Tell me more," or "What happened next?"

- Cued recall prompts: These prompts are used if the child is not responsive to narrative invitations. The interviewer may cue a child's attention on a case fact and ask her to provide more information. For example, "I heard someone is worried about you, tell me about that," or "I heard law enforcement came to your school today, tell me about that." Cued recall prompts are also the preferred technique to encourage children to provide more information about details they have already discussed. For example, "You said Uncle Jim touched you; tell me everything about Uncle Jim touching you."

- Focused questions: When cued recall prompts are exhausted, the interviewer may ask focused questions to gather details the child did not provide in her narrative account. Focused questions generally inquire about specific details, but do not suggest information. These questions start with

words beginning in "wh." For example, "Where did this happen?" or "Who was in the room with you?"

- Option-posing questions: These questions tend to limit a child's responses and may require the interviewer to introduce information. Therefore, option-posing questions should be used as little as possible, or at the end of the child's account of an event. They may also be used at the end of the interview to explore relevant topics the child has not mentioned. Option-posing questions include yes/no, multiple, or forced choice questions, and should be phrased in the least suggestive form possible. If a child responds affirmatively or chooses one of the options posed by the question, the interviewer should ask for more details using an open-ended prompt.

- Neutral closure: At the end of the interview, the interviewer allows the child to ask questions or return to neutral topics. The interviewer may ask the child about what she plans to do after the interview.

Forensic Interviews in Family Court

Family Court judges and investigators are often left in the difficult position of deciding whether children should be re-interviewed in cases law enforcement investigators and child protection workers have pended or closed due to the lack of sufficient substantiating evidence that abuse occurred. One of the factors that may contribute to the case closure was the child not disclosing or providing little information in the investigative interview. Review of the video recordings of the forensic interviews conducted by law enforcement, DCS workers, or DFIs may provide helpful information to the Family Court as to whether additional interviews should be conducted with the child.

Many children may not disclose abuse during forensic interviews out of reluctance or fear. Children may be reluctant due to shame, embarrassment, or lack of rapport or comfort with the interviewer or the interview environment. Reluctant children are often not forthcoming with information during the initial rapport-building phase of the interview. This reticence can be even more pronounced during the substantive phase of the interview (Hershkowitz, Orbach, Sternberg, Pipe, Lamb, & Horowitz, 2007). Family Court judges and investigators may want to consider additional forensic interviews in cases where children were demonstratively reluctant, anxious, or uncooperative during the law enforcement/ DCS investigative interviews.

Children's abilities to provide forensically relevant details during investigative interviews can also be affected by poor interview technique. For example, an interviewer who lacks skill, or who relies heavily on option-posing questions can impede a child's ability to provide as much detail as she can, or worse, encourage her to adopt suggested information. When reviewing prior

interviews, Family Court evaluators should consider whether the interviewer appeared to have a bias, used primarily option-posing questions, or failed to ask appropriate follow-up questions. Consultation or thorough assessment of the interviews by a DFI or other interview expert may be advisable in such cases.

Child abuse allegations that arise during the course of divorce or custody disputes present a challenge to Family Court. Too often these cases are dismissed as erroneous or false, in spite of empirical evidence that the substantiation rate of abuse is higher than in these cases (Thoennes & Tjaden, 1990). Family Court judges and evaluators are often obligated to evaluate the quality and thoroughness of the investigation conducted by law enforcement and DCS workers. Child abuse allegations involving family members should be investigated by both law enforcement child protection investigators. Investigative interviews and medical evaluations can yield valuable information and should be conducted by skilled and highly trained professionals. Complex issues such as children's disclosures, recantation, and suggestibility should be carefully considered.

What Should Parents Do When Their Child Discloses Abuse?

As a parent, it is often difficult to know what to do when a child discloses sexual or physical abuse, especially if a loved one is accused. However, it is important for parents to react as calmly as possible. Responsible parents should attempt to gather necessary information from children, and avoid pressuring children to provide answers. The best way to do so is to encourage the child to provide more information with the following invitations:

Tell me what happened.
Tell me everything that happened.
Tell me more . . .

If the child is reluctant or fearful to disclose more information, parents can provide support and encouragement by telling their child that he or she is not in trouble. If the child does not provide the following information spontaneously, parents may ask the following questions:

What happened?
Who did this?
Where did this happen?
When was the last time?

Parents are encouraged not to ask additional questions, but instead reinforce that the child did the right thing in telling, and he or she may need to talk with someone else about what happened also.

As mandated reporters, parents are required to contact law enforcement in the jurisdiction where the child said the abuse occurred and contact DCS if the abuser resides in the same home as the child. If a report has already been made, parents should contact the case investigators to provide them with any additional information the child disclosed.

National Children's Advocacy Center (NCAC) Forensic Interview

Many children, especially preschoolers, referred for a law enforcement interview when sexual abuse is suspected, need more than one interview to determine the validity of the allegation, inform the investigation, and support case decisions. The NCAC forensic interview model was designed to interview this subset of children who cannot discuss the allegation in one interview.[6] The NCAC Child Forensic Interview Structure is a flexible interview structure that can be adapted to children of different ages and cultural backgrounds, and is appropriate for interviewing children who may have experienced sexual or physical abuse or who may be a witness to violence against another person. The NCAC forensic interview model emphasizes a flexible-thinking and decision-making approach throughout the interview, as opposed to a scripted format. The NCAC Extended Forensic Interview model follows closely the NICHD interview protocol and incorporates updates and changes from their ongoing research, but does not advocate a "scripted" interview approach (Hershkowitz, Lamb, Katz & Malloy, 2013) as the needs of individual children are varied. Each component of the model is research-based and is reviewed annually for appropriate additions or adaptations by a panel of practicing experts. The NCAC Extended Forensic Interview model encourages interviewers to use the most open-ended questions possible and to seek narrative descriptions of remembered events. This model recommends an emphasis on questions that access the child's free-recall memory. Multiple-choice, yes/no, or questions that introduce information not previously mentioned by the child should be followed by an invitation for the child to further describe or elaborate on their response. Forensic interviewers should refrain from using option-posing questions as long as possible (Lamb et al., Saywitz & Camparo, 2009; Saywitz, Lyon & Goodman, 2011). On the other hand 'wh' questions can be a viable option for focusing the youngest children while still eliciting information in their own words (Hershkowitz et. al., 2012).

Following a two-year pilot study at the NCAC (Carnes, Wilson & Nelson-Gardell, 1999), a field study using 22 professionals working at sites in 12 states across all regions of the United States applied the piloted model and collected data on the model's efficiency for 2 years (Carnes, Nelson-Gardell, Wilson & Orgassa, 2011). The pilot study found 47% of the children referred for forensic evaluation made credible disclosures and the court rendered a finding in 71% of the cases.

[6] The Extended Forensic Interview model was formerly called the Extended Forensic Evaluation model.

A multi-site study was conducted. The follow-up study replicated the initial findings—in 44.5% of the cases, children made a credible disclosure and 73% of those disclosures resulted in a court finding.

Many interview protocols strictly limit or prohibit the use of any media in the forensic interview, citing concerns that children will be distracted or encouraged to engage in fantasy. NCAC allows and even encourages the inclusion of media throughout the forensic interview, but does not require that media is used in a particular way. Free drawing has received recent attention in the literature. Concerns that the allowance of drawing while talking led to a child being distracted or engaging in fantasy was not supported by research (Poole & Dickinson, 2013). Several recent studies demonstrated that drawing a remembered event correlated with more detailed description (Katz & Hershkowitz, 2010; Katz & Hamama, 2013; Macleod, Gross & Hayne, 2013; Patterson & Hayne, 2011). Recent literature on use of Human Figure Drawings (HFD) as a method of transitioning to allegation discussion (Aldridge et. al., 2004; Poole & Bruck, 2012; Poole & Dickinson, 2011) provides mixed results and may raise concerns; however, the extant literature does not provide a definitive direction for use or elimination of use of drawing in this process. NCAC does not take a position on the use of HFD other than to advise "use with caution."

Role of Children's Representatives

Arizona Rule of Family Law Procedure (ARFLP) 10 provides for the appointment of a representative for the child if the Family Court believes it is necessary based upon the facts of the case. The reasons enumerated by the rule include if "there is an allegation of abuse or neglect of a child (ARFLP Rule 10(2)(a))." Thus, if there is an allegation of sexual abuse in a family law case, it is appropriate, and arguably should be necessary, to appoint a representative for the child. Three different types of representatives could be appointed:

(1) Best Interests Attorney (BIA);
(2) Child's Attorney; and
(3) Court-Appointed Advisor (CAA).

The three roles differ in many ways. The BIA must be an attorney who assumes a duty of confidentiality to the child client. The BIA's role is to provide a position to the Family Court about what the lawyer feels is best for the client. The BIA may not, however, make recommendations to the court; instead the BIA has the same job as any attorney. The BIA may make argument and present facts supporting his or her position regarding what may be in the best interest of the child. The BIA should speak with collateral sources and read collateral documents in order to help formulate a position.

The child's attorney acts in the same way any attorney acts for any client. This does not mean, however, the child's attorney walks in, asks the child what he wants, and walks out. The role of the child's attorney is just as much to be a counselor at law and help the child client with all legal issues related to the case. Although the child's attorney cannot take a position that differs from that of the child client, the child's attorney can help the child client understand the legal implications of positions, the likely outcome of the case, and the potential criminal issues the offender may face in the future.

There is no requirement that the CAA be an attorney, but oftentimes the CAA is an attorney or a social worker. This role is vastly different than the other two types of representatives and arguably is not actually a child's representative. Instead, the role is more akin to that of an investigator who provides considerations for the Family Court's determination of legal decision-making and parenting time. The CAA's role is to investigate the family situation by interviewing the parties, child(ren), if appropriate, and collaterals, and make a recommendation to the court, either in the form of a report or testimony, or both. This person does not owe a duty of confidentiality to anyone and does not owe any duties to anyone in the case except professional duties to the Family Court.

The Family Court may utilize any of these three representatives to help the child navigate this process. Practically, one of the attorney representatives is in the best position to help the child as opposed to the court. While certainly it would be appropriate for the child to be in therapy, an attorney may help the child understand how the legal process is going to affect his or her life going forward. The attorney representatives also can be the only person in the case only for the child. A therapist can be subpoenaed to testify about what the child and the therapist discussed. An attorney representative may not.

General practice is to appoint a BIA for younger children and as children get older and more mature, the next phase is to appoint a child's attorney. While this recognizes the maturity of the child, it does not always recognize that children may have reasons for wanting certain things to happen in their lives that we, as outsiders, may not understand. Thus, a child's attorney with appropriate training in speaking with children, counseling children, and really understanding children can be incredibly effective, even for very young children. In addition, it helps the child, particularly in a case involving sexual abuse allegations, who has lost much control in his or her life, gain back some of that control. This is especially true if the court is not concerned about whether it will get all the evidence from the parties. If that is a concern, then a CAA (or evaluator) in addition to a child's attorney may be useful. A BIA may also be utilized, but that limits the child's voice in a situation in which the child has already been silenced significantly.

When there are older children for whom the appointment of a BIA may not, at first glance, appear appropriate, may want the appointment of a BIA, particularly when there are allegations of sexual abuse. As noted above, the BIA owes the child a duty of confidentiality, and therefore, the BIA can act as a buffer between the child and the alleged offender. In essence, the BIA can take the heat even if the BIA is doing exactly what the child client is requesting. This is one way to get the appropriate information, get the child client's point of view, and still protect the child client from having to confront the parent in the family law matter (though the child may have to testify in criminal court at a later date).

Therefore, the Family Court has several options regarding a child's representative when there are allegations of sexual abuse. The most important issues to determine are the age of the child, other resources available in the case, and the need for the child to have someone there only to help him or her navigate the legal issues that will arise for that child. In many ways, that can be the most important job the child's representative can fill in these cases. There are other avenues for all the other roles the child's representatives fill, but being there for the child is the only one only the attorney representatives can fill.

In a Juvenile Court case, there are two options for a child's representative. Arizona Rules of Procedure for the Juvenile Court Rule 40.1 provides for the appointment of either a guardian *ad litem* (GAL) or appointed counsel. Rule 40 also provides for the appointment of a GAL. Neither the Juvenile Courts nor the statutes make clear what the difference is between the two GAL roles.

County policy generally dictates which type of representative is appointed initially, but the Juvenile Court may always appoint a Rule 40 GAL to act solely in the minor's best interest. If a GAL is appointed, the GAL has a duty to investigate and remain in touch with everyone involved in the case, but the GAL owes no duty of confidentiality to the minor child. This can be a problem in a dependency case because if there is no attorney for the child then no one in the case owes the child that duty, and often, children are more open with individuals they know cannot tell anyone what they say. That does not mean the child will never allow the information to be shared; in fact, sometimes with enough time and explanation by an attorney, children agree to share the information, but that conversation can happen for the child without any fear of it being shared until the child feels it is safe to do so. This can be very important in a sexual abuse case where everyone is trying to determine the truth, and the child is being torn in several directions at once. Everyone in a dependency case has an agenda (legally speaking) except the attorney for the child. That person's only agenda is the child, and for a child lost in the dependency system, that person can be a huge advantage and safe haven.

Therefore, even if the child already has a GAL in a sexual abuse case, it can be very beneficial to also have an attorney for the child. Likewise, a GAL can be useful to the Juvenile Court in that the GAL has the ability to be an outside voice not limited by the policies imposed by the DCS. Although DCS investigates sexual abuse allegations, sometimes it can be helpful to the Juvenile Court to have two sets of eyes on the issue.

Finally, the Juvenile Court may also request a Court-Appointed Special Advocate (CASA) in a dependency case. Although the CASA is not an attorney, and does not represent the child, the CASA tends to have more time to do investigations, gain rapport with the child, and get to know everyone involved in the case. A qualified and competent CASA on a sexual abuse case can be very helpful in getting all the information before the Juvenile Court and ensuring the child is not lost in the system. CASAs can attend therapeutic team meetings, school meetings, coordinate between DCS and the family, *etc*. Therefore, a CASA, when asked to help in specific ways, can be a huge benefit to the Juvenile Court and everyone involved.

Emergency/Temporary Orders in Family Court

There may be a variety of reasons a parent will file for temporary orders based on behaviors they may be observing at home, including the following:

- Child acting out sexually at home and/or in school;
- Child has precocious sexual knowledge;
- Medical findings with no disclosure from child;
- Concerns about appearance of child's genitalia or of child engaging in excessive scratching/itching/rubbing/touching genitalia;
- Family member, community member who interacts with child, family friend, blended-family member (step-child or significant other's child) is alleged to have committed, or was formerly convicted of, a sex crime; and/or
- Child makes full or partial statement alleging abuse.

If a parent/guardian wishes to bring these issues to the attention of the Family Court, the parent/guardian may do so in the following ways:

(1) Petition for Order of Protection[7] (goes to commissioner) (*see* Orders of Protection FAQs at Appendix C);
(2) Emergency Motion (pre- or post-decree) for Legal Decision Making and Parenting Time without notice (Rule 48, ARFLP); and
(3) Emergency Motion (pre- or post-decree) for Legal Decision Making and Parenting Time with notice (Rule 47, ARFLP).

The Judge must use specific guidelines when determining whether to grant or deny a temporary order request, without notice, such as:

- It clearly appears from specific facts shown by affidavit or by the verified motion that irreparable injury will result to the moving party or a minor child of the party, or that irreparable injury, loss, or damage will result to the separate or community property of the party if no order is issued before the other party can be heard in opposition. *See* ARFLP, Rule 48.

In order to meet the criteria outlined in Rule 48, a judge may consider asking the following questions:

(1) Is there an identifiable "suspect"?

[7] Not to be used in place of legal decision-making and parenting time orders.

(2) Is the suspect in the home or does he/she have contact with the child? If so, the Family Court should consider imposing appropriate restrictions.
(3) Can the protective parent protect the child?
(4) Are medical findings congruent with the likelihood of sexual abuse?
(5) Is there a DCS/law enforcement investigation? (Note: Generally, the Family Court will not have information from an investigating agency at the time of the temporary orders hearing).
(6) Is this developmentally-normal childhood sexual behavior? (*See* Sexual Behavior Continuum of Normal to Abnormal at page 73)

If Emergency Request is Granted

If the relief requested in an Emergency Motion is granted, the Family Court must hold a hearing within 10 days, with or without evidence, and may consider the following:

(1) Determine whether the allegations have been reported to law enforcement/DCS. If not, the court should report;
(2) Whether the requesting parent should be granted temporary sole legal decision making;
(3) Whether to suspend or otherwise restrict access to the child;
(4) Whether to order DCS to appear at the hearing; and
(5) Ordering the parent/guardian to not discuss the allegations with the child.

If Emergency Request is Denied

If the Family Court denies the relief requested in a pre-decree Emergency Motion brought pursuant to ARFLP 47, *i.e.*, without notice, the court may treat the Emergency Motion as if it was brought WITH notice and hold hearing within 30 days. However, if the Emergency Motion without notice is brought in a post-decree matter, there is no time limit within which the court must set a hearing.

First Court Appearance

The first time **both** parties appear in front of the Family Court on the allegations, whether the appearance be the return hearing, which can be evidentiary or non-evidentiary, and within 10 days or 30 days, the Family Court should consider the following:

1. Is the child safe?

2. If there is an ongoing criminal investigation, the court--
   a. Should not order a forensic interview of the child. If there is no ongoing investigation, the court should consider ordering a forensic interview of the child (*see* Child Forensic Interviews at page 12).
   b. Should order the parties to refrain from talking to the child about the investigation or alleged incidents.
   c. Should determine whether or not the investigation is complete. The court cannot disseminate DCS records if the investigation is ongoing or if there is an ongoing criminal investigation.
   d. Should consider ordering the DCS investigator to testify at a later evidentiary hearing or consider ordering the police detective to testify. However, the court should be prepared for the investigator/ detective not to provide detailed information if the investigation is ongoing. The court must clear the courtroom of all individuals except parties when the DCS investigator testifies. The court must also seal that portion of the record.
   e. Cannot control DCS/police investigations.

3. If there is no ongoing investigation--
   a. The court needs to determine if law enforcement or DCS has been notified and if not, the court needs to report the allegation.
   b. The court needs to determine the status of the investigation.
   c. If the investigation is "pending" or "closed" or the allegations did not rise to the level warranting investigation, the court should consider appointing a CAA or other BHP. The CAA or BHP investigates the status of the criminal or DCS investigations. The CAA may also investigate the safety of the child, whether the family is meeting the child's needs, and whether parties are complying with court orders. The court may consider appointing a Therapeutic Interventionist (TI), BHP, or Evaluator to assist the court. The CAA should not interview the child regarding the allegations (*see* Child Forensic Interviews at page 12).

d. If the child is in counseling, determine if the counselor is licensed and forensically-informed (*see* AFCC Guidelines for Court-Involved Therapy at pages 64-68). If child is not in therapy or is in therapy with non-licensed or non-forensically-informed therapist, consider appointing a new/additional provider.

Temporary Pre- or Post-Decree Evidentiary Hearing

If the suspected party requests the hearing, the Family Court should consider whether the parent affected by the orders (Mother's boyfriend, Father's girlfriend, *etc*.) wants a hearing. If the Family Court granted the temporary orders request filed by one parent without notice to the other parent, the other parent may choose to waive an evidentiary hearing.

a. If the parent affected by the modified orders requests the hearing, the court should consider the following:

- If the alleged offender is going to testify, he or she might incriminate himself or herself. If the alleged offender refuses to testify or invokes his or her 5th Amendment right to remain silent, the court may consider the invocation as a negative inference (*see Montoya v. Gardner*, 173 Ariz. 129 (1992)).
- The court must leave it up to the parties to present their case. After the parties have presented their cases, the court may keep its current orders in place, modify them, or consider putting into place any other interventions noted above (BHP, TI, CAA, *etc*.).
- The court should consider holding a status conference in 30, 60 or 90 days to determine the status of interventions from court-ordered BHPs and to determine the status of the investigation.

b. The court will determine when to set a Final Orders hearing. Final Orders may be entered when the criminal investigation is completed and no charges were filed, the criminal investigation is completed and charges were filed, or the criminal investigation is still "pending" and may take a long time to reach completion.

1. If criminal charges were filed, the court may consider the following:
   - The "accused" may be in custody and non-bondable. In this case, the court should impose appropriate restrictions, such as, prohibiting the child from communicating, telephonically or in person, with the

alleged offender. Parents are ordered to not talk to the child about the case or discuss the case within earshot of the child or permit others to do so;
- Ordering the child to have therapy with a forensically-informed BHP.

2. If criminal charges have not been filed, the court should be aware of the lower burden of proof required by Family Court rules (a preponderance of the evidence). The court needs to take evidence to consider if the burden is sufficiently met to restrict a parent's contact with alleged victim and or involvement of behavioral health professionals.
   - If the Family Court finds the proof has met this burden, the court should enter protective orders and interventions of BHPs appropriate to the needs of the family.
   - If the Family Court finds the allegations have not been proven/sufficiently met the burden, then the Family Court should consider the following:
     i. Child probably has not seen the alleged offender for a considerable length of time and reunification therapy may be appropriate.
     ii. Supervised visitation until the court has ordered a TI and has received a written reunification plan from TI.
     iii. Sanctions if the protective parent made an intentionally fabricated/false child maltreatment allegation.

Legal Issues in Child Sexual Abuse

A. History of Child Protection in the United States[8]

In 1875, the New York Society for the Prevention of Cruelty to Children (NYSPCC) was established with the purpose of protecting children. With the establishment of the NYSPCC, the profession of social work and child welfare also began to grow, leading to the many states' governments being involved in child safety; by 1967, almost all states had a Child Protective Services (CPS) agency, or an agency with a similar role. The 1960s brought the biggest boom in interest to the child abuse arena, mainly due to medical professionals finally becoming trained and involved in the area. Once the media begin publicizing incidents of child abuse, Congress also caught on, and amended the Social Security Act in 1962 to emphasize CPS' role in child welfare. With the amendments, reporting laws were also instituted in the late 1960s, which shed new light on the climbing scale of child abuse cases from the 1970s (60,000) to the 1990s (2 million). In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was passed, which finally included a definition of sexual abuse as a form of maltreatment. With nationwide reporting laws being passed and new, groundbreaking research being released, sexual abuse was finally recognized as a serious and common occurrence that needed to be addressed. However, the same reporting laws that were meant to further combat child sexual abuse (CSA) ironically made things worse by flooding the system so much that by the 1980s, the child protection system was extremely backlogged and tremendously overwhelmed.

B. The Effect of Confidentiality and Privilege on Court Testimony

1. Confidentiality

a. Health Insurance Portability and Accountability Act ("HIPAA")

HIPAA can certainly complicate the testimony of witnesses in court. Patients can, of course, consent to a release of their health records and a judge can, of course, order information be released. This is most often the case in Family Court, as since at least 1977, mental health has been deemed automatically relevant when a parent contests custody. *See In re Marriage of Gove*, 117 Ariz. 324, 572 P. 2d 458 (App. 1977); *see also* A.R.S. § 25-403(A)(5). Accordingly, a parent would be hard-pressed to fight a request for the release of his or her mental health records for any reason. Regarding a child's protected health information, however, HIPAA states that "a health care provider may not disclose or provide access to protected health information about an unemancipated minor to a parent

[8] The historical information of child protection laws in America is summarized from John E. B. Myers, *The APSAC Handbook on Child Maltreatment* 3-14 (3rd ed. 2011).are we footnoting?

if doing so is "prohibited by an applicable provision of State or other law, including applicable case law." HIPAA of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996), at § 164.502(g)(3)(ii)(B). Accordingly, a provider would not be able to testify or disclose to a child's parent information related to the child's health, therapy, etc., even with a court order, if doing so would be prohibited by law. In any case, where a person, whether a parent or child, discloses sexual abuse, mandatory reporting laws come into play where the provider must report the suspected abuse to the authorities. This duty to report applies to several professions, including social workers, healthcare professionals such as doctors and nurses, mental health professionals such as psychologists and counselors, teachers, police officers, and child care professionals. *Myers*, supra, 361. Further, the duty to report trumps confidentiality. *Id.*

b. Safe Harbor / Safe Haven Therapy Laws

Arizona's law prohibiting disclosure to a parent if such disclosure would not be in the child's best interests is routinely called Arizona's "safe harbor" or "safe haven" law, found at A.R.S. § 12-2293(B)(1). Arizona's safe harbor / safe haven law provides an exception to the release of medical records, which include mental health records, if the health care professional determines that "[a]ccess by the patient's health care decision maker is reasonably likely to cause substantial harm to the patient or another person." Additionally, Arizona's relocation statute, A.R.S. § 25-408, also makes reference to safe harbor / safe haven therapy in that it states "[p]ursuant to section 25-403.06, each parent is entitled to have access to . . . documents . . . about the child unless the court finds that access would endanger seriously the child's or a parent's physical, mental, moral or emotional health. *See* A.R.S. § 25-408(J). As such, a safe harbor / safe haven therapy law prohibits the disclosure of a child's mental health records to a child's parent if disclosure would not be in the child's best interests. For example, in cases of CSA, if a child participates in therapy, and discloses sexual abuse at the hands of either parent, it would obviously not be in the child's best interests for that parent to receive access to the therapy records and a provider may rightfully refuse to disclose such records. These laws have also been used to shield mental health professionals from becoming embroiled in custody litigation where testimony would be required revealing confidential information learned through the child's therapy. While these laws serve a vital role in protection of the mental health professional-patient privilege and protect children from their sexual abuser parents, some would argue that they are unconstitutional in that a parent has a fundamental right to parent and not allowing a parent to review, or even talk to, their child's therapist violates that fundamental right.

In *Charepoo v. Dahnad*, 2014 WL 1851884 (Ariz. App. 2014), the trial court denied the father's motion to compel disclosure of his children's therapy records requested "so he could ascertain whether Mother's request to relocate was made in good faith." *Id.* at ¶ 10-11. The mother "argued that releasing the children's

records would be against their privacy interests and that she could not afford to pay for the therapist to testify at the upcoming hearing." *Id.* at ¶ 11. The therapist also "comment[ed] that she did not believe it was in the children's best interests to have their records released." *Id.* The Court of Appeals held that "[a]lthough A.R.S. § 25–408(J) creates a presumption of parent entitlement to children's records," a court may preclude disclosure if it finds that such disclosure would "endanger seriously the child's or a parent's physical, mental, moral or emotional health." *Id.* ¶ 13. This language appears in A.R.S. § 12-2293(B)(1).

2. Privilege

Jaffee v. Redmond is a landmark case holding that "a privilege protecting confidential communications between a psychotherapist and her patient promotes sufficiently important interests to outweigh the need for probative evidence," and thereby recognizing the psychotherapist-patient privilege under Rule 501, Federal Rules of Evidence. 518 U.S. 1, 9-10 (1996). The Supreme Court reasoned that "[e]ffective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears." *Id*. at 10. Criminal investigations may also cause a party in a custody proceeding to invoke his or her Fifth Amendment privilege against self-incrimination where sexual abuse allegations have been made. The Arizona statutes pertaining to mental/behavioral health privileges are A.R.S. § 32-2085—the psychologist-client privilege statute—stating in part that the privilege is placed on the same basis as the attorney-client privilege and that "a psychologist shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the psychologist's practice" unless the client or patient waives the privilege in writing or in court testimony, and A.R.S. § 32-3283—the behavioral health professional-client privilege statute—stating in part that the privilege is placed on the same basis as the attorney-client privilege and that a behavioral health professional "shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the behavioral health professional-client relationship" unless the client waives the privilege in writing or in court testimony. As discussed above, though, these privileges often are superseded by the child's best interests and are also superseded by mandatory reporting laws.

C. Dilemmas for Judges

Judges have the difficult dilemma of having to rule on emergency motions alleging sexual abuse without the benefit of having any type of evidence presented. Some emergency motions are filed even before The Department of Child Safety (DCS) or the police are called and the judge is presented with a choice of granting the relief based on the allegations, or denying the motion and possibly leaving a child in a sexually abusive home, at least until the return hearing is held. Additional considerations for the judge in ruling on these types of emergency

motions are the possibilities that the allegations might have been made maliciously or were simply false. Throughout the legal proceedings, the judge also has to consider the effect of multiple interviews on the child to determine the facts behind the allegations, if any. If a criminal investigation is pending, or ensues, the judge must also consider what effect the Family Court proceeding may have on the criminal investigation and vice versa. In instances where a party invokes their 5th Amendment privilege against self-incrimination, the judge "may draw a negative inference from the [party's] invocation of the Fifth Amendment" but the party may testify in order to extinguish the negative inference, in which case the party waives the privilege.[9] Accordingly, if a party chooses to "plead the 5th", he or she may not testify in his or her own Family Court case, but may offer other evidence to support his or her case.

D. Dilemmas for Lawyers

Lawyers are sometimes the "first responders" to a parent's suspicions that his or her child has been or is being sexually abused. One hurdle to a lawyer meaningfully assisting his or her client in such cases is safe haven/safe harbor laws, which prevent a parent from having access to his or her child's therapy records. Aside from arguments centered around the fundamental right to parent[10], this type of therapy causes dilemmas for attorneys because their client may be being accused of sexual abuse but will not be allowed to learn what their child said in therapy.

[9] *Montoya v. Superior Court In and For the County of Maricopa*, 173 Ariz. 129, 131, 840 P. 2d 305, 307 (App. 1992).

[10] *See* A.R.S. § 1-601 stating in part that the "liberty of parents to direct the upbringing, education, health care and mental health of their children is a fundamental right" and that strict scrutiny applies when a parent's rights are infringed upon by the government.

Prevalence of Child Sexual Abuse Allegations in Family Court Disputes[11]

High demands are placed on civil court judges when CSA allegations arise during family court proceedings. The serious negative ramifications of child sexual abuse on a child's psychological and physical health are well-documented (Smit et al., 2015). Timely removal of a child from such circumstances is critical. However, judges must weigh the likelihood of abuse against the possibility of false allegations that can result in a child's estrangement from an accused parent and significantly negatively impact the parent-child relationship (Smit et al., 2015). This is further complicated by the possibility of ulterior motives of a parent or child in alleging abuse to prevent a parent from having access to the child. Alternatively, researchers opine that divorce is a natural time for revelation of child sexual abuse because during marriage, the other parent may have ignored signs of abuse out of loyalty to, or fear of the abusing parent (Smit et al., 2015). Freedom from the marriage may permit a child or parent to voice his/her concerns about abuse. Allegations frequently arise by mothers against fathers, by fathers, or others against mother's new partner or by persons other than the mother or father, including children.

Obtaining accurate data related to incidence of CSA when children are involved in Family Court proceedings is difficult. To date, there have been few studies isolating reported incidents that overlapped with family court involvement. Most studies occurred in the 1980s and 1990s and the information may be outdated. Additionally, much of the research in this narrow scope was conducted outside of the United States and extrapolating results from other countries may lead to faulty conclusions. Information on this topic is further complicated by the sub-categories of allegations. In this realm, there are not simply "true or false" allegations. Categories of allegations may include:

(1) Founded: sufficient information for the civil court to conclude abuse did occur as alleged;
(2) Unproven or Unsubstantiated: insufficient evidence for child protective agencies to conclude abuse did or did not occur. This category makes up a significant number of cases. In most of these cases, the parent who brings forth the allegations has an honest or good faith belief that the abuse did occur (Bala, Mitnick, Trocme and Houston, 2007). Far less frequently, a parent fabricates allegations (Bala et al., 2007).
(3) Unfounded: the civil court has sufficient evidence to conclude abuse did not occur.

[11] References located at Appendix G.

Of the data available on this topic, a study from 1990 indicated that CSA allegations occurred, on average, in only 2% to 3% of divorce and custody proceedings (Thoennes & Tjaden, 1990). This is only slightly higher than the average incidence of CSA reports among the population in general (Thoennes & Tjaden, 1990). Thoennes and Tjaden (1990) also concluded that allegations of CSA in families embroiled in litigation pertaining to legal decision-making and parenting time do not have greater likelihood of being false than allegations raised among the general population. A year later, Faller (1991) corroborated that conclusion with a study of 136 Family Court cases in which CSA was alleged when he determined that of the 136, only three stemmed from calculated untruths. A literature review of empirical studies on the topic identified that between 2% and 18% of CSA allegations in the context of divorce proceedings are intentionally fabricated, but these numbers should be viewed with some caution as sample sizes were very small (Smit et al., 2015). For example, the study that revealed an 18% fabrication rate had a sample size of only 12 cases (Smit et al., 2015).

Until relatively recently, CSA was a largely underreported problem and statistical information was either unavailable or inaccurate (Kellogg & CCAN, 2005). In the United States, 1 in 10 children is estimated to be sexually abused before the age of 18 (Townsend & Rheingold, 2013). A study by Finkelhor, Ormrod, Turner, and Hamby's (2005), utilizing a nationally representative sample of parents and children, found that 82 per 1000 children and adolescents had experienced a sexual victimization in the year prior to survey administration (Whitaker et al., 2007). A 2011 meta-analysis of over 330 prevalence studies worldwide evidenced rates of child sexual abuse at 20% for girls and 8% for boys (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). Notably, these numbers may be skewed by disclose factors, as boys may be less likely to disclose abuse than girls. The recent additional information on incidents may be related to the imposition of the mandated reporting statutes adopted by many states in the late 1990s which required medical and other personnel to report suspected child abuse.

Most child sexual abuse goes unreported (Hanson, Resnick, Saunders, Kilpatrick, & Best, 1999). In the United States, more than 60,000 substantiated new cases were reported annually to child protection agencies in recent years (U.S. Department of Health & Human Services, 2013). Notably, approximately 17.5% of reported maltreatment cases are substantiated (U.S. Department of Health & Human Services, 2013). Therefore, this statistic may not accurately convey the true number of cases of child sexual abuse. Of further note, child sexual abuse that does not include touch and other types of child sexual abuse are reported less often, indicating that individuals who have been sexually abused in their childhood or adolescence may be greater than indicated in the statistics available (Maltz, 2002; Hall & Hall, 2011). Because child sexual abuse is vastly underreported, accurate estimates of prevalence are difficult.

A 2003, five-year longitudinal Canadian study examined CSA allegations processed by child protective agencies. Canada is the only country that maintains data on false allegations of child abuse generally, not sexual abuse specifically (sexual abuse results will be discussed later). To obtain the results, child protective agency workers' assessments of the validity of the claims was used to categorize claims into substantiated, suspected, unsubstantiated but made in good faith, and intentionally false categories (Bala et al., 2007). Of the 11,562 investigated cases, only 4% (512) were deemed intentionally false. Of those intentionally false reports, 9% were made by custodial parents, 15% were made by noncustodial parents and 33% were made by neighbors and relatives (Bala et al., 2007). Thus, in this case, noncustodial parents (typically fathers) were more likely to allege than custodial parents (typically mothers). However, the noncustodial allegations usually related to neglect while the custodial allegations were usually about physical or sexual abuse (Bala et al., 2007). In cases where ongoing legal decision-making or parenting time disputes occurred concurrent to the report of abuse, the rate of intentionally false allegations rose significantly to 14% with 34% levied by noncustodial parents (usually fathers) and only 27% made by custodial parents (usually mothers).

Of the 655 claims specifically related to CSA, approximately 5% were considered intentionally false. In these cases, slightly more (14%) allegations were made by custodial than noncustodial parents (11%). Approximately 4% of the intentionally false allegations of child sexual abuse arose from children, typically adolescents (Bala et al., 2007). In the case of CSA allegations, if the reported abuse coincided with a custody dispute, 18% were considered intentionally false with 44% of those being raised by custodial parents (typically mothers) and only 10% were raised by noncustodial parents (usually fathers).

A 2005 study in the United States reported on 120 high conflict legal decision-making/parenting time cases and noted that allegations of CSA were raised against mothers in 6% of the cases and against fathers in 23% of the cases (Bala et al., 2007). Interestingly, in all cases of alleged abuse or maltreatment, the rate of substantiated allegations by mothers against fathers (51%) was nearly identical to the rate of substantiated claims made by fathers against mothers (52%).

Psychological Assessments for Child Sexual Abuse

Evaluations of Children

In addition to earlier definitions, child sexual abuse is also defined as sexual activities for which a child is not developmentally prepared, cannot comprehend, something to which s/he cannot give consent and a behavior that violates the social taboos or laws of society (Kellogg & CCAN, 2005). CSA is not the same as "sexual play" and may be distinguished by assessing developmental asymmetry among the participants and by determining the coercive nature of the behavior (Kellogg & CCAN, 2005). For example, when two children at the same developmental stage touch or look at each other's genitalia without intrusion of the body and without coercion, because they have mutual interest, this is considered normal (Kellogg & CCAN, 2005). Among children aged 2 to 12 who did not experience sexual abuse, fewer than 1.5% demonstrated behaviors such as: asking to engage in sex acts, touching animal genitals, imitating intercourse, inserting objects into the vagina or anus, or putting the mouth on genitals (Kellogg & CCAN, 2005). Thus, one method of assessing likelihood that abuse occurred can be analysis of sexualized behavior of children. More information on this follows in the section titled "Issues in Sexual Abuse" below.

While a pediatrician or other medical professional may be the first to encounter signs of abuse, it is important to keep in mind their role is diagnostic in nature and not necessarily investigative or confirmatory (Kellogg & CCAN, 2005). Though the medical professionals' evaluation is diagnostic, s/he will likely carefully document the examination and this may include photographs. These records may be obtained in the case of a formal investigation as state laws protecting children preempt HIPAA privacy provisions. Laboratory data may also be gathered in the course of a medical examination, these may include testing for sexually transmitted diseases (STDs), pregnancy, *etc*. All STDs offer diagnostic value, but certain STDs can offer investigative value, such as vaginal infections, anogenital warts, and herpes simplex (Kellogg & CCAN, 2005). It is generally agreed that a medical professional who encounters any STD in a child will report the child to law enforcement or DCS.

In addition to medical examinations and observations of children's sexual behaviors, forensic child interviews, as discussed in a previous section, and formal assessments may be utilized.

Some formal assessment measures utilized in child sexual abuse cases and the potential impact include the following:

- Trauma Symptom Checklist for Young Children (contains validity scales; answered by child's caregivers).
    - Purpose: Designed 'to assess trauma symptoms in children.' Population: Ages 3-12 years.

- Manifestation of Symptomatology Scale.
    - Purpose: Designed 'to identify problems of children and adolescents.' Population: Ages 11-18.

- Checklist for Child Abuse Evaluation.
    - Purpose: 'Provides a standard format for evaluating abuse in children and adolescents.' Population: Children and adolescents.

- Child Sexual Behavior Inventory.
    - Purpose: Designed as a "measure of sexual behavior in children"; used in the identification of sexual abuse. Normed on female caregiver reports. Population: Ages 2-12.

Psychosexual Evaluations in Family Court[12]

What is a Psychosexual Evaluation?

A psychosexual evaluation is often requested to assess adolescent and adult sexual behavior ranging from normal to problematic. The focus of the assessment is on the person who is either accused of problematic sexual behaviors or admits he or she has engaged in problematic sexual behaviors or has been convicted of a sexual crime. A psychosexual evaluation combines the elements of both psychological and sexual evaluations. These assessments often include: a clinical interview, a semi-structured sexual attitudes check-sheet, history and behavior interview, professional and personal collateral interviews, intelligence assessments, personality assessments, sexuality assessment, and physiological assessments. Psychosexual evaluations do not include interviews of children, though they may include a review of child/forensic interview.

A psychosexual evaluation, sometimes called a psychophysiological evaluation, often includes a treatment plan and recommendations when requested by the court. A comprehensive psychosexual evaluation may include a "risk assessment."

Components of a Psychosexual Evaluation

Following a referral, the first step is to meet with the alleged offender and protective parent separately to specify the conditions under which the psychosexual evaluation will be conducted. Information related to allegations is obtained through police reports, detective reports, forensic interviews, other mental health evaluations, and statements made by the alleged offender and protective parent ("Parties"). The best practice is to ask the Parties to summarize in writing their concerns and allegations as well as what the child said verbatim. Supplemental information may be obtained through additional clinical interview(s).

During intake, the Parties read and sign informed consents, including limits of confidentiality, review the court's order, receive an explanation of the tests and other procedures, and notification that a request and review of collateral information will be conducted, as well as a brief, informal assessment of the alleged offender's competency to participate in a psychosexual evaluation.

The first examination should be an intelligence screening device, *e.g.*, the Shipley Institute of Living (the "Shipley") or the Kauffman Brief Intelligence Test, 2nd Edition (the "K-BIT 2"). The Shipley is a brief screening device to test for intelligence and takes only a few minutes to administer.

[12] References located at Appendix H.

An alternative to the Shipley is the K-BIT 2. This test measures both verbal and non-verbal cognitive ability and is used to obtain a quick assessment of one's intelligence. If the person does well on either of these examinations and there are no findings to the contrary discovered through collateral information or through a brief interview, then one could proceed with the psychosexual examination. If problems are present, *i.e.*, especially a low verbal IQ or evidence of neurocognitive dysfunction, *i.e.*, Cognitive Disorder or Learning Disorder, one could administer a test of comprehension, *e.g.*, The Wide Range Achievement Test 4, which includes subtests related to word recognition and sentence comprehension.

Another, more elaborate, test of cognitive abilities is the Woodcock Johnson Test of Cognitive Abilities. This test was recently revised and is referred to as the WJIV. This test also contains a comprehension sub-test. If the person's comprehension is insufficient, that may negatively impact the comprehension associated with various tests included in the psychosexual evaluation; then it would be appropriate to use audio-tapes or CDs.

If a Neurocognitive Disorder (Dementia, Delirium) or Neurodevelopmental Disorder (Intellectual Disability, Autism, Attention Deficit Disorder, Learning Disorder, or other Neurodevelopmental Disorders) are suspected, then a brief neurological screening would/could be conducted. A neurologic screening could involve a test like the Mini Mental Status Examination II. This test contains a cut off score which would indicate the potential presentation of a cognitive disorder.

Additional screening tests that may be administered include the Categories Test, which allows a person to distinguish individuals with brain damage from normal individuals and the Trail Making Test, which is a neuropsychological test of visual attention and task switching. It is sensitive to detecting Neurocognitive Disorders. If Neurodevelopment Disorders are suspected, a referral for a neuropsychological evaluation would be warranted. Otherwise, if it appears, based on these assessments, that the person can precede either with taking (by audio cassette) or by reading the tests, then one would proceed with the psychosexual examination.

<u>Collateral Information</u>

Collateral sources include individuals who know the alleged offender in any capacity. Collateral information includes police reports, detective reports, psychiatric and psychological evaluations, behavioral health treatment records, early educational experiences evaluations, and treatment. The most salient collateral information should be included in detail in the psychosexual evaluation and all else should be listed as reviewed.

Clinical Interview

The clinical interview includes the alleged offender's version of the accusation, the status of the charges (if there are charges), the person making the accusation(s), the rationale for the accusations, admissions (if any), and the client's explanation of the rationale for the (allegations) offense behavior. The clinical interview process includes questioning/discussion of various histories as follows:

- Family medical history. Do we want more detail here as below?
- Comprehensive developmental history, including birth complications, developmental milestones, maternal exposure to substances, childhood illnesses, childhood hospitalizations, childhood traumas, and early childhood problematic behaviors/psychiatric diagnoses.
- Family history, including socio-economic status, relationships with caregivers, treatment by caregivers, personality characteristics of caregivers, discipline styles of caregivers, family history of mental illness, history of domestic violence including substance abuse, health of caregivers, history of emotional, sexual, physical abuse or neglect, significant childhood experiences, and sibling relationships.
- Educational history, including review of educational experiences from preschool through college/professional school. This includes grades, extracurricular activities, any retention or placement in special education and the concerns that were expressed in special education and one's response to the special education services, and involvement in advanced placement/gifted curriculum.
- Relationship history, including marriage/divorce, committed relationships, children from intimate relationships, the quality of the relationships, what caused the end of the relationship and any domestic violence that may have occurred within the relationship.
- Employment history, including chronological timeline of employment, terminations, suspensions, employer discipline, referrals/evaluations for work misconduct, whether or not this person has ever collected unemployment benefits, any financial issues such as denied credit, bankruptcy and threatened garnishments. Military service, discipline and discharge status.
- A detailed history of the alleged offender's psychosexual development including entrance into puberty, onset of masturbation, frequency of masturbation, masturbatory fantasies, first sexual contact and intercourse, detailed history of the person's sexual

behaviors, such as paraphilic interest or deviant sexual behavior. Examples of deviant sexual behavior include:

- incestuous behavior,
- exposure,
- bestiality,
- obscene phone calls,
- non-intimate sexual practices like sex with strangers, prostitution, extra-marital affairs, sadomasochistic behavior, pornography including X-rated movies, DVDs, use of internet pornography, magazines, viewing child pornography,
- potential discipline practices,
- transvestism/fetishism,
- frottage,
- attendance at adult book stores and topless/nude nightclubs
- group sex,
- urophilia,
- taking sexual advantage of incapacitated persons,
- potentially deviant dreams or fantasies, and
- use of the internet to find sex dates or sex partners, live webcam sex acts, use of a smart phone to engage in sexual behavior–using the camera to take explicit sexual images, sexting, sending, or receiving nude images, sex with persons where one works, etc.

- Any sexual victimization should be elicited in detail, as well as any medical problems associated with person's genitals.
- Treatment and assessment history should be detailed, along with the alleged offender's attitude towards the potential for future treatment related to potential sexual misconduct or other mental health issues.
- Substance abuse history, including age of first use, frequency of use, circumstances of use and consequences, history of substance abuse treatment and last use.
- Legal history, including arrests history, disposition of arrests, probation or parole history.
- Leisure/recreation history, including religiosity, recreation activities, companions, future goals.
- Residential history, including current living situation, *e.g.,* the type of home, whether they rent or own, history of residences, and history of individuals with whom s/he has lived.

A brief mental status examination (MSE) and behavioral observations are conducted. An MSE includes an analysis of thinking processes include delusions and ruminations, etc., and assessment of presence of hallucinations, deficits inattention, concentration, and memory. Neurocognitive deficits include difficulty acquiring or expressing information, identifying familiar objects, impaired ability to understand oral or verbal expression, and difficulty in motor output (apraxia).

Psychological Evaluations

The psychological evaluation included in the psychosexual evaluation typically involves standardized psychological assessments for example, Personality Assessment Inventory (PAI), Minnesota Multi-Phasic Inventory, Second Edition (MMPI-2), and/or the Million Clinical Multi-Axial Inventory III (MCMI III).

The PAI by Morey is a 344-item self-report inventory that generates 22 non-overlapping scales, 4 validity scales, 11 clinical scales, 5 treatment scales, and 2 interpersonal scales. Each item is rated on a 4-point scale, *i.e.*, very true, mainly true, slightly true, or false. The PAI by Morey, 1991, is especially appealing in a forensic context because several of its scales are relevant to salient domains that often require investigation in forensic settings. The PAI requires a grade 4 reading level which also increases its utility for forensic examiners. The PAI provides information relative to clinical diagnosis, treatment planning and screening for psychopathology. The scales are divided into four domains: validity, clinical, treatment, and interpersonal (Douglass, Heart, & Kropp, 2001).

The MMPI-2 is an inventory composed of three validity scales, 10 clinical scales and hundreds of specialized scales. This evaluation is used to assess major symptoms of psychopathology, personality characteristics, and behavioral proclivities. The MMPI-2 Restructured Form (MMPI-2-RF) is a restructured, briefer version of the assessment. The test is organized in a hierarchical format with 3 higher order scales, 9 restructured clinical scales, 23 specific problem scales, 2 interest scales and 5 revised psychopathology scales. It also contains 9 validity scales that detect various forms of response bias as well as non-content based, invalid responding such as random (Wall, Wygant, & Gallagher, 2014).

The Millon Clinical Multi-axial Inventory III (MCMI III; soon to be IV) is a diagnostic assessment that contains four validity and modifying indices and requires a 5th grade reading level. It is used in clinical, counseling, medical, government and forensic settings. The MCMI-IV identifies deep, pervasive clinical issues; facilitates treatment decisions and assess disorders based on DSM-5 and ICD-10 classification systems. It should be noted that it would not be considered sound clinical practice to diagnose someone based on the MCMI-III alone (Retzlaff, Stoner, & Kleinsasser, 2002).

Other psychological tests may be employed based on the presenting or collateral information problems that the client may present. For example, if the person presents with alcohol issues then the Michigan Alcohol Screening Test - Revised (MAST) or the Substance Abuse Subtle Screening Inventory, Third Edition (a Fourth Edition is now available), otherwise known as the SASSI-3 or 4 might be utilized. If the person presents with post traumatic symptomology, one might administer the Trauma Symptom Inventory (TSI-2) written by John Briere, Ph.D. If the person presents with possible attention deficit hyperactivity disorder (ADHD) symptoms, the Conners Test for ADHD might be administered.

For a full-scale assessment of intelligence, the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV) is widely considered the "gold standard" (Hartman, 2009). The assessment consists of 10 subtests that comprise four scale scores, what is generally considered the individual's intelligence quotient, with five extra subtests to assist in evaluating range of function. The score is provided to assess the client's verbal abilities, capacity to adapt to new information, concentration, ability to access previously learned information, and the overall cognitive speed at which all of this occurs (Fabian, Thompson, & Lazarus, 2011). Screening devices and nonverbal intellectual assessments have utility but they do not offer the extensive interpretations shown in the WAIS-IV result.

To this end, it is important that the examiner distinguish borderline intellectual functioning and extremely low IQ scores from a learning disability. IQ scores are the result of a globalized assessment of the clients cognitive functioning while learning disabilities are a specific deficit in academic areas. The WAIS-IV represents the strongest overall assessment of a client's intellectual abilities.

Sexuality Testing - Sexual thoughts, behaviors, and fantasies assessment

Tests designed to assess sexual thoughts, behaviors, and fantasies include the Abel Assessment of Sexual Interest (AASI-3), the Wilson Sex Fantasy Questionnaire (SFQ), the Clarke Sex History Questionnaire for Males – Revised (SHQ-R), the Abel and Becker Sexual Interest Card Sort, and the Multi-phasic Sex Inventory II (MSI II).

Abel Assessment

The Abel Questionnaire accompanies the Abel Visual Reaction Time Test and is essentially a clinical interview that was modified for computer (Abel Screening Software version 4.2). It contains the typical demographics including the purpose of the evaluation, occupation, income, relationships, activities and hobbies. The second section contains questions related to sexual attractions and fantasies. Additional information is related to the person's relationship with various substances and potential victimization as a child. There is an extensive section on various paraphilic-like or potential deviant sexual behaviors. For example,

exposure, child molestation, rape, voyeurism, sadism, etc. are addressed. There are 22 different potential sexual behaviors listed in this section and results are received by the referring agent in an abbreviated format, that can be easily converted into a report. There is additional information requested relating to one's relationship with the criminal justice system, to both sexual and non-sexual crimes. The client is also asked to respond to questions related to the impact of various issues that might have impact on their sexual problematic behavior like pornography, alcohol, or drugs. There is a variation of the Abel and Becker Sexual Interest Card Sort (the client is asked to rate various sexual vignettes from sexually arousing to highly sexually arousing on a graduated scale. Following that, the client is asked to indicate how often they might have fantasies involving the previous sexual activities. In conclusion, the questionnaire asks detailed information about one's treatment opportunities related to potential sexual misconduct).

Note: The Abel Assessment also has a number of criticisms. For example, most research has been conducted only on adult males; although Abel uses non-offending samples that work close in composition to the US Census of 2000, the test was not designed for a specific race or ethnicity; subjects can fake response patterns if they know what the vision reaction time test is measuring; no one knows the algorithm used to determine the visual reaction time test scores or probability values; and, not all ages are included in the slides.

Wilson SFQ

The Wilson SFQ is a 40-item self-report questionnaire that assesses 4 types of sexual fantasies: Exploratory, Intimate, Impersonal and Sadomasochistic with 10 items each. It is believed that the SFQ is able to capture differences in fantasy and to discriminate among men with sexual deviations but research indicates that sexual offenders actually tend to report lower levels of sexual fantasies than non-offenders (Baumgartner, Scalora, & Huss, 2002).

Clarke SHQ-R

The Clarke SHQ-R is a comprehensive assessment of an individual's sexual history. It was specifically created to assess male offenders and help evaluate the offender's risk to others and his potential for rehabilitation by determining his specific sexual experiences. There are a number of scales contained within the SH-Q including childhood and adolescent sexual experiences and sexual abuse, sexual dysfunction, frequencies related to adult females, pubescent females, female child, frequency related to adult males, pubescent males, male child, child identification, fantasy activities with male and females, exposure to pornography, transvestism, fetishism (descriptive only), feminine gender identity, voyeurism, exhibitionism (as well as frequency), obscene phone calls, frotteurism (includes toucherism), sexual aggression and a lie scale and infrequency scale. The SHQ-R

is subject to the same problem in all sex offender self-report mechanisms – dissimulation (*i.e.* under or non-reporting). The SHQ-R measures erotic desire and disgust for a variety of sexual behaviors (see above). When investigated across broad categories of sexual interest the SHQ-R correctly classified 45 to 90% of subjects and overall, the scales discriminated between clinically relevant groups and controls (mhs.com; Multi-Health Systems).

Abel and Becker Sexual Interest Card-Sort Questionnaire

The Abel and Becker Sexual Interest Card-Sort Questionnaire contains 75 items describing both normal and subnormal sexual behaviors and interests, and is applied in clinical practice with known sexual offenders by clinicians during clinical interviews. The Sexual Interest Card sort has high face validity. The Sexual Interest Card Sort is similar in nature to the SHQ-R (see above). The Sexual Interest Card Sort demonstrated reliability and validity in a study conducted Holland, Zolondek, Abel, Jordan, & Becker in 2000. The Card sort should be used in a clinical environment and not used to determine guilt or innocence. Furthermore, the Card sort should be incorporated into a larger psychosexual evaluation. The study cited here did not consider deniers in its analysis but even for those who do not admit to sexually problematic behaviors the relative differences in their responses to sexual interest categories on the Card Sort may provide clinically significant sources of information about their true proclivities.

Multiphasic Sex Inventory-II (MSI-II)

The MSI-II is a comprehensive examination of sexual issues that can be completed by offenders and non-offenders. The MSI-II is unusual because it is a single test that includes most of the information noted above integrated into one assessment. The MSI-II is also unusual as it contains information that is provided by the referring clinician related to a number of early childhood and familial behaviors that may impact the examinee and a description of the alleged sexual misconduct. The beginning of the MSI-II includes the accused offender's description of the accusation with any admissions that the accused offender might make. There are scales associated with child molestation, rape, exhibitionism and voyeurism – the most common of paraphilic behaviors. The scales include potential admissions related to deviant arousal, pre-assault behaviors (engagement and grooming), and sexual assault.

There is an additional sex deviance section, *i.e.*, various paraphilia indices that includes sexual harassment, internet sex, obscene phone calls, pornography, transvestism, fetishism, bondage and discipline, along with sadism and masochism. Also included is a section on sexual dysfunction and emotional issues including, but not limited to, social-sexual inadequacies, emotional neediness and cognitive distortions. There is also a section on violence that includes family issues related to domestic violence, general anti-sociality and substance abuse.

Accountability scales assess rationalizations and justifications (cognitive distortions as in normalization, minimization, projection of blame and denial often associated with accused persons; Nichols & Molinder, 2009).

According to Stinson and Becker (2008), indicate that the developers of the MSI II described a number of factors that support the content validity of the scales of the MSI II, as well as their ability to discriminate between different types of sexual behavior and interest.

Note: Criticisms of the MSI-II include cautions against using it in cases which do not involve criminal justice parties because there the norms included in the MSI-II Data sample are convicted criminal justice individuals. This is simply not true as there are 250 norms included in the most recent sample.

Additional Measures of Cognitive Distortions

Assessments of cognitive distortions relate to inappropriate sexual behaviors (rationalizations, normalization, denial, minimization, and projection of blame). These types of tests assess endorsed cognitive distortions that offenders may use to support their sexually problematic behavior. The major problem with these tests is the transparency of the items. For example, one question might include the following comment: "A 13 year old child is old enough to make a decision about being sexual with a 19 year old." The accused may believe that but know how others might interpret a yes response. The basic general distortions are listed above and include 1) normalization: "everyone does it;" 2) minimization: "no one was hurt by the behavior" or "it wasn't that bad;" 3) projection of blame: "she came on to me, she looked older, she had previous experience;" and 4) denial. Denial may present in a variety of ways. These include: first and most obvious is, "I didn't do it," "it was an accident" (there was no plan or it was just a regrettable mistake absent any planning), and other excuses such as, mental illness, high, intoxicated, addicted, immature, no sex education, thought she was an adult, she came on to me, hyper-sexuality, and others.

Examples of tests related to cognitive distortions include (though not limited to): the Abel Assessment of Sexual Interest (Abel Questionnaire-justification sub-test, see above), the Bumby Cognitive Distortion Scale, the Burt Rape Myth Acceptance Scale, and Hansen Sexual Attitudes Questionnaire (Arkowitz & Vess, 2003; Hanson, Gizzarelli, & Scott, 1994; Gray, 2006.)

There are a few tests that are specific to aggressive behavior/violence assessments, and the one most often employed is the Buss-Durkee Hostility Inventory. The Buss-Durkee is a 75-item measure of hostility assessed with a dichotomous true/false response option. The Buss-Durkee is often referred to as the BDHI is conceptualized into eight subscales of hostility with a global evaluation of hostility (Nassar & Hale, 2009).

Finally, if the person has been arrested, charged, and/or convicted of a sexual crime then the following instruments would be appropriate and considered under "risk assessments." These include the Sex Offender Risk Appraisal Guide (SORAG), the Violence Risk Appraisal Guide (VRAG), and the Hare Psychopathy Checklist Revised (PCL-R). The most popular of the risk assessments is the Static 99R that assess recidivism risk of adult male sex offenders. The Static 99R is widely used for treatment planning and community supervision. It contains 10 items drawn from readily available demographic (age at release; relationship history), sexual criminal history (prior sexual offenses, any male victims, any unrelated victims, any stranger victims, any non-contact offenses), and general criminal history (prior sentencing dates, index nonsexual violence, prior non-sexual violence (R. Karl Hansen, Kelly Babchishin, Leslie Helmus, and David Thorton). There are also assessments of dynamic variables that include the Stable 2007, the Acute 2007 and the Structured Risk Assessment Forensic Version.

Protective factors should be assessed as well. The most popular, well researched examination for this is the Structured Assessment of Protective Factors for Violence Risk (SAPROF). Also, there is a published article by Thorton and Mann that includes a comprehensive list of protective factors that should be included in any risk assessment.

There are certain threat assessments that might be used for persons that are not arrested, charged, and convicted. The most popular one, out of Canada, is the HCR-20^{V3} authored by Kevin Douglas, Stephen Heart, Christopher Webster and Henrik Belfrage. The device is not specific to sex offenders but it is seen occasionally in psychosexual reports. It is designed to assess the risk of future violence in adult offenders with a violent history and/or a major mental disorder or personality disorder. The HCR-20^{V3} consists of historical, clinical, and risk management variables that its authors determined had support in the research literature as indicators of potential violence risk. The HCR-20^{V3} has been validated in clinical and forensic settings in different countries (Barber-Rioja, Dewey, Kopelovich, & Kucharski, 2012).

Psychophysiological Testing

The Viewing time test is a manifestation of sexual interest. Sexual arousal is a physiological response to specific sexual stimuli. It is the final stage of sexual attraction. Singer identified three stages of sexual arousal in males: increased visual attention to the object of attraction, movement toward the object and subsequent penile engorgement. Viewing time measures attention (Carich & Mussack, 2000).

The most popular of the viewing time tests is the Abel VRT. Persons are presented with two sets of 80 images. Each age category contains seven pictures of males and females of a specific age (adults, teenagers, grade school children

and preschool children) and race (White and Black). All images show a frontal view in a bathing suit against a neutral background. Initially the clients look at practice slides and are shown how to advance the slides by pressing a key on the keyboard and (next) how to rate their sexual arousal to each slide on a 7-point Likert Scale where 1=highly sexually disgusting, 2=moderately sexually disgusting, 3=slightly sexually disgusting, 4=neutral, 5=slightly sexually arousing, 6=moderately sexually arousing, and 7=highly sexually arousing. During the actual VRT assessment the computer measures the amount of time each participant took to advance the slides as well as the time it took to rate the slides to record their sexual arousal (Gray, Abel, & Garby, 2015).

Two other viewing time tests are The Affinity (Mokros et al., 2013) and the Limestone Visual Sexual Preference test (www.LimestoneTech.com).

A penile plethysmograph measures engorgement of the penis. The typical measurement is done by volumetric (see Kurt Freund Laboratory of Canada) or mercury-in-strain-gage. The volumetric measures displacement of air while the strain gage measures circumference of the penis. They are both accurate at large erections but the volumetric is considered more accurate at lower levels. The erections are graphically depicted on a monitor while the data is manipulated statistically. A straight out comparison can be viewed or transformed into z-score transformations (not unlike IQ tests). Also indexes can be created comparing deviant responses (children and rape for example) to "normal" responses, age appropriate consenting adults. The client is shown images (nude or clothed) or listens to audio stimulus or an interaction between the two to access any penile responding. Also available is video material. Additionally, one can create material based on the client's perceived sexual problematic behavior.

There are two popular commercial plethysmographs available: One through Limestone technologies name the Pref-Test (www.Limestonetech.com) and Monarch 21 PPG Instruments (www.btimonarch.com).

Remember that the PPG and viewing time do not measure the same thing so one might receive different information from the two instruments. For example one may have a sexual interest in children but no erectile response to children. Also, viewing time test are easily dissimulated and threats to validity should be identified in the report

Polygraph testing combines an interview with physiological measurements obtained using the polygraph instrument, which records physiological phenomenon typically respiration, heart rate, blood pressure and electro dermal response (electrical conductance at the skin surface). A polygraph examination includes a series of yes/no questions to which the examinee responds while connected to sensors that transmits data into physiological phenomenon by wire to the instrument, which uses digital technology to record the data. The record of

physiological responses during the polygraph test is known as the polygraph chart. Practitioners do not claim that the instrument measures deception directly, rather it is said to measure the physiological responses that are believed to be stronger during reports of deception than at times of responding truthfully. According to polygraph theorists, a deceptive response to a question causes a larger reaction. A pattern of physiological responses to questions relevant to the issue being investigated that are stronger than those responses to comparison questions indicates that the examinee may be deceptive. (National Research Council, 2003)

There are a number of issues surrounding the polygraph test/examination. One issue is the belief that there is no known physiological response that is unique to deception. However, Palmatier and Rovner (2014) indicate that it has been repeatedly demonstrated that when used properly, the polygraph testing process functions with a high degree of predictive (criterion) validity. A review of the available research literature, including from neurosciences, psychophysiology, and other relevant disciplines, coupled with an intimate understanding of the two commonly used polygraph procedures, the context in which they are used and the scientific method, strongly suggest that such claims are no longer true; that the polygraph procedure must use an applied day-to-day context, that is comparison question testing, Comparison Question Technique (CQT), is atheoretical and lacking construct validity, is not warranted. This paper (Palmatier & Rovner, 2014) discusses the interplay of the two most advocated polygraph procedures – the Comparison Question Technique and the Concealed Information Testing with preliminary process theory, contemporary writings on memory and other contributions from the research literature relevant to the instrumental assessment of credibility. Palmatier and Rovner (2014) conclude that the available scientific evidence not only establishes a plausible theoretical construct that strengthens the practical application of the polygraph process in forensic and other settings, but also concurrently provides directions for future research by scientists interested in the applied assessment of credibility.

Another issue related to polygraph examinations is that polygraph examinations are reportedly more likely to produce a false positive i.e., find an innocent person deceptive. The sensitivity and specificity of the polygraph examination varies across samples and across the type of examination. Also, the false positive rate (indicating someone is deceptive when they are not) varies with the purpose of the examination; for example, screening versus event specific polygraphs. False positives and false negatives are likely to be different primarily because of the great difference in the base rate of actually guilty persons versus actually innocent persons in different settings (National Research Council, 2003). Furthermore, according to the National Research Council (2003), any single value estimate of polygraph accuracy in general use would likely be misleading. The major reason is that accuracy varies markedly across studies. This variability is due in part to sampling factors (sample size and methods of sampling) and undetermined systematic differences between the studies.

The estimates of accuracy are based on examinations of certain populations of naïve examinees, untrained in counter measures and so may not apply to other populations of examinees, across testing situations. Even for naïve populations, the accuracy index most likely overestimates performance and realistic field situations due to technical biases. This is based on the lack of control of test administration and interpretation in the field and artificiality of laboratory settings and possible publication bias. Therefore, the range of accuracy indexes from 0.81 to 0.91 that covers the bulk of polygraph research studies is in the National Research Council's judgment overestimate of likely accuracy and field application even when highly trained examiners and reasonably well standardized testing procedures are used.

The use of confessions in many research studies on polygraphy is considered by some to enhance the perceived accuracy of polygraphy. In many studies, a person who failed a polygraph and did not confess, was not selected (unverified true positive), whereas the person who confessed was selected (true positive now equals 100%). With the in-fact innocent person, a past polygraph was judged to be truthful because of a confession of another accused person so, therefore, that person was selected and became a true negative with a rate at 100%. The person who failed a polygraph with no confession was not selected with a false positive rate of 0. However, a study conducted by Kraypol (2002) indicates the following:

> Many polygraph field studies have relied on confessions as verification of ground truth, a criterion that some critics argue creates an overestimation of polygraph accuracy. This is because there is a relationship between polygraph results and the likelihood that a suspect will confess. Confessions come from interrogations which (often) follow failed polygraph examinations. If a guilty person fails the polygraph, an interrogation is initiated which might yield a confession. If a guilty person passes the polygraph there is no interrogation, no confession and little chance the polygraph error will be uncovered. This would suggest that among guilty suspects there could be qualitative group differences between confession and non-confession cases. The biasing effect of this confession criterion has not been resolved. In this study, a comprehensive sample of field polygraph cases from a large U.S. government polygraph program was examined to uncover differences in the polygraph detectability of guilty confessing suspects and guilty suspects who did not confess but were caught by other means. The present data failed to find any differences in the groups.

It is impossible, however, to quantify how much of the overestimate these numbers represent because of the limitations in the data. The National Research Council's (2003) judgment found that reliance on polygraph testing to perform in

practical applications at a level at or above 0.90 is not warranted on the basis of either scientific theory or empirical data. Many committee members would place this upper band considerably lower. Despite these caveats, the empirical data clearly indicate that for several populations of naïve examinees not trained in counter measure, polygraph tests for event specific investigation detect deception at rates well above those expected from random guessing. Test performance is far below perfection and highly variable across situations.

The final issue to be considered is the issue of culpability. Some researchers believe that most individuals are truthful and this may be true for those being screened for technical or law enforcement positions within national or local governments but is not necessarily true with regard to accused or admitting sex offenders in the court systems. Finally, polygraph examinations are not used in psychosexual evaluations to determine the guilt or innocence of a person, but rather to determine the reliability and thus the validity of the person's disclosures.

Risks/Benefits

A significant risk of a court utilizing a psychosexual evaluation is reliance on the evaluation to determine guilt or innocence. It is recommended that a person conducting these evaluations have extensive experience interpreting the data or have a qualified mentor to assist them.

The psychosexual evaluation is optimally used to guide a family court's determination of the factors under Arizona Revised Statute §25-403 and can provide information related to a party's mental health and the child's best interest. A psychosexual evaluation can also facilitate risk management related to parties when appropriate. A psychosexual evaluation may provide value to the Family Court by yielding information independent of either parties' assertion. This could include such information as sexual preference, sexual problematic behaviors that may pose a risk to various individuals of interest, other behavioral and emotional issues that may need additional assessment and/or treatment.

When to Refer

A court may request a psychosexual evaluation when a person is engaging in high risk behaviors that may relate to potential child or adult abuse. High risk behaviors could include compulsive use of pornography, use of child pornography, prostitutes, sadistic or masochistic behaviors, rape, compulsive masturbation, fetishism, frottage various internet sexual activities and domestic violence that may involve sexual behaviors.

Who is Competent to Conduct Evaluations

Any person conducting a psychosexual evaluation should be a member of The Association for the Treatment of Sexual Abusers (ATSA). ATSA is an international, multidisciplinary organization that is committed to playing a vital role in the prevention of sexual abuse by promoting sound research, informed policy, and effective practice with respect to individuals who have engaged in sexually abusive behavior. This will provide the Family Court with a person who holds at least a Master's Degree or above in the Behavioral Sciences and has engaged in a minimum of 2000 hours providing direct services (assessment, individual and/or group treatment) to individuals who have engaged in sexual offending behavior.

Psychosexual evaluations should be conducted by professionals who are trained in using psychological tests, diagnosing individuals, have experience in assessing individuals with sexually inappropriate/deviant or problematic sexual behaviors, and are able to integrate information from a clinical interview, collateral information, and test results into a written report. Additionally, the Evaluator should have experience in the Arizona Superior Court System.

Association for the Treatment of Sexual Abusers (ATSA) Guidelines and Other Practice Guidelines

ATSA guidelines can provide clarity and direction for other professionals including non-ATSA members with roles and responsibilities pertaining to risk reduction and risk management with male adult sexual abusers. As such, when implemented appropriately, these guidelines can offer a measure of protection for clients, practitioners and the public against unethical, non-informed, or unprofessional practices with this population. The terms client and sexual abuser are used throughout this section to refer to individuals who have engaged in sexually abusive behavior and/or have been convicted or adjudicated in a court of law for sex offenses, as statutorily defined in a given jurisdiction.

The term sexual abuse used in this document refers to sexual or sexually motivated behavior that involves others and may cause harm to them. Such behavior is usually, but not always, illegal. This definition includes, but is not limited to individuals who have forced or threatened another person to have sexual contact, engaged in sexually or sexually motivated acts involving a person under the legal age of consent, or who is otherwise unable to provide consent, or use the internet or other technology to produce or secure sexual images involving minors or others who have neither provided nor are able to provide consent, or solicitation of, or communication with a minor for sexual purposes. One of the guidelines to be interpreted within the context of goals and objectives of ATSA include (not limited to) promoting empirically informed assessment, treatment and other interventions to individuals who have sexually abused or are at risk to sexually abuse.

ATSA Practice Guidelines

In recognizing the heterogeneity of male adult sexual abusers, members conduct sexual abuser-specific assessments to promote informed decision making amongst stakeholders who share responsibility for treatment, risk management, and other domains of intervention. Empirically-informed and reliable sexual abuser-specific assessments can be used, for example, to inform:

- Sentencing and other legal decisions;
- Treatment planning and progress;
- Release decision making;
- Transition and reentry planning;
- Supervision and other case management planning.

Members conduct sexual abuser-specific assessments for the following purposes:

- Understanding the nature and extent of the client's sexually abusive behaviors;
- Exploring the criminogenic and other needs that should be the focus of treatment and other interventions;
- Estimating short and long term recidivism risk, both sexual and nonsexual;
- Identifying specific responsivity factors;
- Obtaining baseline information regarding a client against which progress and changes can be gauged.

Members recognize that sexual abuser-specific assessments are not designed or reliable for and should not be conducted for the following purposes:

- Substantiating or refuting allegations that are the focus of a criminal, civil, child custody or other investigations;
- Exploring the voracity or motivations of an alleged victim's statements;
- Guiding law enforcement, prosecutorial or charging determinations;
- Suggesting the existence of a predetermined profile of a sexual abuser against which an individual can be compared to determined fact;
- Addressing or alluding to the client's potential guilt or innocence or otherwise speaking to issues that are within the purview of a trier of fact.

ATSA members recognize that some individuals may present for sexual abuser treatment in the absence of legal or other mandates and that appropriate services should be made accessible to such individuals.

Collaborating with Child Protective/Child Welfare Professionals

This section pertains to clients with sexually abusive behaviors, interests, preferences or arousal involve children and the potential for these clients to have planned or unplanned contact with children (*e.g.*, children in their own families, the children of new romantic partners, friends, coworkers, or neighbors). It is important to note that contact is not limited to the client's close physical proximity with a child or adolescent, but also includes one-to-one interactions such as telephone calls, electronically facilitated communication, written notes and communication through third-parties. For the purposes of this section, the term "children" refers to minors under the legal age of consent.

When contact with children is at issue under the terms of any legal disposition (*e.g.*, court order, probation/parole order) involved professionals may provide written assessment driven recommendations regarding an individual client's acceptable level of contact with children that range from no contact to supervised or unsupervised contact.

American Psychological Association: Specialty Guidelines for Forensic Psychology

Forensic examiners signature says the trier of fact understands the evidence or determine a fact in issue, and they provide information that is most relevant to the psycho-legal issue. Through reports and testimony, forensic practitioners typically provide information about the examinee's functional abilities, capacities knowledge and beliefs an address their opinions and recommendations to the identified psycho legal issues.

Forensic practitioners use assessment procedures in the matter and for the purposes that are appropriate in light of the research on or evidence of their usefulness and proper application.

Forensic practitioners use assessment instruments whose validity and reliability have been established for use with members of the population assessed. When such a validity and reliability have not been established, forensic practitioners consider and describe the strengths and limitations of their findings.

Forensic practitioners consider and seek to make known that the forensic examination results can be affected by factors unique to, or differentially present in, forensic contexts including response style, voluntariness of participation, and situational stress frequently affiliated with involvement in forensic or legal matters.

Issues in Child Sexual Abuse[13]

In the United States, 1 in 10 children is estimated to be sexually abused before the age of 18 (Townsend & Rheingold, 2013) and research indicates that annually approximately 82 per 1000 children and adolescents experience a sexual victimization (Finkelhor et al.,2005). Worldwide rates of CSA have indicated that 20% of female children and 8% of male children experience CSA victimization (Stoltenborgh et al., 2011).

Most sexual abuse goes unreported and accurate estimates of prevalence rates are challenging to obtain (Hall & Hall, 2011; Hanson et al.,1999; Matz, 2002). However, the literature explains risk and protective factors that may influence the occurrence of CSA.

What are the risk factors associated with CSA:

Risk factors for child maltreatment are defined as "measurable characteristic[s] of an individual that heightens the probability of a worse outcome in the future" (Masten & Wright, 1998, p. 9). When combined with limited protective factors, risk factors increase the probability of children experiencing child abuse or neglect.

Gender: Some CDC research estimates that roughly 1 in 6 boys and 1 in 4 girls are sexually abused before age 18. Female children tend to be approximately 2.5 to 3 times more likely to be at risk of CSA than male children (Stoltenborgh et al., 2011). There is some indication that male children may be underrepresented in psychiatric samples. Research identifies that mental health providers rarely ask male clients about CSA (Lab et al., 2000). Research further indicates that although girls are more likely to be abused than boys, boys are also less likely to report abuse (Chadwick et al., 2014).

Age: Research has pointed to the increased risk of CSA of teenagers. In general, the risk of being a victim of CSA appears to increase as children age. There is some suggestion that age as a risk factor operates differently for girls and boys, with high risk starting earlier for girls and lasting longer. Though girls are at greater risk, boys are more likely to be victimized by a non-familial offender. Finkelhor and Barent have identified that children are most vulnerable for abuse of this nature between the ages of 7 and 13 years (Chadwick et al., 2014). Notably, older children are more likely to report abuse and this quality may skew the data.

School Enrollment: According to the Fourth National Incidence Study of Child Abuse and Neglect (NIS–4) Report to Congress (Sedlak, et al., 2010), school-aged children who were not enrolled in school were sexually abused more often than

[13] References located at Appendix I.

enrolled children. The rate of sexual abuse for children not enrolled in school is 1.6 times higher than the rate for those enrolled.

Workforce: Children with no parent in the labor force have a notably higher rate of sexual abuse (3.7 per 1,000) compared to those with one unemployed parent (0.9 per 1,000) or steadily employed parents (1.1 per 1,000).

Socioeconomic Status (SES): Children in families of low-SES also experienced a significantly higher risk of sexual abuse. The estimated incidence rate for children in low-SES families is two times the rate of children not in low-SES families.

Family Composition: NIS-4 data (2010) indicated that children living with two married or non-married biological parents were sexually abused at a significantly lower rate than children living in other conditions. Children residing in single parent homes appear to be at greater risk. The presence of a co-habitating partner in the home doubles the risk of victimization for girls. Not living with one's natural parents for extended periods of time increases risk of victimization by non-biological family members. Sexual abuse rates also differed significantly for children living with two married biological parents compared to children living in all but one of the other conditions. The exception is the comparison with children living with unmarried parents, whose rate of sexual abuse does not statistically differ from the rate for children with married biological parents. Only 0.7 per 1,000 children living with two married biological parents were sexually abused, compared to 12.1 per 1,000 children living with a single parent who had an unmarried partner and at least 3.4 per 1,000 children in the other living arrangements with different rates. Children in households where violence is common are also at increased risk of CSA.

Parenting: Factors in the child's environment that diminish supervision and support enhance risk. Parental inadequacy, parental unavailability, and poor parent-child relationship account for parenting factors associated with risk of abuse (Chadwick, Giardino, Alexander, Thackeray & Eserino-Jenssen, 2014).

Geography: The differences between the rate of sexual abuse in rural areas and the rates in major urban and urban areas are statistically marginal.

Offender: Most children are abused by someone they know and trust, typically a male. Intrafamilial perpetrators account for 50% of perpetrators in CSA with female children as the victim and 10-20% of CSA with male children as the victim (Chadwick, Giardino, Alexander, Thackeray & Eserino-Jenssen, 2014). NIS-4 data indicates that the most common offenders of sexual abuse were persons other than parents or parents' partners (40-42% of sexually abused children were sexually abused by someone other than a parent (whether biological or non-biological) or a parent's partner (23%), whereas just over one-third (36-37%) were sexually abused by a biological parent). The prevalence of male offenders was strongest in the category of sexual abuse, where 87% of children were abused

by a male compared to only 11% by a female. A recent meta-analysis of 89 studies comparing sex offenders against children, sex offenders against adults, and non-sex offenders indicated that sex offenders against children were more likely to have a history of sexual abuse, antisocial personality, attachment and bonding challenges, difficulty with intimate relationships, experience of harsh discipline as a child, and loneliness. This meta-analysis suggests a strong relationship between being a victim of sexual abuse and perpetration of CSA. The "cycle of sexual violence" has been discussed at length in the literature (Ryan, 1999; Widom, 1989b), but there has been limited empirical support for this popular notion. Most sex offenders against children have not been sexually abused as a child (*e.g.*, Marshall & Mazzucco, 1995) and most individuals who are sexually abused as children do not become offenders of CSA (Paolucci et al., 2001; Salter et al., 2003). Being a victim of CSA is a strong risk factor, but is by no means the only important risk factor. Notably, adolescents represent 30% of sexual offenders in offenses against younger children (Chadwick, Giardino, Alexander, Thackeray & Eserino-Jenssen, 2014). Of further note, adolescents who offend typically do so in early adolescence and are less likely to offend in the future, particularly if these adolescents receive appropriate treatment.

Substance Abuse: According to the NIS-4 study (Sedlak et al., 2010), offenders' substance use was a factor in 11% of maltreatment cases. The data indicated that children who are sexually abused are about equally likely to have offenders using alcohol and drugs (8.4% and 9.1%, respectively).

Mental Illness: According to the NIS-4 report to Congress (Sedlak et al., 2010), 7% of the children were maltreated by an offender with a known mental illness. Children who were sexually abused appeared to have been less likely to have offenders who are mentally ill.

Disability Status: A disability, prior history of victimization, or absence of one or both parents increases risk.

What are the protective factors associated with CSA:

Protective factors have been defined as "a correlate of resilience that may reflect preventive or ameliorative influences: a positive moderator of risk or adversity" (Masten & Wright, 1998, p. 10). These protective factors may function as safeguards. Researchers, practitioners, and policy-makers are increasingly focused on protective factors within children, families, and communities in the hopes of reducing risk and fostering resilience.

Individual protective factors: Increased resiliency in children who have experienced maltreatment has been shown to be related to personal characteristics that may include a child's ability to recognize danger and adapt, distance oneself from intense feelings, create relationships that are crucial for

support, and project oneself into a time and place in the future in which the perpetrator is no longer present (Mrazek & Mrazek, 1987). Other factors that may serve as protective factors include sound health, an above-average cognitive functioning, hobbies or interests, positive peer relationships, an easy temperament, a positive disposition, active coping strategies, positive self-esteem, positive social skills, an internal locus of control, and a balance between seeking help and autonomy. (Child Welfare, n.d.)

Family protective factors: Parent and family protective factors may include secure attachment with children, parental reconciliation with their own childhood history of abuse, supportive family environment including those with two-parent households, household rules and monitoring of the child, extended family support, stable relationships with parents, family expectations of pro-social behavior, and high parental education. Via healthy parenting, children acquire problem-solving skills, develop emotional management, and grow social skills that provide a foundation for the construction of healthy relationships. (Child Welfare, n.d.; Claussen, Eisner & Wells, 2013).

Participation in school-based child sexual abuse prevention program: Participation in programming of this nature enhances children's awareness of and knowledge about sexual abuse, builds their preventative skills, and enhances their self-protective factors. (Family Support Network, 2002; Child Welfare, n.d.; Claussen, Eisner & Wells, 2013)

How does the sexually abused child present?

There is no "typical" or defining presentation for a child who alleges CSA and was not abused as well as for a child who has been sexually abused. A child victim's reactions to sexual abuse vary widely. Furthermore, one-fourth to one-third of child victims do not exhibit any symptoms (Kuehnle & Connell, 2008).

Sexually abused children may present in a variety of ways; given this variety in presentation as well as the likelihood that the child may have been coerced into secrecy, a high degree of suspicion is warranted in efforts to identify if CSA has occurred in a suspected victim. Kenneth L. Miller, Marianne K. Dove, & Susan M. Miller (2007) summarized information from The American Academy of Pediatrics (2006), The American Academy of Child and Adolescent Psychiatry (2004), the Child Welfare Information Gateway (2007), and the National Center for Post-Traumatic Stress Disorder (Whealin, 2006) in describing signs and symptoms generally that may be indicative of CSA. Additionally, Chadwick and colleagues (2014) in their Encyclopedia of Child Maltreatment, provided symptoms of childhood sexual abuse. These signs and symptoms are summarized below and categorized into four domains: physical; emotional; behavioral; and sexual.

Physical: Physical signs of CSA may include swelling or rash in the genital area, urinary tract infections, pain on urination, headaches, chronic stomach pain, and sexually transmitted diseases (STDs). Somatic complaints that do not appear to have a specific physical locus may also be present.

Emotional: Emotional CSA symptoms account for some of the more common indications of CSA. These signs include inappropriate anger, anxiety, depression, dissociative symptoms, rebellion, and suicidal ideation/attempts.

Behavioral: Behavioral CSA symptoms account for some of the more common symptoms of CSA as well. These signs may include bed wetting, nightmares, irritability, temper tantrums, eating problems, compulsive washing and/or masturbation, secretiveness, refusal to attend school, unwarranted fear of people, unwarranted fear of places, withdrawal, running away from home, self-injury, school problems, and reenactment of abuse behaviors.

Sexual: Sexual CSA symptoms may also present as indications of CSA. These symptoms may include seductive behaviors, unusual interest in sexual ideas or avoidance of the same, drawing of sexual acts, and encouraging other children to perform sexual acts. Of note, a research review conducted by Kendall-Tackett et al. (1993) determined that PTSD and sexual behaviors were the only two symptoms that reliably differentiated sexually abused children from non-abused children. However, of further note, there is no one particular sexual behavior or pattern of sexual behaviors that is diagnostic of sexual abuse (Chadwick et al., 2014).

What happens to the sexually abused child?

Child sexual abuse victimization has been shown to be associated with various physical, emotional, behavioral, and social problems.

Emotional: Increased rates of mood disorders, personality disorders, somatization, post-traumatic stress disorder, para-suicidal behaviors, and suicidality as well as decreased self-esteem (Elliot, 2001) have all been shown in sexually abused populations (Paolucci, Genuis, & Violato, 2001; Putnam, 2003; American Academy of Child & Adolescent Psychiatry, 2004; American Academy of Pediatrics, 2006; Child Welfare Information Gateway, 2006; Elliot, 2001; Hopper, 2006).

Social: The literature suggests that survivors of CSA frequently experience interpersonal challenges in adulthood including insecure/disorganized attachments in relationships, unstable and/or unfulfilling romantic partnerships, and increased risk of separation and divorce (Mullen & Fleming, 2006).

Physical: Childhood sexual abuse has been correlated with increased risk of sexualized behaviors (Nagy, Adcock & Nagy, 1994), which may lead to early or

unintended pregnancy (Dietz et al., 1999; Widom & Kuhns, 1996), sexually transmitted illness infection (Brown, Lourie, Zlotnick, & Cohn, 2000), substance abuse, and disordered eating behaviors (Putnam, 2003). There appears to be long-term adverse health effects associated with CSA such as neurobiological issues (Putnam, 2003) as well as cancer, lung disease, and heart disease, particularly when this abuse is experienced in conjunction with other adverse child experiences (Felitti et al., 1998).

Behavioral: Childhood sexual abuse victims tend to have higher rates of academic and conduct problems, greater risk for committing property offenses, domestic violence, or felony assaults. Recent research indicates that sexually abused preschool children who go unidentified, undiagnosed, and untreated at the time of abuse often surface 7-10 years later in the legal system as runaways, delinquents, or prostituted children (NAPSAC, 2008).

Notably, research indicates that positive outcomes for victims of CSA appear to be affiliated with early detection and treatment (American Academy of Child & Adolescent Psychiatry, 2004).

Who treats the sexually abused child?

Court-Involved Therapist (CIT):

Families involved with the Family Court often seek therapeutic services. Court-Involved Therapy encompasses therapeutic services provided to a parent, child, couple, or family who is involved with the Family Court during treatment. These services may be voluntary or court-ordered and the Court-Involved Therapist (CIT) delivers these services. Therapeutic services of this nature are best delivered by CITs who are forensically informed. A forensically informed therapist has experience and education in both the legal issues and the psychological dynamics associated with court-involved families.

Court cases that involve therapeutic services typically include issues and dynamics that necessitate consideration in the treatment process. The treatment process as well as the information provided while in treatment may be significantly influenced by the family's involvement with the Family Court. Consequently, appropriate therapeutic treatment can help the family whereas inappropriate treatment can harm the family and intensify familial conflict. In order to ensure the former is of greater likelihood than the latter, AFCC (2010) constructed guidelines to guide and support the court in their selection, involvement, and assessment of court-involved behavioral health professionals. These guidelines provide direction in helping the Family Court to recommend effective treatment and assess the quality of treatment services. The guidelines also serve to assist the Family Court in developing clear and effective court orders and parenting plans that may be necessary for treatment to be effective. The guidelines are a best

practice guide for behavioral health professionals, attorneys, other professionals, and judicial officers when there is a need for therapeutic interventions with court-involved children or parents. The purpose of these guidelines is to "educate, highlight common concerns, and to apply relevant ethical and professional guidelines, standards, and research in handling court-involved families" (AFCC, 2010).

These guidelines (AFCC, 2010) are summarized as follows:

1. Assessing Levels of Court Involvement: A CIT should assess the degree to which legal processes will impact the treatment and consider issues that may impact the client or parent's functioning in treatment and the implications of treatment interventions on the legal processes. The CIT is to be aware of and take into account the unique circumstances of court-involved roles with children.

2. Professional Responsibilities: A CIT should establish and maintain appropriate roles and boundaries, demonstrate respect for parties, families, the legal process and its participants, maintain professional objectivity, manage relationships responsibly, maintain accountability, and provide clear, non-technical communication of observations and opinions to adult clients, parents of child clients, and other professionals when appropriate and permitted by applicable privilege.

3. Competence: A CIT is responsible for developing and maintaining specialized competence appropriate to and sufficient for the roles they undertake. A CIT should be aware of the areas of competence required for the various roles and therapeutic undertakings with the Family Court and maintain this professional competence through appropriate trainings, *etc*. A CIT should demonstrate understanding of professional roles and resources, such as research on empirically-supported, evidenced-based techniques in treatment. The CIT should accurately represent their competence and professional knowledge, while demonstrating an understanding of the limits of scientific knowledge and professional opinions. A CIT should remain informed of the current research regarding the influence of personal beliefs, biases, and experiences in the therapeutic process and the CIT should recognize and acknowledge the manners in which these factors may come into play in their cases. The CIT should manage these factors appropriately and seek appropriate consultation to support their maintenance of their professional objectivity.

4. Multiple Relationships: The CIT should refrain from serving multiple roles, particularly if this overlap may generate a conflict of interest. As an example, the CIT should not serve simultaneously as therapist and evaluator or as therapist and friend. The CIT should disclose to all relevant

parties any multiple relationships that cannot be avoided and the potential effect of the dual roles.

5. Fee Arrangements: Prior to commencing treatment, the CIT should establish a clear written fee agreement with the responsible parties, providing written documentation to each responsible party including a description of this arrangement and corresponding treatment services as well as the parameters of informed consent. For court-ordered therapy, so that the Family Court can issue an appropriate and comprehensive order inclusive of these arrangements, the CIT should provide the court with all information required to engage the CIT.

6. Informed Consent: At the outset of therapy, the CIT should provide a thorough informed consent process to adult clients and parents or legal guardians of child clients. A CIT treating a child should avoid accepting a child into treatment without notifying or consulting with both parents and request copies of court orders or custody judgments documenting each parent's right/authority to make decisions regarding treatment and delineation of each parent's access to treatment information. A CIT should explain the nature and purpose of the treatment to a child in age-appropriate language and the CIT should discuss the limits of parental involvement and confidentiality with the parents or guardians of a child or adolescent involved in treatment. When a CIT becomes involved in treatment at the request of a third party such as the Family Court, an attorney, or a social service agency, the CIT should be especially attentive to informed consent issues. When more than one individual participates in the therapy, the CIT should clarify with each person the nature of the relationship between the participants and between each participant and the therapist. The CIT should also clarify his/her roles and responsibilities, the anticipated use of information provided by each person, and the extent and limits of confidentiality and privilege. On a case-specific basis, the CIT should explain to the client the manner in which treatment information will be handled. The parent/client should be encouraged to consult with counsel before signing a therapy/informed consent agreement, if the parent or client is represented. If the CIT's level of court involvement changes or requests are made to change the CIT's role, the CIT should inform the client of the risks, benefits, and impact of any potential changes in treatment. The CIT should be sensitive to the possibility of being asked to provide feedback to third parties or to testify as a witness.

7. Privacy, Confidentiality, and Privilege: With regard to client/patient confidentiality and privilege, the CIT should understand the principal issues that arise in court-related therapy. The CIT should have awareness and understanding of ethical, clinical, and legal issues related to confidentiality and/or privilege and how this may differ contingent on whether a parent,

child, couple, or family is in treatment. The CIT should be aware of clinical issues related to disclosure of confidential information as well as the impact of litigation on decisions regarding use of treatment information. The CIT should also be cognizant of the potential impact a client's decision to release or decline release of treatment information may have on the legal matter. When making this decision, the CIT should encourage the client/parent to seek appropriate legal consultation. A CIT should recognize the limits of his/her expertise and seek legal advice or request direction from the Family Court in the face of ambiguity or uncertainty. A CIT has an ongoing obligation to inform clients. Accordingly, the CIT should discuss confidentiality with the client as circumstances change or as issues arise in therapy that may result in the disclosure of treatment information. When working with children, a CIT should be familiar with general provisions governing confidentiality of children's treatment information in his/her jurisdiction and the CIT should clarify the provisions of the order or therapy agreement regarding the child's treatment information at the onset of treatment. If the CIT is a HIPAA-covered entity, the CIT should have awareness of their HIPAA obligations, as well as the dynamic between these obligations and the legal process if a client is or becomes court-involved. The CIT should obtain legal consultation, if they are uncertain about how court-involvement may affect HIPAA obligations and vice versa. A CIT should respond to requests for treatment for information from third parties, court-ordered releases of treatment information, and subpoenas in an appropriate manner. The CIT may appeal to the Family Court. There are some circumstances in which a CIT may believe that disclosing information may violate ethical or professional practice guidelines applicable to mental health practice in which case the CIT may wish to consult an attorney familiar with the laws of mental health privilege/confidentiality in that jurisdiction.

8. Methods and Procedures: The CIT should adhere to the methods and procedures generally accepted in his/her particular discipline as well as methods and procedures consistent with being involved in situations, which may include litigation, testimony, and the reporting of various matters to the Family Court, the parties, or their attorneys. The CIT should attempt to obtain all information necessary to conduct the court-ordered therapy and should discuss the goals of the court-ordered therapy with the client. The CIT should clearly identify their role and process. The CIT should clearly identify the goals, procedures, and beneficiaries based on any relevant orders and in collaboration with the client(s) and other professionals as appropriate, and should clearly communicate this information to participants in the therapy. The CIT should understand that the information provided by the client during the course of the treatment is based upon the client's experience and perspective, which may sometimes be distorted or lacking balance and comprehensiveness. The CIT should select appropriate

treatment methods, critically examine information, take into account potential clinical impact when asked to release information, work to mitigate risk, and seek appropriate advice when necessary.

9. Documentation: A CIT should create documentation so that the Family Court can understand the treatment process, progress, and financial arrangements. A CIT should establish and maintain a system of record-keeping that is consistent with applicable law, rules, and regulations, and that safeguards applicable privacy, confidentiality, and legal privilege. Records should be organized and sufficiently detailed. A CIT should make all reasonable efforts to maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under his/her control. A CIT should also be cognizant of and follow relevant ethical and statutory requirements regarding maintaining records and communicate and clarify record-keeping with the client and/or parent.

10. Appropriate Communication: Communication from a CIT to another therapist, the client, parents, counsel, or the Family Court carries with it an obligation to ensure that the communication is authorized, clear, and accurate. A CIT should recognize the adversarial nature of the legal system and the potential impact of the therapist's observations and opinions. A CIT should take to the appropriate steps to communicate with a third party in an authorized manner and take reasonable steps to make certain this communication is accurate and capable of being understood by consumers. A CIT should communicate the bases and limitations of observations and opinions. A CIT is to include the appropriate parties in a communication and carefully consider who should be aware of and involved in each professional communication. A CIT should recognize the limits of his/her knowledge and the potential impact that testifying in Family Court may have on the client and on treatment. Prior to testifying, a CIT should thoroughly discuss these issues with adult clients and should engage in age-appropriate preparation of child clients. A CIT should comply with any limits on the scope of his/her testimony, which have been specified by a judicial officer in conjunction with any applicable ethical code.

What type of treatment is most appropriate for the sexually abused child?

Children who have seen sexually abused suffer a variety of sequelae including PTSD, depression, anxiety, and behavioral difficulties. Children's learned responses to trauma can significantly influence whether they recover optimally or continue to struggle throughout adolescence and adulthood. Given the research that sexually abused children suffer a broad range of debilitating short range and long term consequences of their trauma, it is important that children receive timely and effective treatment (Reece, Hanson, & Sargent, 2014). Evidence-based

treatment is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). Evidence-based practice in psychology advocates for improved patient outcomes by informing clinical practice with relevant research (Sox & Woolf, 1993; Woolf & Atkins, 2001).

Consistent with indications from research, evidence-based treatment for childhood sexual abuse advocates for each and every child victim, in the context of their family, to be assessed for what treatment approach is best suited to their needs. Behavioral Health Professionals are encouraged to use trauma-informed, evidenced-based practices in treating traumatized children. Sexual abuse-specific counseling is not indicated unless there is an offender confession and/or a conviction (Reece, Hanson, & Sargent, 2014).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is the most widely used, evidence-based treatment for childhood trauma (Allen & Johnson, 2012). TF-CBT has the strongest empirical base for the effective treatment of children who have experienced sexual abuse, child maltreatment, and other traumas (Saunders, Berliner, & Hanson, 2004). TF-CBT is a short-term, components-based treatment that involves the child victim and their family in the treatment (Cohen, Mannarino & Deblinger, 2006). TF-CBT has empirical support that it significantly reduces trauma symptoms and improves parental support and parenting skills. The primary goal of TF-CBT is to enhance the parent/child relationship to be safe and nurturing. As children work in treatment side by side, children feel empowered again through the parent's attunement and emotional support.

TF-CBT helps the victim "unlearn" the reminders of the trauma and their unhelpful coping mechanisms to avoid the trauma. The victim, along with their parent/caretaker, "relearn" healthy ways to cope with the trauma. The parent/ caretaker respond to the victim's maladaptive behavior in a positive, skillful, and supportive manner. Therefore, the victim learns new ways to cope with their trauma. The TF-CBT model is appropriate for children ages 3 to 17 years. Of note, this model is not intended for use with offending parents who have been physically abusive toward their children or parents/children who are actively psychotic, suicidal, or too dangerous/aggressive (Runyon & Deblinger, in press). These sessions are typically time-limited from 8 to 20 sessions of 90 minutes per session. The victim and the parent/caregiver work conjointly and individually to meet the treatment goals. TF-CBT consists of the following components: Psychoeducation; Parenting skills training; Relaxation training; Affective expression and modulation; Cognitive coping; Written traumatic narrative; In vivo mastery of trauma reminders; and Child safety skills (Allen & Johnson, 2012; Saunders, Berliner, & Hanson, 2004).

Parent-Child Interaction Therapy (PCIT)

PCIT is an empirically-supported treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT was originally developed to train parents how to manage their pre-school children's disruptive behavior. PCIT has not been empirically tested with the sexually abusive parent and child conjointly, but can be used with the protective parent and the child victim. Although PCIT is not an empirically based treatment for trauma, it is a well-researched treatment methodology for the symptoms of trauma (internalizing behaviors such as anxiety, depression, and PTSD and externalizing behaviors such as acting out and aggressive acts, and to rebuild the parent-child relationship. PCIT goals include increasing positive parenting skills, enhancing the parent-child relationship, teaching parents behavior management strategies, and decreasing child behavior problems. The overarching task of PCIT is to help the parent follow the child's lead. Parent skills include praising the child, reflection (active listening) on what the child is communicating through the play, imitation or modeling of appropriate behaviors while enjoying time with child, and description (used to convey interest in positive behaviors and enjoyment (setting the tone for the affective tone of the sessions). (Goldfine et al., 2015)

This treatment focuses on two basic interactions: Child-Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship and using skillful parenting to shape the child's behavior (Goldfine et al., 2015). Parent-Directed Interaction (PDI) resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child. PCIT requires the parents to demonstrate parenting skills, along with homework assignments to strengthen what is learned in the sessions.

Trauma-Focused Play Therapy

Play therapy is a child-centered, theoretically-based, empirically-validated approach to therapy that builds on the normal communicative and learning processes of children (Carmichael, 2006; Landreth, 2002; O'Connor & Schaefer, 1983). The Association for Play Therapy (APT) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." The curative powers inherent in play are used in many ways. Therapists strategically utilize play therapy to help children express what is troubling them when they do not have the verbal language to express their thoughts and feelings (Gil, 2004). In play therapy, toys are like the child's words and play is the child's language (Landreth, 2002). Through play, therapists may help children learn more adaptive behaviors addressing emotional or social skill deficits (Pedro-Carroll &

Reddy, 2005). The positive relationship that develops between therapist and child during play therapy sessions can provide a corrective emotional experience necessary for healing and foundational for future healthy relationship building (Moustakas, 1997). Play therapy may also be used to promote cognitive development and provide insight about and resolution of inner conflicts or dysfunctional thinking in the child (O'Connor & Schaefer, 1983; Reddy, Files-Hall, & Schaefer, 2005).

Through play therapy, children learn to communicate with others, express feelings, modify behavior, develop problem-solving skills, and learn a variety of ways of relating to others. Play provides a safe psychological distance from their problems and allows expression and integration of thoughts and feelings appropriate to their development.

Play therapy is utilized to help children cope with difficult emotions and find solutions to problems (Moustakas, 1997; Reddy, Files-Hall, & Schaefer, 2005). By confronting problems in the clinical play therapy setting, children find healthier solutions. Play therapy allows children to change the way they think about, feel toward, and resolve their concerns (Kaugars & Russ, 2001). Even the most troubling problems can be confronted in play therapy and lasting resolutions can be discovered, rehearsed, mastered, and adapted into lifelong strategies (Russ, 2004).

Although everyone may benefit from this form of treatment, play therapy is especially appropriate for children ages 3 through 12 years old (Carmichael, 2006; Gil, 1991; Landreth, 2002; Schaefer, 1993). Research supports the effectiveness of play therapy with children experiencing a wide variety of social, emotional, behavioral, and learning problems, including children whose problems are related to life stressors, such as divorce, death, relocation, hospitalization, chronic illness, assimilate stressful experiences, physical and sexual abuse, domestic violence, and natural disasters (Reddy, Files-Hall, & Schaefer, 2005; Saxe, Ellis & Kaplow, 2007).

Play therapy has been evidenced to help children:

- Become more responsible for behaviors and develop more successful strategies.
- Develop new and creative solutions to problems.
- Develop respect and acceptance of self and others.
- Learn to experience and express emotion.
- Cultivate empathy and respect for thoughts and feelings of others.
- Learn new social skills and relational skills with family.
- Develop self-efficacy and thus a better assuredness about their abilities.

Meta-analytic reviews of over 100 play therapy outcome studies (Bratton et. al., 2005; Leblanc & Ritchie, 2001) have found that the overall treatment effect of play therapy ranges from moderate to high positive effects. Play therapy has proven equally effective across age, gender, and presenting problem. Additionally, positive treatment effects were found to be greatest when there was a parent actively involved in the child's treatment.

Families play an important role in children's healing processes. The interaction between children's problems and their families is always complex. Sometimes children develop problems as a way of signaling that there is something wrong in the family. Other times the entire family becomes distressed because the child's problems are so disruptive. In all cases, children and families heal faster when they work together.

With advanced, specialized training, experience, and supervision, behavioral health professionals may have Registered Play Therapist (RPT) or Registered Play Therapist-Supervisor (RPT-S) credentials conferred by the Association for Play Therapy (APT).

Play therapy is not used to rule in/rule out child sexual abuse. The child's play is symbolic or metaphorical play used to understand a child's world – their struggles and their healthy adjustment to their world. The play is not to be interpreted literally and used in Family Court as a reliable means of determining child maltreatment. A behavioral health professional may opine in Family Court that a child's behavior or play is consistent with known children who have sexual abuse histories along with multiple hypotheses for the play.

Eye Movement Desensitization Re-Processing (EMDR)

EMDR is an evidence-based psychotherapy for the treatment of child and adult PTSD. In addition, successful outcomes are well-documented in the literature for EMDR treatment of other psychiatric disorders, mental health problems, and somatic symptoms. The model on which EMDR is based—Adaptive Information Processing (AIP)—posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the victim's ability to integrate these experiences in an adaptive manner. The 8-phase, 3-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers. (Adler-Tapia & Settle, 2012)

EMDR procedures facilitate the effective reprocessing of traumatic events or adverse life experiences and associated beliefs to an adaptive resolution.

Specific procedural steps are used to access and reprocess information, which incorporates alternating bilateral visual, auditory, or tactile stimulation. These well-defined treatment procedures and protocols facilitate information reprocessing. The 8-phase, 3-pronged approach to treatment optimizes sufficient client stabilization before, during, and after the reprocessing of distressing and traumatic memories and associated stimuli. The intent of the EMDR approach to psychotherapy is to facilitate the victim's innate ability to heal. Therefore, during memory reprocessing, therapist intervention is kept to the minimum necessary for the continuity of information reprocessing. (Adler-Tapia & Settle, 2012)

EMDR therapy is widely used with children. It is designated as an effective treatment for trauma and considered "Well-Supported by Research Evidence" by the California Evidence-Based Clearinghouse for Child Welfare. Numerous studies with children have demonstrated that EMDR therapy is effective in reducing PTSD symptoms, as well as behavioral and self-esteem problems. Playful and child-friendly strategies are used to make EMDR therapy developmentally appropriate and appealing for children. The amount of time needed will vary depending on the level of traumatization, internal resources, and external support available. The well-trained EMDR clinician will be able to assess how extensive the preparation should be for each child. As a result, when EMDR therapy is done appropriately, children will arrive at the moment of accessing and processing trauma memories with the proper psychological resources and abilities. (Adler-Tapia & Settle, 2012)

The overarching goal of EMDR therapy is to tap into the child's own information processing system so these memories of trauma can be processed and integrated (Shapiro, 2001).

Ultimately, child sexual abuse is a family problem and families may likely benefit from being court-ordered to participate in treatment. Research on reducing sexual behavior problems in children suggests that the most effective way to reduce sexual acting out is to involve the entire family in treatment. Helping the family practice coping strategies with their sexualized child (behavioral parent training) were among the factors most strongly predictive of reducing sexual behavior problems in children (Friedrich, 2007). In order to best treat the child, the family must be active in healing as well.

SEXUAL BEHAVIOR CONTINUUM OF NORMAL TO ABNORMAL

(Adapted from Toni Cavanaugh Johnson, Ph.D.)

Spectrum of Young Children's Sexual Behaviors: Preschool to Kindergarten

Normal/Expected[14]	Sexually Reactive	Sexually Aggressive
Touches/rubs private parts to self soothe or reduce anxiety in public/private	Continues to touch/rub private parts in public after being told to stop; masturbates with hand	Touches/rubs private parts to the exclusion of normal play; frequency of touching causes harm to private parts
Humping a pillow or stuffed animal	Humps furniture or others – child and others are clothed	Continues to hump furniture/others after being told to stop or while child/adult is nude
Shows own and asks to see private parts of known peers/siblings	Persists in asking/showing private parts to known peers after being told to stop	Forces others to show/view private parts; chooses unknown peers/ adults or vulnerable peers/adults
Explores private parts of known peers or adults out of curiosity; plays "doctor" with known peers/siblings	Persists in touching known peers/adults or own private parts in view of others or after being told to stop	Touches private parts of unknown peers/adults, touches sneakily or uses force/manipulation; forcibly undresses others
Appears to insert object into private parts - one time out of curiosity	Continues to insert objects into private parts of self or others after being told to stop or for masturbation purposes	Causes harm to private parts of self or others by persistent insertion of or masturbation with objects
Likes to be nude, tries to see others nude	Consistently wants to be nude despite being in view of others or being told to dress	Refuses to wear clothes at home despite visitors
Sexual curiosity	Persists in asking age-appropriate questions about sexual topics	Precocious/advanced sexual knowledge and questions; discusses sexual acts; is sexual about non-sexual topics
Plays house, explores gender roles (mom/dad, boyfriend/ girlfriend), plays kissing; giggly, shy, embarrassed if discovered	Persists in this behavior or behavior becomes sneaky or secretive; anxious, afraid, guilty if discovered	Acts out or engages in oral-genital contact with toys or others, seeks vulnerable children, friendships focus on sexual behavior, acts aggressively or compulsively; denies, blames
Participates in potty talk	Potty talk in public and private persists despite consequences	Refuses to give other privacy in bathroom; forces way into bathroom; uses precocious language

[14] Behaviors are transient, few, and distractible.

Future Directions:
Trauma-Informed / Trauma-Responsive Courts

It is encouraging that most jurisdictions in the United States have begun a dialogue about how to address tertiary trauma caused by the judicial process for victims and their families. There is a significant amount of information about trauma-informed and trauma-responsive courts. To be informed about the impact of child sexual abuse on families, it is vital to understand what trauma is and how it affects families both short-term and long-term. An understanding the issues are necessary to support appropriate responses from courts and intervenors.

There are a few basic tenets to consider in the development and implementation of a trauma-informed and trauma-responsive court system. The trauma-informed aspect begins by recognizing how widespread trauma is among the children and families we serve. Almost every child has experienced at least one of the adverse childhood experiences examined by the ACE study. Any family entering the court system that has been experienced sexual abuse has experienced a significant trauma. At almost every turn, trauma increases for these families; children are removed from their parents, parents separate, and children typically children have been interviewed repeatedly about the traumatic events. Many of the families have been interviewed by police officers, child protection workers, and likely several others before ever entering the court system. Often children and families re-experience the trauma with each interaction.

To be trauma-informed, court professionals understand the etiology, process, symptoms and outcomes of trauma. Trauma affects victims in a myriad of different ways; but commonly trauma causes individuals to react rather than to respond in a calm and modulated manner. Trauma can make it increasingly difficult for individuals to properly encode information making it challenging to accurately recall memories and process incoming information. Individuals who have experienced trauma and have not had sufficient time and resources to resolve the symptoms are going to act in ways professionals may find difficult and disrespectful. It is vital to understand that an individual's responses are often trauma driven and not necessarily from disrespect. Individuals who have been traumatized can present remarkably different; from inordinately withdrawn to extremely labile and emotionally reactive.

Trauma-informed courts are attuned to how we, as professionals, act in the courtroom. It is not sufficient to understand what trauma is, and how it affects our families. We must change our behavior to be more accommodating and respectful when interacting with traumatized families. Lowering the tone of voice can help make individuals feel more comfortable. Calling individuals by their names instead of "mother" and "father" helps individuals feel more like humans than a case file. Most importantly, it is vital to look up from the script and speak to individuals

directly. Asking questions instead of giving edicts can give families a chance to have some control back in their lives. Trauma diminishes victim's sense of control.

It is critical to assure the courtroom a safe space. The physicality of the courtroom can reflect a sensitivity to trauma responses; this is accomplished with neutral-toned paint and indirect lighting. Allowing families to be active participants in decisions helps provide the sense of purpose and control, thus helping families heal. Trauma-informed means recognizing that placing victims in the same room as their perpetrator can be overwhelming for the victim. Although at times it is necessary for them to be in the same room, appropriate seating arrangements in the courtroom and separate waiting room spaces for victims and perpetrators as well as providing supportive information to victims prior to the hearing can be of further benefit to the victim and the process.

It is also important to allow families to have their emotions. Although courtrooms are often expected to be free of emotion, when individuals have experienced trauma, the trauma causes individuals to act primarily from a place of emotion. We must allow them to experience overwhelming emotions and provide a physical place and or space to become modulated again. A trauma-informed court honors differences in culture and gender and provides accommodations if needed. Many jurisdictions have implemented peer support programs to assist individuals with special needs and provide emotional support. Trauma-responsive courts ensures families understand the information we provide in the courtrooms. Investing the resources to understand how trauma affects families leads to better outcomes for the families served as well as reducing our own vicarious trauma.

APPENDIX A

DSM V Codes

Parent-Child Relational Problem V61.20 (p 715 – DSM-V)

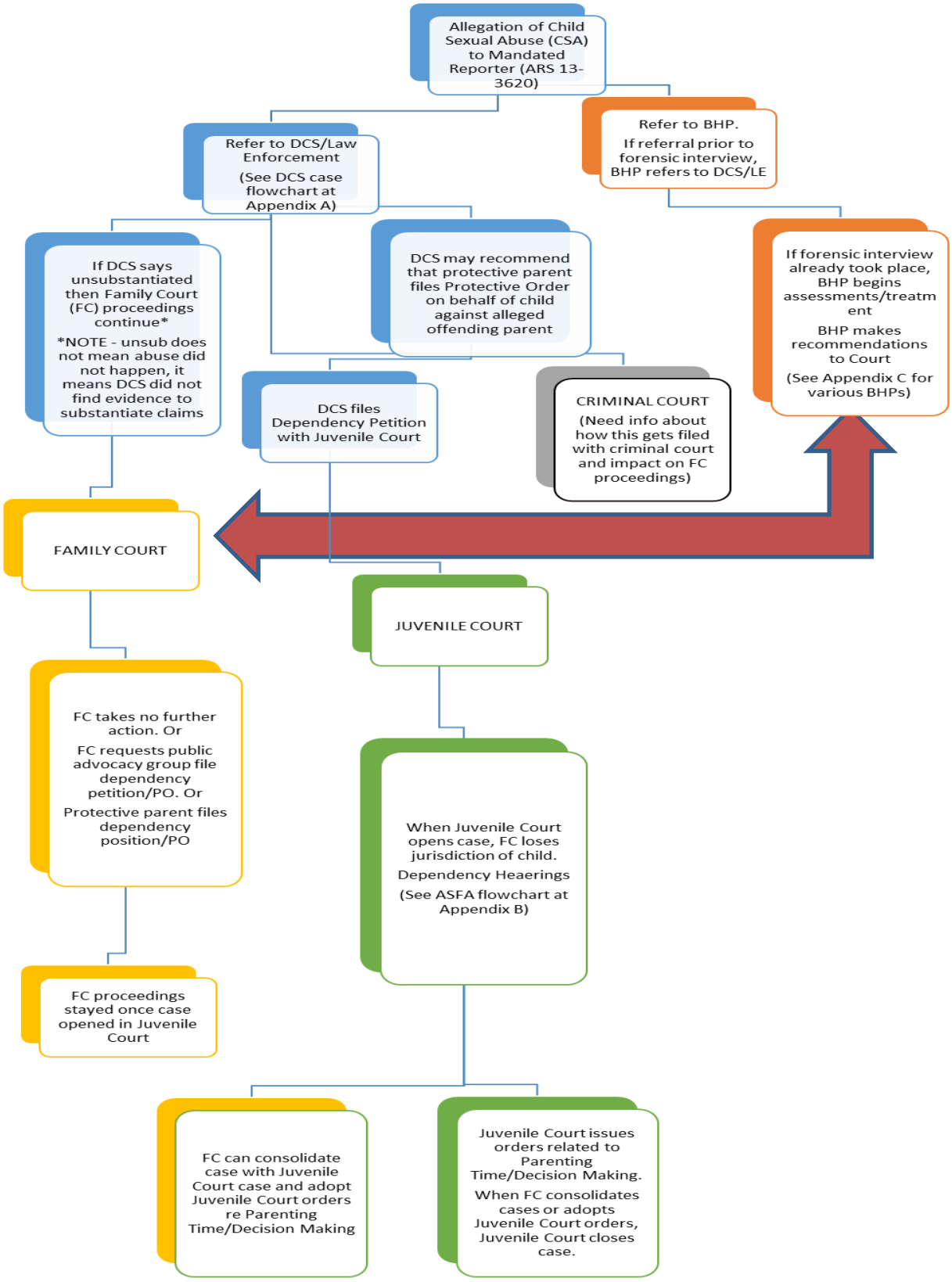
Child Sexual Abuse – Confirmed, Suspected (initial and subsequent encounters) 995.53 (p 718)

Child Neglect 995.52

Child Psychological Abuse 995.51

Child Physical Abuse 995.54

APPENDIX B


Allegation of Child Sexual Abuse (CSA) to Mandated Reporter (ARS 13-3620)
Refer to DCS/Law Enforcement
(See DCS case flowchart at Appendix A)
Refer to BHP.
If referral prior to forensic interview, BHP refers to DCS/LE
If DCS says unsubstantiated then Family Court (FC) proceedings continue*
*NOTE - unsub does not mean abuse did not happen, it means DCS did not find evidence to substantiate claims
DCS may recommend that protective parent files Protective Order on behalf of child against alleged offending parent
If forensic interview already took place, BHP begins assessments/treatment
BHP makes recommendations to Court
(See Appendix C for various BHPs)
DCS files Dependency Petition with Juvenile Court
CRIMINAL COURT
(Need info about how this gets filed with criminal court and impact on FC proceedings)
FAMILY COURT
JUVENILE COURT
FC takes no further action. Or
FC requests public advocacy group file dependency petition/PO. Or
Protective parent files dependency position/PO
When Juvenile Court opens case, FC loses jurisdiction of child.
Dependency Heaerings
(See ASFA flowchart at Appendix B)
FC proceedings stayed once case opened in Juvenile Court
FC can consolidate case with Juvenile Court case and adopt Juvenile Court orders re Parenting Time/Decision Making
Juvenile Court issues orders related to Parenting Time/Decision Making.
When FC consolidates cases or adopts Juvenile Court orders, Juvenile Court closes case.

APPENDIX C

Introduction

When the Court appoints a Behavioral Health Professional ("BHP") to perform a service for the Court, the bench expects the BHP to communicate in writing about:

- If the BHP was appointed on the correct proposed form of Order;
- If the appointment Order contains all the necessary language (*e.g.*, fee split, immunity language, BHP's unique role requirements/duties, due dates, expiration date of BHP's term, and referral questions); and
- If the appointment Order is appointing the BHP to a role that the BHP cannot perform (*e.g.*, there is a conflict for the BHP due to dual roles such as psychotherapist and parent coordinator roles for the same family).

Proposed Form of Order for Child Sexual Abuse Cases:

TEMPORARY ORDERS
LEGAL DECISION-MAKING AND PARENTING TIME

The Evidentiary Hearing in this matter was conducted on_____. During the proceedings, the Court heard from the parties. The Court has since considered the evidence, including the demeanor of the witnesses, reviewed the exhibits as well as the case history, and considered the parties' arguments.

After significant deliberation, the Court makes the following findings and enters the following orders:

LEGAL DECISION-MAKING AND PARENTING TIME

Jurisdictional Findings

THE COURT FINDS that Mother and Father have XX minor ***child/ren*** in common: XXX. The parties and the minor ***child/ren*** have resided in Arizona continuously for at least the six months preceding the filing of the petition for ***child/ren***. This Court, therefore, has jurisdiction as Arizona is the "home state" of the minor ***child/ren***. *See* A.R.S. § 25-1031. Further, this Court has jurisdiction pursuant to A.R.S. § 25-402.

THE COURT FURTHER FINDS that the federal Parental Kidnapping Prevention Act does not apply and that no international law concerning the wrongful abduction or removal of children applies.

Best Interest Findings: A.R.S. § 25-403

A.R.S. § 25-403(A) enumerates specific factors for the Court to consider, among all factors that are relevant to the ***child/ren***'s physical and emotional well-being. The best interest of a child is the primary consideration in awarding legal decision-making authority and parenting time. *Hays v. Gama*, 205 Ariz. 99, 102, ¶ 18, 67 P.3d 695, 698, ¶ 18 (2003). The court further considered A.R.S. §§ 25-103(B) and -403.01.

THE COURT FINDS: (the following are options)

There is an allegation of sexual abuse.
There **is/is not** an ongoing criminal/DCS investigation.
The accused party **lives/does not live** in the ***child/ren***'s home.
There **has been/has not been** a forensic interview of the ***child/ren***.
The allegation of sexual abuse has been **proven/not proven** by a preponderance of the evidence.

LEGAL DECISION-MAKING

Legal decision-making authority, as defined by A.R.S. § 25-401(3), means the legal right and responsibility to make all non-emergency legal decisions for a child, including those regarding education, health care, religious training, and personal care decisions. For the purpose of interpreting or applying any international treaty, federal law, a uniform code, or the statutes of other jurisdictions of the United States, legal decision-making means legal custody.

THE COURT FINDS that based on the above, it is in ***child/ren***'s best interest that ***Mother/Father/Mother and Father*** be awarded ***sole/joint*** legal decision-making authority regarding _____ (born _____).

IT IS THEREFORE ORDERED awarding ***Mother/Father/Mother and Father sole/joint*** legal decision-making authority regarding _____ (born _____).

PARENTING TIME

THE COURT FINDS that allowing ***Mother/Father*** to have unsupervised parenting time with the ***child/ren*** would or could endanger seriously the ***child/ren's*** physical, mental, or moral health or would significantly impair the ***child/ren's*** emotional development because_____.

IT IS THEREFORE ORDERED that parenting time shall be exercised as follows:

The ***child/ren*** shall have **no contact/supervised contact** with alleged abuser/abuser. The supervised parenting time shall be as follows:_____

The parties shall not discuss the allegations nor allow to be discussed the allegations with the ***child/ren***.
The ***child/ren*** shall be interviewed by a forensically-informed behavioral health professional -- OR -- The ***child/ren*** shall be interviewed by a forensic interviewer.

APPENDIX D

Orders of Protection FAQs

Honorable Wendy S. Morton, Commissioner
Superior Court of Arizona in Maricopa County

1. What is an Order of Protection?

An order of protection is another word for a restraining order. It is a "keep away order" that requires the defendant (the person against whom the OOP is requested) to keep away from the Plaintiff (the person who has asked for the Order. Orders of Protection are tools to change or enforce other court orders. They are not custody or parenting time orders. You cannot change parenting time with an Order of Protection.

2. How do I qualify for an Order of Protection (OOP)

In order to qualify for an OOP, two things must be satisfied. There must be a Qualifying Relationship and an act or threat of Domestic Violence.

a. Qualifying Relationship

- A romantic or domestic relationship: (Spouse or former spouse, Resides or resided together, Romantic or sexual relationship now or in past, Pregnant by the defendant or has child in common with defendant
- A Relationship by blood or adoption (parent, grandparent, child, grandchild, brother or sister)
- OR a Relationship by Marriage: (related by marriage parent-in-law, grandparent-in-law, step-child, step-parent, step-grandchild, brother-in-law, sister-in-law)
- Please note that Aunts and Uncles, Nieces and nephews and Cousins do not meet this test unless they had a domestic relationship.

AND

b. Act or Threat of Domestic Violence within the past year (unless there is good cause to consider acts passed one year, *see below*).

Acts of Domestic Violence are defined by A.R.S. 13-3601:

- § 13-604.01 Dangerous crimes against children
- § 13-1201 Endangerment
- § 13-1202 Threatening or intimidating
- § 13-1203 Assault
- § 13-1204 Aggravated assault
- § 13-1302 Custodial interference
- § 13-1303 Unlawful imprisonment
- § 13-1304 Kidnapping
- § 13-1406 Sexual Assault
- § 13-1502 Criminal trespass, third degree
- § 13-1503 Criminal trespass, second degree
- § 13-1504 Criminal trespass, first degree
- § 13-1602 Criminal damage
- § 13-2810 Disobeying a court order
- § 13-2904 Disorderly Conduct
- § 13-2910(A)(8) and (A)(9) Cruelty to Animals
- § 13-2915(A) Prevention of Use of Telephone in an Emergency
- § 13-2916 Use of Telephone to harass
- § 13-2921 Harassment
- § 13-2921.01 Aggravated Harassment
- § 13-2923 Stalking
- § 13-3019 Surreptitious videotaping or filming
- § 13-3601.02 Aggravated Domestic Violence
- § 13-3623 Child or vulnerable adult abuse

Please note that Threats to pursue custody, threats to contact law enforcement, immigration or DCS, property theft, libel or slander <u>are not</u> acts of Domestic Violence.

3. <u>What if the person who needs the order is incapacitated and cannot ask for the order on his/her own?</u>

If a person is either temporarily or permanently unable to request an order, a third party may request an order of protection on behalf of the plaintiff. After the request, the judicial officer shall determine if the third party is an appropriate requesting party for the plaintiff. See <u>A.R.S. § 13-3602(A)</u>.

4. <u>Is there a time-frame that the Court will consider when it comes to acts of Domestic Violence?</u>

Generally, the Court will consider acts of Domestic Violence within the past year, unless good cause is shown under ARS 13-3602(E)(2) to consider acts within a longer period of time. Under the law, time that the defendant has been incarcerated or out of this state shall not be counted.

5. What goes on the Order?

If the Court grants an Order of Protection, the Court will order the Defendant to stay away from you. The Court may order the Defendant to have no contact at all, or, if the parties have children together, the Court may limit the contact to allow for the discussion of parenting issued only.

The Court may order the Defendant to stay away from certain locations to prevent physical contact between the parties. The Court may order the Defendant to stay away from a plaintiff's home or place of employment. The Court will not include foot requirements in Orders of Protection. These are almost impossible to enforce.

6. What does it mean to have an address "protected"?

Having a protected address means that the address is not published on the Order of Protection. This happens when a plaintiff tells the Court that he/she wants to keep the address a secret from the Defendant. If the Defendant already knows where the Plaintiff lives, that address can still be included on the Order of Protection, but it will be printed on the Order of Protection.

7. Can the parties' home be included in the Order of Protection if the parties still live there together?

Yes. If the Court finds that physical harm may otherwise result and therefore, Plaintiff may be granted exclusive use of the residence. It does not matter who pays the bills, is on the lease or owns the home. It does not resolve property issues in dispute between the parties.

8. If the parties have common children, will the children be automatically included on the Order of Protection?

No. No judicial officer has the authority to include a child of the defendant in a protective order unless there is reasonable cause to believe: 1. Physical harm has resulted or may result to the child, or 2. The alleged acts of domestic violence involved the child.

9. Can the Defendant be restricted from possessing a weapon through an Order of Protection?

Yes. The Defendant can be prohibited from possessing a weapon either before or after a hearing on an Order of Protection.

Does the Defendant have the right to contest the issuance of an Order of Protection?

Yes. If the Order of Protection prohibits the Defendant from returning to the home where Defendant lived with the plaintiff, the Defendant has the right to have a hearing set within 5 days of the request. Otherwise, the Defendant has the right to have a hearing within 10 days of the request.

10. Can Animals be included on an Order of Protection?

Yes.

11. What is the difference between the Petition and the Order of Protection?

The Petition is the document that the Plaintiff wrote in order to obtain the OOP. The Petition is not a Court Order and it says so on the face of the document. It is important to read both carefully and to follow the OOP. Only the OOP is a binding court order.

12. What if Defendant contacts me after an OOP has been served?

If Defendant does anything that Plaintiff believes is in violation of the OOP, Plaintiff should contact the law enforcement.

13. Can Orders of Protection be obtained on behalf of juveniles?

Yes. A Parent/guardian should be the named plaintiff where minor is seeking protection

14. Can Orders of Protection be obtained against juveniles?

Yes. If the child is under 12 years old, refer to Juvenile Division of Superior Court. If the child is over 12 years old but under 16, both minor and parent must be served.

15. How are OOPs served?

OOPs must be personally served upon the Defendant. They may be served by law enforcement (law enforcement officer or sheriff's deputy) or by a process server. They may not be sent in the mail, handed to the Defendant by the Plaintiff, handed to the Defendant by a friend or relative or served by attorneys or to attorneys on behalf of a client.

16. The parties are getting divorced. Will my Order of Protection be a part of the family court case?

No. When someone comes in for an OOP, he/she will be assigned to a case number. That case number is not the same as the Family Court case number. By federal mandate, the case will not be consolidated with the Family Court case number.

17. Can a Plaintiff ever change an OOP once it has been issued?

Yes. Plaintiff may come to court and ask for the OOP to be modified. The new order will then have to be served on the Defendant. However, once the Defendant has asked for a hearing, or a hearing has been held, the OOP may not be modified without a hearing on that issue.

18. Can a Plaintiff ever dismiss an OOP once it has been issued?

Yes. Once an OOP has been issued, a Plaintiff must personally appear before a judicial officer to ask for it to be dismissed. This cannot be done in writing.

19. Which rules apply to OOPs? Family Court rules? Criminal Court rules? Juvenile Court rules or Rules of Civil Procedure?

None of the above. Orders of Protection are governed by the Arizona Rules of Protective Order Procedure (ARPOP).

20. What happens if there is a request for hearing?

If there is a request for a hearing, the plaintiff will be notified by Court staff either by phone, email, fax or regular mail, if time permits. Usually phone and email is the quickest type of notice. We must provide a hearing on a quick setting, sometimes as little as 5 days, but most of the time within 10 days. The Court is required to provide reasonable notice, not actual notice. The Court will attempt to contact Plaintiff at the last phone number/email/address on file with the Court. If the phone number is disconnected or if mail boxes are full, the Court will not be able to effectively contact Plaintiff. It is up to Plaintiff to keep updated contact information on file with the Court within the year that the OOP is in place. If Plaintiff fails to do so, he/she may not get notice of a hearing date and the hearing court take place in the Plaintiff's absence. The Plaintiff could lose the protection of the Order if he/she does not appear after reasonable notice.

21. What happens at hearing?

At hearing, the Court will take evidence from both parties regarding the allegations on the Order of Protection. The Court may consider documents, such as photographs, law enforcement or DCS reports, medical documents, emails, text messages, etc. All documents stored electronically should be printed in a hard copy form as the Court may not take cell phones or digital cameras into evidence. If the parties bring witnesses to court, the Court may hear from witnesses other that Plaintiff and Defendant. *The parties should never bring children to court.

After the presentation of the evidence, the Court will determine if the Plaintiff has sustained the burden of proof to keep the Order of Protection in place. The Order may be affirmed (kept in place), modified (changed) or dismissed (dropped) depending on the outcome of the hearing.

22. When can family court judge modify order of protection?

If the defendant has requested and received a hearing on the order of protection, the family court judge cannot modify the order. If there has not been a hearing and resulting order, the family court judge may modify the order.

APPENDIX E

Resources and How to Obtain Copies of Forensic Interview Reports

All forensic interview records are held by the agency that employs the interviewer. It does not matter where the interview took place. The records are held by the agency that employs the detective/interviewer. (Note: Names were correct as of November 2016 and are subject to change as personnel changes occur.)

Phoenix Children's Hospital:
Attn: ROI
1919 Thomas Road
Phoenix, AZ 85016
Phone: (602) 933-1490, option 1
Fax: (602) 933-1477
Email: HIMRecordRequests@phoenixchildrens.com

Interviewers: Amy Hile and Wendy Dutton

ChildHelp Children's Advocacy Center:
2120 North Central Avenue, Suite 130, Phoenix, AZ 85004
Telephone: (602) 271-4500
Administrative Director: Maureen
Clinical Director: Kristi Murphy
Email: Gabby Ghan to request records
gghan@childhelp.org

Interviewers: Jennifer Ingalls and Drew Kaplin

Phoenix Law Enforcement Department/Maricopa County:
1717 East Grant Street, Suite 100, Phoenix, AZ 85034
Phone: (602) 534-1127

Any Detective Employed by Phoenix Law Enforcement Department/Maricopa County

Independent Contractors: Chris Schoepen, Adriana Frias, Aaron Engelbeck

Department of Child Safety
Attn: Ruben Ruiz
1812 West Monroe Street
Phoenix, AZ 85005
Telephone: (602)364-4319
E-Mail: DCSRecordsRequest@azdes.gov

Glendale Law Enforcement Department
Attn: Records Division
6835 N 57th Drive
Glendale, AZ 85301-2599
Telephone: (623) 930-3100

Peoria Law Enforcement Records
8351 W. Cinnabar Ave
Peoria, AZ 85345
Telephone: (623) 773-7098
E-Mail: records@peoriaaz.gov

APPENDIX F

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APPENDIX I

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