INDICATOR LISTS

In the 1980s and early 1990s there have been lists of behaviors circulating in legal circles, mental health meetings, medical conferences, etc. None of the behaviors on any of these lists were empirically/scientifically validated at that time and can be found in the general population. In the middle and latter 1990s the researchers found that these behaviors are widespread with the abused and non-abused and overlap to such an extent that they cannot be used diagnostically (Kendall-Tackett and Friederich).

The correct answer to each question should be "Yes" unless otherwise indicated.

1. Is it your belief/opinion that the behavioral indicators you relied on in arriving at your opinion in this matter are, in fact, reliable (accurate) and diagnostic indicators of sexually abused children?
2. If these indicators are reliable (accurate) indicators of sexually abused children, then can we expect that two or more mental health professionals – independently evaluating the same child – would reach the same conclusions using these indicators?
3. If two or more mental health professionals independently evaluate the same child and reach the same conclusion, does that demonstrate inter-rater reliability?
4. In your opinion this list of behavioral indicators is reliable (accurate), is it true that you cannot cite any empirical/scientific evidence published in a legitimate, peer reviewed journal demonstrating their inter-rater reliability?
5. In other words, this court can only rely on your unsubstantiated opinions regarding the reliability of these indicators. Correct?
6. Would you please tell the court what the difference is between diagnostic **sensitivity** and diagnostic **specificity**? [**Sensitivity** (also called the *true positive rate*) measures the proportion of actual positives which are correctly identified as such (e.g. the percentage of sick people who are correctly identified as having the condition). **Specificity** measures the proportion of negatives which are correctly identified as such (e.g. the percentage of healthy people who are correctly identified as not having the condition, sometimes called the *true negative rate*). These two measures are closely related to the concepts of type I and type II errors. A perfect predictor would be described as 100% sensitive (i.e. predicting all people from the sick group as sick) and 100% specific (i.e. not predicting anyone from the healthy group as sick).
7. Would you agree that applied to this case, a) diagnostic sensitivity refers to how accurately an indicator identifies children who have been sexually abused? B) Diagnostic specificity refers to how accurately an indicator identifies children who have not been sexually abused?
8. In arriving at your opinions in this matter, I assume you were very concerned with considerations of diagnostic sensitivity. Isn't it true that these indicators do not clearly indicate and differentiate between the abused and not abused?
9. In arriving at your opinions in this matter, did you even think about considerations of diagnostic specificity, that is, do these indicators accurately identify children who have not been sexually abused?
10. Is it true that indicator lists have been designed for the express purpose of ruling in allegations of sexual abuse?
11. Is it true that indicator lists do not allow a mental health expert to rule out such allegations?
12. Is it true that there is no empirical/scientific evidence published in a legitimate, peer reviewed journal reporting the diagnostic sensitivity and diagnostic sensitivity of these indicators? (Note no evidence exists as of this time)
13. Would you agree that it is absolutely ill advised for any mental health professional to rely on indicator lists when testifying under oath in a legal proceeding?

14. Once again, then, this court can only rely on your unsubstantiated opinions regarding the diagnostic sensitivity and diagnostic specificity of the indicators. Correct?
15. Are you stating that you are using an indicator list(s) that is not accepted by the relevant professional community?
16. If your thinking in this case responded more to considerations of diagnostic sensitivity rather than diagnostic specificity, could that be because of a systematic/pervasive/persistent bias on your part? (Note: forces admission of bias)

Note: Indicator lists have been used previous to research. In 1985, the American Medical Association published a list claiming to identify children who have been sexually abused. The various behavioral indicators have not been scientifically supported. The list includes:

Become withdrawn and daydream excessively
Evidence poor peer relationships
Express general feelings of shame or guilt
Display a positive relationship toward the offender
Display regressive behavior
Display enuresis and/or encopresis
Engage in excessive masturbation, etc.

Other lists contain items such as: overly compliant behavior, acting-out aggressive behavior, pseudo-mature behavior, arriving early at school or leaving late with few, if any, absences, inability to concentrate at school, sudden drop in school performance, etc (Sgroi, S.M., 1982, Handbook of Clinical Intervention in Child Sexual Abuse, Lexington, MA: Lexington Books)

2nd Note: Diagnostic sensitivity refers to how accurately an indicator identifies a population exhibits some characteristic of such as sexual abuse. Diagnostic specificity refers to how accurately an indicator identifies the population that does not exhibit that characteristic. In other words:

Diagnostic sensitivity: “Can this indicator rule in sexual abuse?”
Diagnostic specificity: “Can this indicator rule out sexual abuse?”

Berliner & Conte (1983) from Kuehnle (p-159) “…fundamentally, there is little, if any, empirically based evidence that the criteria discriminate sexually abused from non-sexually abused children”.

Tests/Scales/Projective Tests/Drawings

(Kathyrn Kuehnle and Mary Connell: The Evaluation of Child Sexual Abuse Allegations: A Comprehensive Guide to Assessment and Testimony, 2008)

There are no psychological tests or psychological profiles that can determine who has been abused or who is the abuser. The term "valid" means the test tests what it is purported to test (ex: intelligence tests are used to test intelligence and not personality). The term "reliability" means the accuracy of a test. "Inter-rater reliability" means that two or more evaluators may agree or disagree on the interpretation of the instrument/results.

1. Is it true that assessment tools/instruments that have reliability in differentiating the sexually abused from the non-sexually abused do not exist? (p 223).
2. Would it be fair to say that the evaluator should derive information from multiple sources of data? (p 223)
3. Are objective tests, behavior rating scales or projective tests sometimes used in evaluations? (p 223)
4. Is it true that all of the tests/instruments should be reliable? That is, to yield accurate and consistent results? Between different evaluators? (p 223)
5. Is it also true that all of the tests/instruments should be valid? That it measures what it is supposed to measure? Like reading achievement? Like intelligence? Like spelling? Like personality status? (p 223-224)
6. Is it true that the reliability and validity of a test/instrument are critical factors when using this kind of information to develop a more comprehensive understanding of a child? (p 224)
7. Would it be fair to say that if an assessment instrument does not have adequate psychometric properties (reliability and validity), the information from this instrument would be suspect? Simply should not be used? Should not ever be presented in a court of law? (p 224)
8. Would it be fair to say that professionals who base their conclusions on data from assessment tools that are not reliable and valid are at a higher risk to make false positive and false negative errors? Are at a higher risk to simply be in error? (p 224)
9. Is it true that behavior rating scales (Burks' Behavior Rating Scales, Child Behavior Checklist, Louisville Behavior Checklist, Personality Inventory for Children, etc.) may be useful in identifying the presence of emotional and behavioral problems, but lack specificity and sensitivity regarding markers/symptoms of sexual abuse? (pp 226-227)
10. Would you agree that no test should be relied on in isolation as a primary indicator of sexual abuse? In the light of reliability/validity factors? Also in the light of sensitivity? Specificity? (p 232)
11. Is it true that these instruments (behavior rating scales) do not have predictive diagnostic ability? (p 235)
12. Should all assessment instruments be cautiously interpreted with the larger context of a full forensic evaluation? (p 235)
13. Is it true that picture tests, drawings and artwork do not have empirically/research/evidenced based quantitative scoring symptoms? Making them not reliable and not valid? (p 237)
14. Is it true that techniques such as pictures, drawings and artwork cannot be used for diagnostic purposes to determine if an individual has been abused or not abused? (p 237)
15. Is it a fact that the use of these instruments is strongly discouraged given the absence of reliability and validity data? (p 237)
16. Is it true that different evaluators may interpret picture tests/drawings/art work differently? That one evaluator may see "personality problems" and then another evaluator may not? (p 244)
17. Is it true that when interpreting drawings/art work that the evaluator must rely on intuition? Analytic skill? Not science? (p 244)

18. Would it be fair to say that the "results" of these non-standardized instruments typically be confounded with the skill level/training of the evaluator using these instruments, according to Anastasia, 1998? (p 244)
19. Is it true that research does not support the assumption that qualitative differences between the sexually abused and the non-sexually abused exist? (p 245)
20. Is it also a fact that scientific research does not have strong data to support that genitalia drawn on human figures is a marker of sexual abuse? (245)
21. Is it a fact that scientific research does not support the use of children's drawings as a tool to diagnose child sexual abuse? (p 245)
22. Is it a fact that research does not support that the drawings of sexually abused children will differ from non-sexually abused children on the presence of specific qualitative features? (p 253)
23. Simply, would it be fair to say that over-interpretation of children's behaviors/test results/artwork/drawings can lead to faulty conclusions? (p297)

Additional source: Smoke and Mirrors by Terrence Campbell

Behaviors

Behaviors cannot be used as diagnostic indicators of abuse. Behaviors are specific, observable and countable (tabulated) such as punching, tardiness, crying, etc. Terms such as "anxiety" are non-specific, too suggestive, judgment calls, vague and not directly observable.

1. Is it true that there are no behaviors exhibited by children that are "consistent" with sexual abuse? "Diagnostic" of sexual abuse?
2. Is it also true that many of the supposed behaviors associated with sexual abuse (fighting, sleeplessness, separation anxiety, aversion to certain foods, bad temper, bed wetting, etc.) are commonplace in childhood? With the abused and non-abused?
3. Is it also true that signs of "hypersexual behavior" are no proof of actual sexual abuse?
4. Is it true that "hypersexual behavior" signs are often exhibited after the investigators had arrived? After parents and investigators had subjected the child to days of talk about bad touching? About genitals? About pee-pees? And people pulling their pants down? Watching television? Watching movies with violence? Watching movies with explicit sexual subjects? Playing video games?
5. Would it surprise you that children immersed in any of these activities might show signs of increased sexual awareness? (Let them answer either yes or no)
6. Would you agree that children are also immersed in the sexual world because of television? Magazines? Movies? National events?
7. Would you also agree that counseling or forensic interviewing for sexual abuse may increase a child's sexual awareness? May contaminate the child's memory? May be a form of abuse in itself?
8. Would you agree that it would be unethical to counsel a child for sexual abuse when sexual abuse has not been established? At least questionable ethics?
9. Would you agree that group counseling with children who are known to have been sexually abused might taint/contaminate their memories?
10. Would you agree it would be unethical to subject a child to group counseling with known sexually abused children when sexual abuse of that child has not been established?
11. Would you agree that some children who have not been sexually abused act out sexually?
12. Would you agree that only a minority of sexually abused children exhibit sexual behavior problems?
13. Would it be fair to say that while the presence of sexual behavior may be significant, it is not determinative of abuse?
14. Would you agree that you cannot automatically assume the child was sexually abused because of his/her sexualized behavior(s)?
15. Would you agree that on the issue of sexualized behaviors that there still needs to be additional research?
16. Would it be fair to say that just because there are certain behaviors that are exhibited by a child does not mean automatically that that child was sexually abused?
17. Would you agree with the consensus of research that states that sexualized behaviors can't be used alone to satisfactorily distinguish between sexually abused and non-sexually abused children?