

CERT Topic: **The NICHD Standard**

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Toward a Better Way to Interview Child Victims of Sexual Abuse

Sara Harris, National Institute of Justice (nij.gov). NIJ Journal No. 267, Winter 2010, NCJ 233282

A study tests interview protocols in the hope of getting better case outcomes.

Child protection authorities substantiated 68,000 cases of child sexual abuse in 2008, according to the Department of Health and Human Services.[1] In many child sexual abuse cases, there is no witness other than the child and no corroborating evidence — the entire case can hang on a child's recollection of the alleged abuse. One way to help avoid false accusations and ensure justice in these cases is to strengthen law enforcement's ability to elicit accurate information from children. As the authors of the study discussed in this article note, "The quality of forensic interviewing practices is of utmost importance if child victims are to be protected, at the same time as the rights of the innocent suspects are to be upheld." [2]

We have gained considerable knowledge in the last two decades about child development, memory and cognition, and researchers have developed several techniques for improving the way child victims of sexual abuse are interviewed. One technique that showed promise in a laboratory has now been tested in the field in Utah's criminal justice system. The interview protocol was developed by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD). The NICHD began developing its interview protocol in the 1990s. According to Margaret-Ellen Pipe, a member of the team that has developed and tested the protocol, "In the '80s people started recognizing children could provide reliable evidence. There had been real skepticism prior to that whether you would believe children."

In an NIJ-funded study, a team of researchers led by Pipe investigated how the NICHD protocol might affect prosecution outcomes. Their findings make it clear that the training and NICHD protocol elicit more information from possible victims. The findings cannot, of course, determine whether the information is more accurate — that is, the findings cannot definitively confirm details of what happened. But it is clear that after the protocol was introduced, prosecutors accepted more cases; and more cases that went to trial resulted in conviction than before the protocol was introduced.

The NICHD Protocol

The techniques employed by the NICHD protocol were designed to integrate advances in scientific understanding about memory and children's linguistic and cognitive development.

Over the years, various aspects of the NICHD protocol have been evaluated in the field. In fact, the authors note, the techniques developed under the auspices of the NICHD constitute the only protocol for forensic interviews with children to have been evaluated systematically. "The NICHD protocol has been researched in the field; that's what sets it apart," Pipe said.

Training in forensic interviewing techniques often increases interviewer knowledge without resulting in any meaningful change in how interviewers conduct the interviews.[3] NICHD training is effective in getting interviewers to use the new information learned. Studies testing the protocol have examined how best to train people in its use and, in particular, how to ensure that interviewers reliably acquire and actively use the new skills. Training can raise awareness, Pipe et al. note in their report, but it is important to guarantee that new techniques are adopted as

a matter of practice. The NICHD training model promotes this by providing guidance and feedback for interviewers even after training has concluded.

The NICHD interview protocol includes three phases:

- Introductory
- Rapport-building
- Substantive or free recall

At the beginning of the conversation, the child and the interviewer discuss expectations and set ground rules: this is the introductory phase. Interviewers then ask children to talk about events unrelated to the suspected abuse; the idea is to encourage the child to be comfortable leading the conversation by developing this rapport. In this phase, the "child learns the conversational rules, because they are different from many conversations in which children take part," Pipe explained. Later, interviewers encourage children to recall the target incident and talk about it in a narrative stream, as opposed to answering directed questions about it, one after another. Evidence indicates open-ended prompts draw out more accurate information than ones that simply elicit a child's recognition. The techniques discourage suggestive leads or questions with yes/no or either/or answers: "Where were his clothes?" for example, is preferred over, "Were his clothes on the floor?"

Nearly a decade of research confirms that when interviewers follow the guidelines outlined in the NICHD protocol, children give both more and higher-quality information. Their narrative accounts reveal greater detail when the NICHD protocol is implemented.

How the Study Was Conducted

The study examined the outcomes of cases before and after police detectives were trained on the NICHD Investigative Interview Protocol. The 11 detectives in the study performed forensic interviews at the Salt Lake County Children's Justice Center (CJC), an arm of the Utah Attorney General's Office. They were all experienced in conducting child abuse investigations and child forensic interviews but had never been trained in the NICHD protocol. The detectives' NICHD training took place over several days, included both simulated and actual forensic interviews, and included ongoing contact and feedback from the trainers.

Researchers from the City University of New York, Cambridge University in England, the NICHD and the CJC examined 1,280 sexual abuse cases between 1994 and 2000 that were referred to authorities in Salt Lake County, Utah, and investigated by the 11 detectives. Of the total sample, these detectives conducted 551 interviews before receiving training on the NICHD protocol and 729 after they had implemented the protocol. The same detectives, prosecutors and judges who handled the cases were used throughout the study period.[\[4\]](#)

Among the cases of alleged abuse that the researchers reviewed, nearly 60 percent involved improper touching and 5 percent were characterized by exposure; penetration was alleged in 35 percent of the cases reviewed. Detectives interviewed children between the ages of 2 and 14 and then presented their evidence to the district attorney, who decided whether or not to prosecute.[\[5\]](#)

Impact of Using the Interview Protocol

Researchers compared the outcomes of the cases that used the interview protocol with cases that did not. They found that after local detectives adopted the NICHD interview protocol, the percentage of investigated cases in which the district attorney filed charges rose from 45 percent to over 54 percent. Furthermore, these cases held up as they progressed through the system.

Although the number of cases that went to trial was small — 30 of a total of 513 cases in which charges were filed — 94 percent of those prosecuted after implementation of the NICHD protocol resulted in conviction (16 of 17 cases), compared with 54 percent before its introduction (7 of 13 cases). In the majority of cases, both before and after the NICHD protocol was implemented, a plea agreement was reached. Of those, 81 percent led to a guilty plea on one or more charges. See Table 1 for more details on case outcome.

Table 1. Case Outcome by Interview Type

	Pre-Protocol	Protocol
Total	551	729
Cases accepted for prosecution	198 (35.9%)	315 (43.2%)
Cases with plea agreements	160 (80.8%)	255 (81%)
 Pled guilty	105 (53%)	177 (56.2%)
 Reduced	52 (26.3%)	76 (24.1%)
Cases with charges dismissed	15 (7.5%)	36 (11.4%)
Cases that went to trial	13 (6.6%)	17 (5.4%)
 Not guilty verdict	6 (3%)	1 (0.3%)
 Guilty verdict	7 (3.5%)	16 (5.1%)

(Cases that were diverted or were active/had no outcome information available were omitted from this table.)

While the percentage of cases in which charges were filed increased for three of the four age groups after the protocol was implemented, the impact of the protocol was strongest in cases in which the children were between 7 and 9 years old. This age group accounted for approximately 26 percent of the pre-protocol and post-protocol samples (135 and 167 cases respectively). For children in this age group, the rate at which prosecutors filed charges rose from 42 percent before to 64 percent after detectives were trained.

Given the nature of testing an interview protocol in the field, results like those in this study cannot definitively determine whether or not a protocol elicits more complete or accurate information from children; there is usually no way for researchers to know with absolute certainty if the alleged sexual abuse occurred.

Previous studies have established that use of the NICHD protocol increases the amount of information children reported with little or no interviewer input, a core feature of the NICHD protocol. There is a significant body of research demonstrating that interview techniques emphasizing the use of open-ended prompts and other methods that encourage a child's free recall elicit more accurate details than more focused prompts — ultimately, the kind of details on which investigators build their case. These techniques have proven effective at getting better information from preschoolers, elementary school children and teenagers alike. The evidence-based nature of the NICHD protocol lends credence to the researchers' assertion that, when employed by well-trained interviewers, the protocol likely improves the detail and accuracy of information elicited from children in most age groups during forensic interviews and positively affects case outcome.

Notes

[1] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment 2008* (pdf, 182 pages), Washington, DC: U.S. Government Printing Office, 2010.

[2] Pipe, M., Y. Orbach, M.Lamb, C. Abbott, and H. Stewart, *Do Best Practice Interviews with Child Sexual Abuse Victims Influence Case Outcomes?* (pdf, 123 pages), Final report for the National Institute of Justice, Washington, DC: National Institute of Justice, November 2008, NCJ 224524.

[3] Lamb, M., Y. Orbach, I. Hershkowitz, P. Esplin, and D. Horowitz, "Structured Forensic Interview Protocols Improve the Quality and Informativeness of Investigative Interviews with Children: A Review of Research Using the NICHD Investigative Interview Protocol," *Child Abuse & Neglect* 31 (2007): 1201-1231.

[4] The judges and prosecutors were likely aware that the detectives received new training on a forensic interview protocol.

[5] The study divided the children into four age groups: 2- to 4-year-olds; 5- to 6-year-olds; 7- to 9-year-olds; and 10- to 13-year-olds. The youngest child in the study was 2.80 years old; the oldest was 13.97 years old.

Research on NICHD

Assessing the value of structured protocols for forensic interviews of alleged child abuse victims.

Orbach, Yael, Hershkowitz, Irit, Lamb, Michael E., Esplin, Phillip W., Horowitz, Dvora. *Child Abuse & Neglect*, Vol 24(6), Jun, 2000. pp. 733-752.

Abstract:

Examined the effectiveness of the National Institute of Child Health and Human Development (NICHD) investigative protocol, a flexibly structured protocol incorporating a wide range of strategies believed to enhance retrieval with child witnesses. Six forensic investigators were trained to use the NICHD protocol while conducting feedback-monitored simulation interviews. The protocol's was evaluated by comparing 55 protocol interviews (PRIs) with 50 prior interviews by the same investigators, matched with respect to characteristics likely to affect the richness of the children's accounts. The comparison was based on analysis of investigators' utterance types, distribution, and timing, and quantitative and qualitative characteristics of information produced. PRIs contained more open-ended prompts than non-PRIs did. More details were obtained using open-ended invitations and fewer were obtained using focused questions in PRIs than in non-PRIs, although total number of details elicited did not differ significantly. In both conditions, older children provided more details than younger children did.

A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: A review of research using the NICHD Investigative Interview Protocol.

Lamb, Michael E., Orbach, Yael, Hershkowitz, Irit, Esplin, Phillip W., Horowitz, Dvora, *Child Abuse & Neglect*, Vol 31(11-12), Nov, 2007. pp. 1201-1231.

Abstract:

Objective: To show how the results of research on children's memory, communicative skills, social knowledge, and social tendencies can be translated into guidelines that improve the quality of forensic interviews of children. Method: We review studies designed to evaluate children's capacities as witnesses, explain the development of the structured NICHD Investigative Interview Protocol, and discuss studies designed to assess whether use of the Protocol enhances the quality of investigative interviews. Results: Controlled studies have repeatedly shown that the quality of interviewing reliably and dramatically improves when interviewers employ the NICHD Protocol. No other technique has been proven to be similarly effective. Conclusions: Use of the structured NICHD Protocol improves the quality of information obtained from alleged victims by investigators, thereby increasing the likelihood that interventions will be appropriate.

Review of 'A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: A review of research using the NICHD Investigative Interview Protocol'.

American Journal of Family Therapy, Vol 36(4), Jul-Sep, 2008. pp. 346-347.

Abstract:

Reviews the article, A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: A review of research using the NICHD Investigative Interview Protocol by M. E. Lamb, Y. Orbach, I. Hershkowitz, P. W. Esplin, and D. Horowitz (see record 2007-18380-006). This review paper aims to, "show how the results of research on children's memory, communicative skills, social knowledge, and social tendencies can be translated into guidelines that improve the quality of forensic interviews of children." The other primary purpose of the article was to describe and report on the utility of a new interview tool and training materials that were designed specifically with this research in mind. In reviewing the current knowledge base, the authors state that the most important issue is the, "interviewer's ability to elicit information and the child's willingness and ability to express it, rather than the child's ability to remember it." The paper also presents a summary of a series of studies conducted nationally and internationally in which the NICHD protocol was used.

Re: The development of forensic interview training models: A reply to Lamb, Orbach, Hershkowitz, Esplin, and Horowitz (2007).

Vieth, Victor, Child Abuse & Neglect, Vol 32(11), Nov, 2008. pp. 1003-1006.

Abstract:

Comments on an article by M.E. Lamb et al. (see record 2007-18380-006). The article contains several statements about the NICHD as well as the Finding Words forensic interviewing models that warrant clarification or elaboration. The authors properly note that the most effective forms of forensic interview training programs are those that "provide continued support, guidance, and feedback on interviewer behavior in interviews conducted after starting to use the Protocol." However, the authors incorrectly assert that "only the NICHD training model includes feedback beyond the training period (i.e. in post-training investigative interviews as well)." The authors contend it is "well-established" that the NICHD protocol elicits "accounts that are more likely to be accurate and less likely to be challenged in court." The authors, however, do not provide any evidence that the NICHD protocol has met the rigorous legal standards for its admissibility in a court of law or that investigators using the model have been qualified as experts in a court of law on forensic interviewing issues. The authors' claim that drawings and dolls are "potentially risky tools," ignores the fact that the vast majority of research supports the usage of these tools provided they are properly used. Moreover, these tools are widely accepted in court. The authors recognize that NICHD is not a "panacea" and that more research needs to be done to assess whether the protocol assists in finding corroborating evidence and how it can be modified to address "special circumstances."

Authors' response to Vieth (2008): Legal and psychological support for the NICHD interviewing protocol.

Lyon, Thomas D., Lamb, Michael E., Myers, John, Child Abuse & Neglect, Vol 33(2), Feb, 2009. pp. 71-74.

Abstract:

Reply by the current authors to the comments made by Victor Vieth (see record 2008-17415-002) on the original article (see record 2007-18380-006). Vieth agreed with Lamb and colleagues that there is a "substantial degree of consensus regarding the ways in which investigative interviews should be conducted". It is indeed well accepted that interviewers should "introduce as little information as possible while encouraging children to provide as much information as possible in the form of narratives elicited using open-ended prompts ('Tell me what happened.')." Research has shown that among children disclosing abuse, "responses to individual free-recall prompts are three to five times more informative than responses to more focused prompts". Vieth did not question this research. Also, Vieth did not question the well-replicated finding that interviewers trained to use the NICHD Protocol use more open-ended prompts and reduce their use of more risky question-types, risky because they elicit less accurate information. He also agreed that improving the quality of forensic interviewing requires "continued support, guidance, and feedback on interviewer behavior", pointing to ways in which the Finding Words program encourages peer review of interviews.

INDICATOR LISTS

Beginning 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 specificity 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

(Kathryn 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?