Categorization of Abuse Criteria by Expert Ratings and the Elusive Diagnosis of Abuse

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Abstract

There are several indicators that assist in the identification of child victims of sexual abuse, such as medical evidence, precocious sexual behavior, and emotional distress. In this article, expert ratings were used to investigate how these indicators group together to form different presentations of child victims of sexual abuse. Independent analysis of sexual-abuse indicators produced eight factors. An analysis of variance (ANOVA) and a post-hoc Tukey's Test revealed that no one factor, or group of abuse indicators, was optimal for describing the presentation of an actual victim of abuse according to experts. This finding suggests there is no prototypic presentation of a victim of abuse, which is helpful in a forensic context when a finding of abuse is challenged based on a child's presentation.

Keywords: child sexual abuse, assessment, diagnosis, forensic, testimony

It is currently understood that the impact of child abuse and maltreatment includes, but is not limited to, emotional, somatic, social, and academic sequeli (Friedrich, 2002). A clinician's ability to organize and communicate commonly observed presentations that are characteristic of victims of abuse is important for the development of effective treatments, recommendations, and court testimony regarding harm. There are conceptual frameworks that help in this regard, but there are no diagnostic systems to clinically identify child victims of sexual abuse. The conspicuous absence of such research suggests that child abuse and maltreatment clinicians do not believe that there is a prototypic clinical presentation of a victim of abuse or that child abuse is diagnosable. As a result, abuse professionals have had little to rely upon when their findings of abuse are challenged based on the clinical presentation of a child victim. The current study sought

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out to address this gap in the research by improving upon past conceptual frameworks that have organized abuse indicators, and by exploring if any group of indicators is clinically prototypic of a victim of abuse.

Multiple researchers have developed models for validating children's disclosures of abuse (Faller, 2007; Heiman, 1992, Raskin & Esplin, 1991). As one would predict, considering the heterogeneity amongst victims' experiences and presentations, these models are as diverse as the presentations of child abuse and maltreatment are themselves. Raskin and Esplin (1991) published content criteria for analysis of children's disclosures of sexual abuse. Their criteria included, but were not limited to, General Characteristics, such as amount of details, and Specific Contents, such as unusual details, as well as the child's subjective experience. Raskin and Esplin (1991) additionally identified psychological indicators to assess the veracity of children's disclosures. However, Raskin and Esplin's (1991) system was not intended to provide the breadth of psychological characteristics that mental-health evaluators require to communicate their findings for clinical purposes, beyond capturing the veracity of a disclosure.

Similar to Raskin and Esplin (1991), Heiman (1992) conducted a thorough literature review of studies that investigated indicators of truthfulness in children's disclosures of sexual abuse. Some of the research cited by Heiman (1992) include Corwin (1990); De Young (1986); Sgroi, Porter, & Blick (1982); Summit (1983); and Witt (1990). Heiman (1992) organized criteria indicative of truthfulness into a conceptual framework that included "history of symptoms," "verbal report," "phenomenological experience," "presentational style," and "corroborating evidence" (Heiman, 1992, p. 313). Unlike similar studies (e.g., Raskin & Esplin, 1991), Heiman's (1992) conceptual framework provided the breadth of psychological characteristics that mental-health evaluators require to clinically communicate child sexual-abuse presentations beyond merely capturing the veracity of a disclosure.

For example, Heiman's (1992) "history of symptoms" (p.313), includes criteria such as withdrawal, aggression, sleep disturbance, and dissociation. The criteria for "verbal report" (p.313), includes explicit sexual details and reports of bribes or rewards. "Phenomenological experience" (p.313), includes criteria such as a sense of betrayal, feelings of entrapment, a sense of shame, guilt or fear, or feelings of powerlessness/helplessness. "Presentational style" (p.313), includes criteria similar to Raskin and Esplin's (1991) system, such as consistency, change in affect, and attempts to minimize or avoid during the disclosure. Finally, criteria for "corroborating evidence" (p.313), includes medical evidence and other victims' and witness' statements.

The criteria identified in Heiman's (1992) study provide the necessary breadth to quantitatively explore if they load into meaningful groups or clinical presentations of child victims according to abuse professionals. The current investigation explored how Heiman's (1992) criteria statistically combined into different clinical presentations characteristic of actual victims of sexual abuse according to abuse professionals. This process of variable reduction by consolidating the sexual-abuse criteria into meaningful groups can improve the communication of findings in child-abuse evaluations; however,

even more, it allows for post-hoc analysis of the child-abuse profession's sentiment regarding the diagnosis of abuse.

It was anticipated that factor analysis of the criteria would produce several possible sexual-abuse presentations, with no particular factor being more prototypic of sexual abuse, or optimal for describing the presentation of an actual victim of abuse. It was hypothesized that none of the statistically derived sexual-abuse presentations would significantly differ from all of the other abuse presentations. In other words, it was predicted that no single factor (group of abuse indicators) would be optimal for describing the presentation of an actual victim of abuse. Rather, it is predicted that each factor will contribute to a comprehensive view of the way victims of sexual abuse present, with no one factor emerging as characteristic of all victims.

Methods

Recruitment for the study began after approval by the Hackensack University Medical Center Internal Review Board. Participants were recruited from four groups of abuse professionals. The groups include: 1) practitioners from the four New Jersey Regional Diagnostic and Treatment Centers (NJ – RDTC) who are specifically trained in the assessment and treatment of children who have been sexually and/or physically abused; 2) professionals in the field of child abuse who were in attendance at "When Words Matter," which is a national conference for professionals, most of whom have completed Child First/Finding Words; 3) graduates of the Child First/Finding Words – New Jersey (CF/FW – NJ), which is a national forensic interview training program; and 4) members of the American Professional Society on the Abuse of Children – New Jersey (APSAC – NJ), which is a state chapter of a national organization that supports professionals working in the field of child sexual abuse and maltreatment.

Data were administered via online and paper survey to professionals in the field of child sexual abuse and maltreatment. Employees of the NJ – RDTC's, professionals who completed CF/FW – NJ prior to June 2009, and members of APSAC – NJ completed the online survey. Those who completed the online survey were emailed instructions and a personalized link in order to complete the Internet-based questionnaire through Survey Gizmo. Online acknowledgement of their consent was required before they were able to proceed to the survey. Professionals who attended the "When Words Matter" conference and participants of the June 2009 CF/FW – NJ training were administered the paper survey. These professionals acknowledged their consent by signing the required consent form prior to their participation. The online administration group completed a survey containing criteria of sexual and physical abuse. The paper and pencil administration group only completed the sexual-abuse portion of the survey because of its relevance to the training program. The online and paper formats were identical with regard to content. For the purpose of this study, only the sexual-abuse items were analyzed.

The questionnaire included demographic data, job title, educational degree, work setting, and 48 indicators of sexual abuse derived from Heiman's (1992) criteria. Specifi-

cally, the questionnaire was developed by listing Heiman's (1992) criteria in the order she presented them. In the header above the criteria, participants were asked to rate how characteristic the indicators were of an actual victim of sexual abuse by selecting "none, some, quite a bit, a large amount, and completely." Completion time for the questionnaires was approximately 10 to 15 minutes. Participation was anonymous and voluntary for all respondents. Date of birth was requested from participants to match survey responses with any potential future waves of data collection.

Results

There were 70 online and 59 paper and pencil respondents. The entire sample of 129 professionals completed the sexual-abuse questionnaire items. Table 1 summarizes the demographic data. Participants who endorsed "other" for occupation (n=14) included art therapists, victim-witness advocates, investigators, and researchers. All students included in the study were either Masters or Doctoral level externs or interns with specific training and clinical experience in child sexual abuse. The current study used factor analysis to reduce the number of variables and to categorize criteria by how demonstrative they were of actual abuse according to abuse professionals. Subsequently, analysis of variance (ANOVA) and post-hoc Tukey tests were used to explore which, if any, categories of criteria were more characteristic of the presentation of an actual victim of abuse according to abuse professionals. All questionnaires were completed in their entirety and were used in the factor analysis (N=129). Correlations for sexual-abuse criteria were all higher than $r = .40$.

Table 1

Demographic Characteristics

	Sexual abuse Responses	
	N	%
Total	129	100.0
Mean age (SD)	41.8 (11.8)	
Gender		
Female	96	74.4
Male	33	25.6
Race/ethnicity		
African-American	9	7.0
Hispanic	10	7.8
Caucasian	109	84.5
Asian/Pacific Islander	1	0.8
Marital Status		
Single	32	24.8
Married	74	57.4
Separated	5	3.9
Divorced	17	13.2
Widowed	1	0.8

Job Title			
Mental Health Clinicians	41		31.8
Forensic Interviewer	21		16.3
Police Officer	10		7.8
Lawyer	10		7.8
Child Protection Worker	15		11.6
Medical Professionals	13		10.1
Student	5		3.9
Other	14		10.9
Mean years of experience in field (SD)		11.4 (9.7)	
Theoretical Orientation			
Cognitive Behavioral	17		24.3
Psychodynamic	8		11.4
Systems	6		8.6
Interpersonal	3		4.3
Integrative	4		5.7
Eclectic	12		17.1
Not Applicable	13		18.6
Other	7		10.0
Work Setting			
Private Practice	8		6.2
Regional Diagnostic & Treatment Center for Abuse	30		23.3
Child Advocacy Center	35		27.1
Hospital	4		3.1
Law Enforcement	13		10.1
School	2		1.6
Legal/Government	13		10.1
Child Protective Services	9		7.0
Other	15		11.6

The criteria were factor analyzed using the maximum-likelihood method and a varimax rotation. Using this method, if maximum-likelihood factors are extracted, Chi-square tests are used to determine the significance of residuals after the extraction of the given factor(s). The null in this case would be that none of the common factors significantly ($p < .05$) explains the inter-correlations among the variables. A non-significant value for this statistic would suggest that inter-correlations are not strong enough to warrant performing a factor analysis. In the current study, eight factors emerged for the sexual-abuse analyses, which were then compared to a screen plot to see how they differed. Each factor explained between 32% and 55.9% of their respective criteria's variability in how demonstrative each was of sexual abuse according to professionals (see Table 2).

Table 2

Factor Loadings for Sexual-Abuse Criteria and Latent-Factor Correlations

Criteria	F1	F2	F3	F4	F5	F6	F7	F8
Reported contextual details of abuse scenario	.74							
Reports being subjected to a progression of abusive activities	.69							
Reported affective details of abuse scenario	.68							
Description of engagement process/grooming	.66							
Description of distinguishing or idiosyncratic details	.64							
Report of sexual details that exceed the child's developmental level	.63							
Reports of threats, coercion, or pressure	.59							
Multiple modes of describing the abuse (i.e., dolls, drawings, play)	.55							
Other victims have reported abuse by alleged perpetrator	.54							
A sense of shame		.87						
A sense of guilt		.77						
Feelings of being damaged or different		.65						
Feelings of powerlessness/ helplessness		.59						
A sense of fear		.51						
A sense of betrayal		.50						
Aggression			.72					
Sleep disturbance/nightmares			.69					
Withdrawal			.66					
Dissociation			.56					
Child does not appear to be easily suggestible during disclosure				.63				
Disclosure of abuse provided in the first person				.63				

Criteria	F1	F2	F3	F4	F5	F6	F7	F8
Reports of disclosing to others				.58				
Child provided a consistent disclosure of abuse scenario				.54				
Reported abuse scenario in a varied and rich manner opposed to a rehearsed litany				.51				
Child's verbal report included sexual details				.49				
Family dynamics including power imbalances					.79			
Family dynamics including role reversal					.55			
Medical evidence of abuse						.87		
Available witness statements						.80		
Other victims have reported abuse by alleged perpetrator						.53		
Unusual emotional associations to sexual activities							.82	
Inappropriate or precocious sexual behavior							.59	
Feelings of entrapment/ accommodation								.57
% Variance Explained	40.94	43.98	43.81	32.16	46.57	55.90	60.96	32.00

For the sexual-abuse analyses, Factor 1 was labeled Idiosyncratic Details (9 items). Factor 2 was labeled Depressogenic Beliefs (6 items). Factor 3 was labeled Post-traumatic Response (4 items). Factor 4 was labeled Naturalistic Disclosures (6 items). Factor 5 was labeled Family Dysfunction (2 items). Factor 6 was labeled Corroborated Disclosures (3 items). Factor 7 was labeled Sexual Reactivity (2 items). Factor 8 was labeled Entrapment (1 item). The correspondence of the factors with Heiman's (1992) conceptual framework demonstrates support for the resulting factor pattern. Reduction of the criteria allowed for between group comparisons to explore which, if any, categories of sexual-abuse criteria were more prototypic than other presentations of actual victims of abuse. A one-way ANOVA indicated there were significant differences in the ratings of how demonstrative each factor was of actual sexual abuse (F (2,25) = 4.53, $p < .0022$).

Tukey's Honestly Significant Differences (HSD) analyses were conducted to identify the categories of abuse criteria with significantly different mean ratings of how demonstrative they were of actual abuse while controlling for experimental-wise Type 1 error. When the means were compared, Factor 6 (Corroborated Disclosures) was found to be significantly ($p<.05$) less characteristic of an actual victim of abuse than Factor 1 (Idiosyncratic Details); Factor 2 (Depressogenic Beliefs); and Factor 4 (Naturalistic Disclosures) (see Table 3). However, after comparing the mean scores for each of the categories, no individual factor or abuse presentation was found to be optimal, meaning better than all of the other categories. When relative comparisons are made between specific categories' mean scores in how characteristic participants found the criteria to be of actual victims of abuse, some categories were found to be more descriptive of actual victims of abuse than other categories. However, no individual factor or abuse presentation was optimal or prototypic of actual abuse.

Table 3

Tukey's (HSD) Test for Differences in Mean Responses to Sexual-abuse Criteria

	F1	**F2**	**F3**	**F4**	**F5**	**F6**	**F7**	**F8**
F1		-.24	.23	00	.30	.57*	.21	-.08
F2	.24		.48	.24	.55	.81*	.45	.17
F3	-.23	-.48		-.24	.07	.33	-.03	-.31
F4	00	-.24	.24		.31	.57*	.21	-.07
F5	-.30	-.55	-.07	-.31		.26	-.10	-.38
F6	-.57*	-.81*	-.33	-.57*	-.26		-.36	-.65
F7	-.21	-.45	.03	-.21	.10	.36		-.28
F8	.08	-.17	.31	.07	.38	.65	.28	

Discussion

Child-abuse professionals have had little to rely upon when their findings of abuse are challenged based on the clinical presentation of a victim. The current study attempted to address this problem by building upon past studies that organized abuse indicators, and then by exploring if there is a prototypic presentation of a victim of abuse according to child-abuse professionals. Utilizing the conceptual framework of Heiman (1992), this investigation examined the multi-dimensional assessment of alleged victims of child abuse according to Heiman's (1992) "history of symptoms," "verbal report," "phenomenological experience," "presentational style," and "corroborating evidence" (p. 313). History of symptoms includes withdrawal, aggression, sleep disturbance, and dissociation, while "verbal report" includes explicit sexual details and reports of bribes or rewards. Phenomenological experience includes a sense of betrayal, feelings of entrapment, a sense of shame, guilt or fear, or feelings of powerlessness/helplessness. Presentational style includes consistency, change in affect, and attempts to minimize or avoid the disclosure, while corroborating evidence includes medical evidence and other victim and witness statements.

The results of the current investigation suggest that there are eight unique factors that emerge from Heiman's framework that are related to presentations of sexual abuse. The factors for sexual abuse are as follows: Idiosyncratic Details; Depressogenic Beliefs; Posttraumatic Response; Naturalistic Disclosures; Family Dysfunction; Corroborated Disclosures; Sexual Reactivity; and Entrapment. Post-hoc analyses of the data suggest that no particular factor was found to be overall more characteristic of sexual abuse despite some relative differences. In other words, no one presentation of symptoms holds more value than all of the other presentations of symptoms. A child who is sexually abused may present with idiosyncratic detail (e.g., reports of threats, coercion, or pressure), while another child might present with family dynamics suggestive of risk (e.g., power imbalances and/or role reversal). However, the clinical presentations of both children emerged as equally demonstrative of child sexual abuse.

The findings of this investigation would resonate with many seasoned professionals in the field of child abuse and neglect who are reluctant to identify specific symptom patterns as more or less diagnostic of sexual abuse due to the belief that there is no truly prototypic clinical presentation of child sexual abuse. The finding of no symptom pattern or presentation style as being more demonstrative of child sexual abuse may frustrate those who would prefer a rubric to assess the clinical presence or severity of abuse. However, the acceptance of diverse symptoms as demonstrative of abuse permits the validation of the abuse experiences of each unique victim. Due to factors such as the child's premorbid functioning, history of trauma, or presence of a supportive caregiver, a child with a seemingly "less abusive" experience or circumstance may present as more symptomatic than a child with a seemingly "more abusive" experience or circumstance. In either case, abuse has occurred.

The relative differences that were found in the investigation deserve some attention, although no gold-standard presentation of a victim of abuse emerged. Relative differences were found, such that corroboration in the form of medical evidence, available witness statements, and disclosures by other victims of the perpetrator were found to be relatively less demonstrative of sexual abuse than variables such as disclosure of idiosyncratic details, depressogenic beliefs, and having a clear and consistent disclosure from a seemingly non-suggestible child. Initially, these findings are counter-intuitive. One would presume that medical evidence would trump all other indicators of sexual abuse. However, most abuse professionals know that physical evidence of sexual abuse is rarely available. It is reasonable to believe that respondents to the questionnaire value medical evidence and other corroborating data when assessing sexual abuse; however, they know that corroborating information such as eye-witness statements are often unavailable and are therefore not as characteristic of a victim of sexual abuse as other criteria that are commonly present such as idiosyncratic details and depressogenic beliefs.

Some might suggest that identifying common presentations will help to communicate the likelihood of abuse of a child based on these presentations. However, this research suggests that professionals who specialize in the area of child abuse and neglect must be willing to consider all symptoms and circumstances that may suggest risk. In a study

of a related concept, Kohl, Johnson-Reid, and Drake (2009) suggest that substantiation may not be the best determinant of recidivism (e.g., re-reports, substantiated re-reports, or subsequent foster care placements) for families with Child Protective Services' (CPS) involvement. The findings of their research suggest that risk of recidivism was similar regardless of substantiation status of the investigation.

In situations where expert testimony is provided, generally the expert is employed to educate the jury about the dynamics of child sexual abuse in order to explain situations such as accommodation to abuse and/or delayed or unconvincing disclosures of sexual abuse. Roland Summit's seminal paper on the Child Sexual Abuse Accommodation Syndrome (CSAAS) is typically the standard to describe the dynamics that maintain sexual abuse within families (Summit, 1983). Summit (1983) explains that CSAAS is not a diagnostic tool, but instead is a description of the abused child's experience, the child's disclosure of the abuse, and the resulting aftermath. The same is true with respect to the categories identified in this study. Also, the findings of this study may be useful in Frye states where the validity standard for admission of expert evidence is based on what is conventional in the field. The use of abuse professionals' ratings in the current study statistically supports that a conventional belief in the field is that there is no prototypic clinical presentation of a victim of abuse. In addition to expert testimony, the findings of this study may be useful in situations where fact witnesses are needed to explain the unique experiences of victims of child sexual abuse. When testimony is provided, there will be no explanation that will fully explain each child's experience of abuse. The child's experience must be taken as it is and must be defended accordingly.

Limitations and Future Research

The following limitations from this research should serve to inform future research. As was indicated in the discussion above, the current research was successful in identifying factors typical of children who have been sexually abused. Future research may seek to explore the predictive relationships among factors. Future research may also explore the predictive relationships between factors and the child's functioning (e.g., amenability to treatment, symptoms, prognosis, and re-referral) over time. Should one or more of these factors be found to predict outcomes, one would be inclined to develop a structured or semi-structured interview that could guide assessment and treatment referral.

While expanding the research would provide useful gains, so too would replication of the current study. Replication of the current study for reliability would be particularly beneficial in confirming the factor structure. Modifications including increasing sample size, and future analysis of physical abuse criteria generated from Heiman's model is recommended. Future research on these factors and their related criteria should be conducted by collecting data from standardized measures completed by the victims of abuse rather than abuse professionals as was done in the current research. Further confirmation of the established factors across, and within, divergent demographics of victims of abuse (e.g., developmentally disabled, etc.) and divergent demographics of

professionals (e.g., by occupation and experience level) can provide an indication of the stability of the factors. That is, one may seek to investigate whether mental-health clinicians support the presence of different factors than child protection workers do.

The sample in the current study included a diverse range of professionals who have specific training, observation experience, and expertise in the field of child sexual abuse. Restricting the sample to mental-health clinicians would have been beneficial. However, for this initial investigation, the composition of the current sample has its benefits in the generalization of these findings considering the multidisciplinary nature of assessment in the child sexual-abuse field. Also, the findings, despite the inclusion of non-clinicians, were consistent with the widely held belief amongst clinicians that there is no prototypic clinical presentation of a victim of abuse.

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