Psychosocial Evaluation of Suspected Psychological Maltreatment in Children and Adolescents

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I. Statement of Purpose

The purpose of these guidelines is to provide guidance for professionals evaluating children to determine whether they are or have been victims of psychological maltreatment. The results of such evaluations may be used to assist in case planning, legal decisionmaking, and treatment planning. The guidelines concern psychological maltreatment that occurs in isolation as well as psychological maltreatment that occurs in conjunction with other forms of abuse and neglect.

The guidelines apply primarily to forensic assessments of psychological maltreatment. Professionals providing treatment and performing non-forensic assessments may also find the guidelines helpful.

The guidelines will be modified as research and practice evolve. Because each child is unique, the guidelines will not apply equally or exactly to all children. Assessment of psychological maltreatment is complex, and professionals must have the flexibility to exercise clinical judgment in individual cases.

The guidelines are not intended to serve as a rigid blueprint for practice, nor are they intended to establish a legal standard of care to which professionals must adhere. Rather, the guidelines provide a model of desirable professional practice.

II. Meaning of Key Terms

This section defines some key terms employed in the guidelines. The definitions should be read in conjunction with definitions provided in applicable Federal and State laws.

"Child maltreatment" means the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child by a person who is responsible for the child's welfare under circumstances which indicate harm or threatened harm to the child's health or welfare. This definition is drawn from the Federal Child Abuse Prevention and Treatment Act. 42 United States Code § 5106g(4). See also, 45 C.F.R. § 1340.2(d). "Child
maltreatment” includes child abuse and child neglect. Definitions specific to a particular state will generally be found in one or more of its civil or criminal statutes.

“Forensic assessment,” for the purpose of these guidelines, means a psychosocial assessment that is conducted wholly or in part for use in legal proceedings¹. For example, a psychosocial assessment conducted at the request of a juvenile court judge for use in legal proceedings is a “forensic assessment.” Psychosocial assessments that are not conducted for use in legal proceedings may nevertheless be relevant to such proceedings.

“Intervention,” in this context, means action on behalf of a child who may be psychologically maltreated. Intervention is a broad concept. Some forms of intervention involve official action by government agencies such as child protective services and juvenile courts. Examples of official intervention include investigations conducted by child protective services agencies and juvenile court orders designed to protect children from psychological maltreatment. Some official intervention is taken over the objection of caregivers, and represents the legal authority of government to intervene in families. Other official intervention can be received on a voluntary basis. In addition to official action on behalf of children, intervention includes a wide range of acts by professionals in public and private sectors. Examples of non-official intervention include providing therapy for children and referring caregivers to appropriate agencies.

“Psychological maltreatment” means a repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another’s needs. The term “psychological,” instead of “emotional,” is used because it better incorporates the cognitive, affective, and interpersonal conditions that are the primary concomitants of this form of child maltreatment. Professionals should be aware of legal definitions of psychological maltreatment that are applicable in their community. Psychological maltreatment includes acts of commission (e.g., verbal attacks by a caregiver) as well as acts of omission (e.g., emotional unavailability of a caregiver). Definitions specific to a particular state will generally be found in one or more of its civil or criminal statutes.

“Psychosocial assessment” means a systematic process of gathering information and forming a professional opinion regarding whether or not a child has been or is being subjected to psychological maltreatment. Psychosocial assessments are broadly concerned with understanding developmental, familial, and historical factors that might be associated with psychological maltreatment. The results of a psychosocial assessment might be used to assist in legal decision making and in treatment planning. In the guidelines, the terms “assessment” and “evaluation” are used interchangeably, and have the same meaning. Some psychosocial assessments are “forensic assessments” as that term is defined in the guidelines.

III. PREVALENCE OF PSYCHOLOGICAL MALTREATMENT

Psychological maltreatment can occur alone, without co-occurrence of other forms of child abuse or neglect. Approximately 10% of reports to child protective services are for psychological maltreatment alone. Although psychological maltreatment occurs in isolation, it is often associated with other forms of maltreatment and is commonly consid-

¹A mental health professional providing solicited therapy typically is not expected to conduct a forensic evaluation in the course of therapy, but, like all professionals, is expected to report maltreatment if it is suspected.
ered to be embedded in all forms of child abuse and neglect. Thus, children who are physically abused, sexually abused, or neglected, in most cases are also be psychologically maltreated.

Psychological maltreatment, in stand-alone occurrences, is the third most common form of maltreatment reported in the United States. Although there are no fully accurate national statistics on the prevalence of psychological maltreatment, this form of maltreatment is likely to be underreported and widespread.

IV. SHORT- AND LONG-TERM EFFECTS OF PSYCHOLOGICAL MALTREATMENT

Psychological maltreatment produces both acute and long-term negative effects. Research establishes a connection between psychological maltreatment and attachment disorders, limitations in cognitive ability and problem solving, poor academic achievement, poor peer relationships, behavior problems, anxiety disorders (especially PTSD), and anti-social behavior (see Hart, Brassard & Karlson, in press, for extensive references).

Other forms of child maltreatment are also associated with the foregoing effects (see Berliner, Briere, Bulkley, Jenny, & Reid, in press). An assessment of suspected psychological maltreatment should attempt to differentiate effects caused primarily by psychological maltreatment from effects caused by other factors, including other forms of maltreatment.

V. CONFIDENTIALITY AND PRIVILEGE

Professionals conducting forensic assessments should be aware of basic legal principles in their jurisdictions governing confidentiality and privileged communications with caregivers, children, and others. Professionals should maintain confidentiality and privilege to the extent reasonably possible.

In the forensic context, confidentiality and privilege are often limited. For example, when a professional conducts an assessment at the request of a judge, the professional’s findings and report may not be confidential, and communications between the professional and the subject of the assessment may not be privileged from disclosure in legal proceedings. Professionals should be aware of applicable limitations on confidentiality and privilege, and should inform appropriate individuals of such limitations.

VI. INFORMED CONSENT

Professionals conducting forensic assessments should be aware of legal and ethical principles governing informed consent. Informed consent should be obtained unless such consent is unnecessary because of the forensic nature of the assessment. Whether or not informed consent is obtained, the professional should advise persons being assessed of the purposes of the assessment and the intended uses of any report or testimony resulting from the assessment.

In forensic situations where informed consent is required but the person being assessed is incapable of giving such consent, the professional should consult with legal counsel or the judge regarding the appropriate way to proceed.
VII. Training and Experience of Professionals Conducting Assessments

A professional conducting a forensic assessment should possess an advanced mental health degree in a recognized discipline or an advanced health services degree with training and substantial experience in mental health. The professional should hold the licensure or credentials required to practice in the jurisdiction. Child protective service employees who meet the experience standards set forth in this section, but who are not licensed or credentialed in a mental health discipline, may carry out forensic assessment functions under the supervision of a mental health professional meeting the criteria outlined in this paragraph.

The professional should have broad experience in evaluation and treatment of both functional and dysfunctional children and families. The professional should possess a minimum of two years of experience with abused and neglected children. Two or more years of experience with non-maltreated children is desirable. The professional should also have specialized training in or knowledge of child development and psychological maltreatment. The professional should be familiar with current literature on psychological maltreatment. If the professional lacks the experience described in this paragraph, appropriate supervision by someone with such experience is required.

The professional should have experience conducting forensic assessments and testifying in court. The professional should be familiar with the forensic implications of interviews of children and adults, including the importance of proper interviewing and documentation. If the professional lacks the experience described in this paragraph, appropriate supervision is required.

The professional should approach the assessment with an open mind regarding what, if anything, might have happened to the child.

If a multidisciplinary team of specialists conducts an assessment, it is advisable for one member of the team to assume the responsibility to coordinate the assessment process, integrate findings, and develop any report. Where the opinions of team members differ, it is recommended that this be identified in reports provided.

VIII. Assessment Considerations

A. Global Assessment Considerations

Psychological maltreatment is often accompanied by or embedded in other forms of child abuse and neglect. Thus, when professionals evaluate possible physical abuse, sexual abuse, or neglect, it is recommended that psychological maltreatment also be considered.

The goal of forensic assessments is often to determine for a court of law whether a caregiver has maltreated or is psychologically maltreating a child and, if so, the severity of maltreatment and the degree to which maltreatment is related to existing or future harm to the child. Acts of maltreatment are in themselves deplorable regardless of the degree to which a child is damaged by them or is coping with them; however, depending on the
cause of action or type of proceeding, laws and practices of many states require evidence of both acts and harm (extant or predicted) for case determinations. Therefore, these guidelines deal with both acts and harm.

Psychological maltreatment is a repeated pattern or extreme incident(s) of caregiver behavior that convey the message that a child is worthless, flawed, unloved, unwanted, endangered, or only valuable in meeting someone else’s needs. Virtually every caregiver, at some point, sends such unfortunate messages. There are few perfect caregivers. Most psychological maltreatment occurs when such negative messages pass from isolated incidents to a consistent caregiving style.

Psychological maltreatment can occur as part of a one-time incident, such as a painful divorce. For example, a parent who is depressed and traumatized by a bitter custody battle might terrorize a child with threats about the child’s future.

In some cases, psychological maltreatment occurs only when some specific, recurring triggering event occurs. For example, with an alcoholic or drug addicted caregiver, psychological maltreatment may occur only when the caregiver is intoxicated.

Some psychological maltreatment is chronic, regular, and embedded in the child’s daily existence. An example is a caregiver who levels a daily barrage of verbal abuse at a child.

Child behavior often provides evidence of psychological maltreatment. One must be cautious, however, about inferring causation from behavior. Multiple pathways lead to particular behaviors. When considering the possibility of psychological maltreatment, the professional should rule out other factors such as psychological trauma unrelated to maltreatment, inherited or congenital vulnerabilities, and various forms of mental illness.

Professionals should understand the influence of base rates on the diagnostic value of specific behaviors. For example, post-traumatic stress disorder is more prevalent in inner city neighborhoods with high crime rates than in most suburban and rural areas. Thus, children living in dangerous neighborhoods may have a higher incidence of PTSD than children living in safer environments (Osofsky & Jackson, 1994). Presence of PTSD symptoms in a child living in a dangerous neighborhood may be the result of environmental influences rather than caregiver-perpetrated psychological maltreatment.

Although child behaviors can yield useful information, behavior alone is not a sufficient basis to determine whether psychological maltreatment has occurred. Moreover, some victims of psychological maltreatment demonstrate no detectible signs or symptoms. Evaluators should consider various influences on caregiver-child and family interaction, and should investigate as many sources of information as possible.

B. The Child’s Developmental Level

An assessment for possible psychological maltreatment should include consideration of the child’s developmental level. The caregiver-child relationship should be considered within a developmental framework that takes into account the primary developmental tasks of the child and the related tasks placed upon the caregiver. For example, one of an infant’s primary developmental tasks is to form a secure attachment with an adult caregiver, learning in the process to trust others to provide a stable, loving, nurturing, responsive environment, and to believe in his/her own ability to solicit that care. A caregiver
who predominantly rejects a child’s bids for attention (for comfort, play, or assistance) negatively shapes a child’s sense of self, worthiness, competence, efficacy, and trust in others. Professionals may use the list of “Developmental Tasks” contained in Table 1 to assist in the assessment process.

**TABLE 1**

**DEVELOPMENTAL TASKS**

| Infancy                  | Attachment
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Assistance in the regulation of bodily states, emotion.</td>
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<tr>
<td>Toddlerhood</td>
<td>Development of symbolic representation and further self–other differentiation</td>
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<tr>
<td></td>
<td>Problem-solving, pride, mastery motivation.</td>
</tr>
<tr>
<td>Preschool</td>
<td>Development of self-control - the use of language to regulate impulses, emotions, store information, predict and make sense of the world.</td>
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<td></td>
<td>Development of verbally mediated or semantic memory</td>
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<tr>
<td></td>
<td>Gender identity.</td>
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<tr>
<td></td>
<td>Development of social relationships beyond immediate family and generalization of expectations about relationships.</td>
</tr>
<tr>
<td></td>
<td>Moral reasoning.</td>
</tr>
<tr>
<td>Latency age</td>
<td>Peer relationships.</td>
</tr>
<tr>
<td></td>
<td>Adaptation to school environment.</td>
</tr>
<tr>
<td></td>
<td>Moral reasoning.</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Renegotiation of family roles.</td>
</tr>
<tr>
<td></td>
<td>Identity issues (sexuality, future orientation, peer acceptance, ethnicity).</td>
</tr>
<tr>
<td></td>
<td>Moral reasoning.</td>
</tr>
<tr>
<td>Young adult</td>
<td>Continued differentiation from family.</td>
</tr>
<tr>
<td></td>
<td>Refinement and integration of identity with particular focus on occupational choice and intimate partners.</td>
</tr>
<tr>
<td></td>
<td>Moral reasoning.</td>
</tr>
</tbody>
</table>

**C. Forms and Severity of Psychological Maltreatment**

This subsection discusses forms and severity of psychological maltreatment.

1. **Forms of Psychological Maltreatment**

Table 2 describes six forms of psychological maltreatment. These forms find support in research and clinical experience. The forms are intended to help professionals analyze cases. A child’s maltreatment experiences may be categorized by one or more of these forms and will not necessarily fit simply or completely within one form. The six forms of psychological maltreatment are: (a) spurring, (b) terrorizing, (c) isolating, (d) exploiting/corrupting, (e) denying emotional responsiveness, and (f) unwarranted denial of mental
health care, medical care, or education. These forms are recommended for consideration as complements to legal and regulatory definitions of psychological maltreatment particular to the state.

**TABLE 2**
**PSYCHOLOGICAL MALTREATMENT FORMS**

<table>
<thead>
<tr>
<th>SPURNING (Hostile Rejecting/Degrading) includes verbal and non-verbal caregiver acts that reject and degrade a child. SPURNING includes:</th>
</tr>
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<tbody>
<tr>
<td>— belittling, degrading and other nonphysical forms of overtly hostile or rejecting treatment</td>
</tr>
<tr>
<td>— shaming and/or ridiculing the child for showing normal emotions such as affection, grief or sorrow</td>
</tr>
<tr>
<td>— consistently singling out one child to criticize and punish, to perform most of the household chores, or to receive fewer rewards</td>
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<tr>
<td>— public humiliation</td>
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</table>

<table>
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<tr>
<th>EXPLOITING/CORRUPTING includes caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, anti-social, criminal, deviant or other maladaptive behaviors) EXPLOITING/CORRUPTING includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>— modeling, permitting or encouraging antisocial behavior (e.g. prostitution, performance in pornographic media, initiation of criminal activities, substance abuse, violence to or corruption of others)</td>
</tr>
<tr>
<td>— modeling, permitting, or encouraging developmentally inappropriate behavior (e.g., parentification, infantilization, living the parent’s unfulfilled dreams)</td>
</tr>
<tr>
<td>— encouraging or coercing abandonment of developmentally appropriate autonomy through extreme over-involvement, intrusiveness, and/or dominance (e.g., allowing little or no opportunity or support for child’s views, feelings, and wishes; micromanaging child’s life)</td>
</tr>
<tr>
<td>— restricting or interfering with cognitive development</td>
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</tbody>
</table>

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<tr>
<th>TERRORIZING includes caregiver behavior that threatens or is likely to physically hurt, kill, abandon or place the child or child’s loved ones/objects in recognizably dangerous situations. TERRORIZING includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>— placing a child in unpredictable or chaotic circumstances</td>
</tr>
<tr>
<td>— placing a child in recognizably dangerous situations</td>
</tr>
<tr>
<td>— setting rigid or unrealistic expectations with threat of loss, harm, or danger if they are not met</td>
</tr>
<tr>
<td>— threatening or perpetrating violence against the child</td>
</tr>
<tr>
<td>— threatening or perpetrating violence against a child’s loved ones or objects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DENYING EMOTIONAL RESPONSIVENESS (Ignoring) includes caregiver acts that ignore the child’s attempts and needs to interact (failing to express affection, caring, and love for the child) and showing no emotion in interactions with the child. DENYING EMOTIONAL RESPONSIVENESS includes:</th>
</tr>
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<tbody>
<tr>
<td>— being detached and uninvolved through either incapacity or lack of motivation</td>
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<tr>
<td>— interacting only when absolutely necessary</td>
</tr>
<tr>
<td>— failing to express affection, caring, and love for the child</td>
</tr>
</tbody>
</table>

**TABLE 2 continued next page**
### TABLE 2, continued

<table>
<thead>
<tr>
<th>ISOLATING includes caregiver acts that consistently deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home. ISOLATING includes:</th>
</tr>
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<tbody>
<tr>
<td>—confining the child or placing unreasonable limitations on the child’s freedom of movement within his/her environment</td>
</tr>
<tr>
<td>—placing unreasonable limitations or restrictions on social interactions with peers or adults in the community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MENTAL, HEALTH, MEDICAL, AND EDUCATIONAL NEGLECT includes unwarranted caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs of the child. MENTAL, HEALTH, MEDICAL, AND EDUCATIONAL NEGLECT include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>—ignoring the need for, failing or refusing to allow or provide, treatment for serious emotional/behavioral problems or needs of the child</td>
</tr>
<tr>
<td>—ignoring the need for, failing or refusing to allow or provide, treatment for serious physical health problems or needs of the child</td>
</tr>
<tr>
<td>—ignoring the need for, failing or refusing to allow or provide, treatment for services for serious educational problems or needs of the child</td>
</tr>
</tbody>
</table>

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2. **Levels of Severity**

In determining the level of severity of psychological maltreatment, consideration should be given to: (a) Intensity/extremeness, frequency, chronicity; (b) The degree to which psychological maltreatment pervades the caregiver-child relationship; (c) Number of forms of psychological maltreatment which have been or are being perpetrated; (d) Influences in the child’s life that may buffer the child from psychological maltreatment. For example, does the maltreating caregiver also provide nurturance for the child? Does the child have regular access to a nurturing, nonmaltreating adult? (e) Salience of the maltreatment given the developmental period(s) in which it occurs and the developmental periods that will follow; and (f) Extent to which negative child developmental outcomes exist, are developing, or are predicted.

3. **“Severe Emotional Disturbance” Defined in the Federal Individuals with Disabilities Education Act.**

This subsection of the guidelines draws on the Federal Individuals with Disabilities Education Act, commonly known as 94-142, and formerly titled the Education of the Handicapped Act. Regulations implementing 94-142 define “severe emotional disturbance” (See 34 Code of Federal Regulations § 300 7(9).) The 94-142 definitions incorporate psychological criteria for: (a) major mental disorders and (b) interpersonal, cognitive, and emotional behavior problems. Professionals assessing children for possible psychological maltreatment will find these definitions of severe emotional disturbance and the standards included in the American Psychiatric Association’s Diagnostic and Statistical Manual(s) of Mental Disorders (i.e., DSM III-R and DSM IV) useful to guide determinations of extant or predicted harm related to psychological maltreatment.

The 94-142 definitions provide:

“Serious emotional disturbance” is defined as follows:

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance—
(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors;
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(C) Inappropriate types of behavior or feelings under normal circumstances;
(D) A general pervasive mood of unhappiness or depression; or
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

D. ASSESSMENT TECHNIQUES AND SOURCES OF INFORMATION

1. The child-caregiver relationship

Psychological maltreatment consists primarily of messages a child receives about him- or herself and about important interpersonal relationships. When feasible, the professional should observe the child-caregiver relationship. Because of the chronicity of much psychological maltreatment, repeated observations may be necessary to obtain a representative sample of behavior and to provide grounds on which to recognize patterns of child-caregiver interaction. Although direct observation of the child-caregiver relationship is often useful, such observation is not always necessary to form an opinion regarding psychological maltreatment. Observations of caregiver-child interaction have limitations because parents may not behave in their usual manner when being observed.

The child-caregiver relationship can also be assessed through interviews of the caregiver and the child, review of pertinent records, observation, consultation with other professionals, and collateral reports from siblings, grandparents, school and daycare personnel, neighbors, and others.

2. Child characteristics

Psychological evaluation procedures such as observations, interviews, questionnaires, and projective techniques, with due consideration of their reliability and validity, can provide clarifying and corroborative information about patterns of interaction, care, and treatment, and their impact on the child. Deviance or delay in the child's functioning are assessed through direct observation by the evaluator, testing, the observations of others, and available reports and records (e.g., school, health, therapy).

3. Caregiver/family competencies and risk factors

Evaluation of caregiver competencies and risk factors assists in determining the existence of psychological maltreatment, in developing a prognosis for improvement in the child-caregiver relationship, and in identifying issues to address in treatment. Relevant areas of functioning include: (1) Caregiver's representational models or attitudes toward past attachment figures, current partner, and child(ren); (2) Personal resources (intelligence, job skills, social skills, personality variables, mental health); (3) Social support/resources (marital status, family, friends, financial status, community involvement); and (4) Life stresses or transitions in the family.
Assessment of the caregiver usually includes one or more interviews, review of collateral reports and records, and psychological testing.

Interaction with caregivers or members of the extended family should normally be carried out so as to increase the likelihood of voluntary involvement in the assessment and any intervention.

4. Consideration of societal and cultural context

A family's community context and immediate social and economic circumstances should be taken into consideration when evaluating caregiver behavior. The psychological conditions jeopardizing a child's development may not be under the control of a caregiver. Homelessness, poverty, or living in a violent neighborhood can have an adverse impact on quality of care and child development. Caregivers are not responsible for conditions over which they have no control.

Professionals should be knowledgeable about and sensitive to cultural and ethnic differences in caretaking styles and customs. If the evaluator is not familiar with the cultural context of the child and family, consultation with appropriate experts is required.

IX. Reporting Findings

Professionals conducting forensic assessments typically prepare reports that contain findings and recommendations.

A. Findings of Assessment

The report of a forensic assessment should document all sources of information considered by the professional during the assessment. The report should state the professional's findings. In appropriate circumstances the report may set forth the professional's opinion concerning whether a child has or is suffering from psychological maltreatment or other forms of child abuse or neglect. The report may indicate findings consistent or inconsistent with psychological maltreatment.

If the professional concludes that psychological maltreatment has or is occurring, the report should: (a) State the form(s) of psychological maltreatment; (b) Describe specific occurrences of caregiver behavior that constitute psychological maltreatment; (c) Document the severity through reference to intensity/extremeness, frequency, chronicity, pervasiveness, multiplicity of forms, counterbalancing positive treatment, developmental saliency, and probable short- and long-term effects of the maltreatment; and (d) Describe the relations between the psychological maltreatment and harm to the child.

In some cases the assessment is inconclusive. In such cases the professional should state the reasons for the inconclusive finding, and should indicate whether, in the professional's judgment, the child is at risk of harm.

B. Recommended Interventions

The report should contain recommendations for appropriate intervention
X. Testifying in Court

Professionals should always be prepared for the possibility that they will be required to testify in court. Professionals should only provide expert testimony on matters for which they possess special competence that can assist the legal system, and should always acknowledge the limits of their competence.

When called upon to testify in court, professionals have an obligation to testify in a manner that is accurate and fair to all parties. Although straightforward and forceful presentation of findings and recommendations is proper, professionals reporting the results of forensic evaluations should avoid the temptation to become advocates for one side or the other in litigation.

XI. Related Guidelines and References

Guidelines

Professionals conducting forensic assessments and testifying in court should consult guidelines and ethical codes that apply to their particular specialty. The following list is provided as a reference:


References

The following references provide clarification and supportive information for the statements and recommendations presented in these guidelines.


Acknowledgments

These guidelines are the product of the National Psychological Maltreatment Consortium and APSAC's Task Force on Psychological Maltreatment, chaired by Stuart Hart, PhD, and Marla Brassard, PhD. Seventy professionals commented on the first draft of these guidelines at the San Diego Conference on Responding to Child Maltreatment in January, 1993. Members of the Consortium and the Task Force, and all APSAC members who participated, are thanked for the significant contributions they have made to the development of these guidelines. John E. B. Myers, JD, is recognized particularly for provision of extensive editorial support. The guidelines will be updated periodically. Any comments or suggestions about them should be directed to APSAC, 407 S. Dearborn, Suite 1300, Chicago, IL 60605.

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The American Professional Society on the Abuse of Children (APSAC) is the premiere, multidisciplinary professional association serving individuals in all fields concerned with child maltreatment. The physicians, attorneys, social workers, psychologists, researchers, law enforcement personnel and others who comprise our membership have all devoted their careers to ensuring the children at risk of abuse receive prevention services, and children and families who become involved with maltreatment receive the best possible services.

APSAC meets our goal of ‘strengthening practice through knowledge’ by supporting, aggregating and sharing state-of-the-art knowledge though publications and educational events. Our publications include the peer-reviewed, professional journal Child Maltreatment; the widely distributed translational newsletter The APSAC Advisor; news blasts on current research findings, The APSAC Alert; and Practice Guidelines like this document. Regular training events include our annual colloquia, attracting the top experts in the field to present to peers and colleagues at all stages of their careers; highly acclaimed forensic interviewing clinics and advanced training institutes held at the International Conference on Child and Family Maltreatment. We regularly initiate and test new CEU eligible training courses, and are currently developing, and an online course for early career professionals.

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