Evaluating young children

Brigid Barrer considers best practice child forensic assessment

He kokonga whare e kitea,
He kokonga ngakāu e kore e kitea
(The corners of a house can be seen,
but not the corners of the heart)

Introduction

At Specialist Services Unit (SSU) Puawaitahi, Auckland Central, the first multi-agency service in New Zealand, referrals are received for assessment and therapy from social workers from Child, Youth and Family. This article describes the processes of extended forensic assessment (Carnes, C et al 1999, 2001), or diagnostic assessment, when the statutory investigation by the social worker requires detailed evaluation of a young child. Diagnostic assessments were designed in 1995 (Rugg, 2001) to provide a service for children where there were care and protection concerns due to a child presenting with crucial behaviours, or risk factors, the function of which required explanation. This forensic evaluation model represented an alternative for children who did not meet the criteria for the evidential videotaped interview under the Evidence Amendment Act 1989.

The whakatauākā at the beginning of this article provides a metaphor about the child who is to be the subject of the forensic assessment. It is suggested that the corners of the house represent the outward and concerning behaviours and the corners of the heart represent the child's untold experiences. In a sense diagnostic assessment may be said to aim to reveal the corners of the heart. The observable concerns about the child, or the house corners, enable us to identify the need for evaluation. For example, the child may exhibit a personality change, as in becoming withdrawn or fearful. Another child may portray developmental psychopathology (Calvert and Lightfoot, 2001) such as secondary enuresis. The child may make statements about abuse that are unclear and require further assessment. The child's narrative may be difficult to access due to psychological factors such as anxiety, embarrassment, distress, post-traumatic stress disorder, dissociation, agitation or attentional difficulties.

Diagnostic assessments are provided for young children between three and eight years of age who require approximately six sessions conducted by a trained specialist. Assessment strategies to access information from the child are derived from the growing literature on interviewing children. Hypotheses about the child other than abuse explanations are considered, including mental health causes, parental variables and child characteristics such as confabulation.

Research on the extended forensic assessment model

The multi-session model of forensic assessment has been evaluated in the US (Carnes et al,1999, 2001) and, quite independently, the multi-session model has also evolved in New Zealand. This has led to similar protocols in these two different countries, with five child sessions and a single parent interview in the Carnes model compared with six sessions and two parent interviews in New Zealand. In 1999 Carnes reported a result of 47 per cent disclosure statements in a sample of preliminary data from a survey of 51 children. These disclosures were further analysed and 77 per cent fell into three separate categories:

- credible disclosures
- credible nondisclosures
- noncredible disclosures.

These results were regarded as successful outcomes. In Madison County, Alabama, where the research was conducted, the forensic evaluation was accepted, and 71 per cent of the credible disclosures proceeded to become substantiated by a civil or criminal court finding.

In New Zealand the forensic evaluation model differs from the practice of a single evidential interview and is not videotaped but is monitored by a specialist who records what is said and observed. However, in some cases a child is referred for an evidential interview after a forensic assessment and may go on to provide evidence for the Family Court or a criminal trial. New Zealand's Evidence Amendment Act 1989 requires that children's evidence in the criminal court be given in prescribed ways, such as showing the videotaped interview and cross-examination by closed circuit television. The diagnostic assessment report is available to the Child, Youth and Family social worker and may be sought by the Family Court in addition to reports by court-appointed psychologists.

Recent research on talking with children

An hourglass approach is recommended in the forensic interviewing of children, starting broadly with open questions and narrowing down to focused questions, followed by a return to an open style (Faller, 2004).

One of New Zealand's communication characteristics is a fast pace of speech. Anxiety can also speed up speech, but the response time required by a child can be as long as 20 seconds, which is considerably longer than that used in adult speech (Anne Graffam Walker, 2004).

Motivational instructions, such as requesting the child to tell everything, can be used to facilitate children's responses (Saywitz and Nathanson, 2004). Saywitz suggested the use of the sentence “I wasn't there” to assist children to not only elaborate on their words but understand the specialist's role. They should be viewed not as an expert eclipsing a child's view, but as a facilitator trying to assist children to tell about their experience. Amplification with similar phrasing can further this concept in the child's mind.

The techniques of narrative elaboration with learning disabled children have been well described and documented by Saywitz and Snyder (1996), Saywitz and Camparo (1998), and Nathanson and Saywitz (2000). A simplified procedure of training or rehearsing children's free narrative is followed in all cases to provide rehearsal opportunity and information on language ability as well as to aid rapport. Children are instructed to tell all about it, to tell the specialist more, amplified with “I wasn't there” and followed up with some focused questions to systematically prompt recall about what has been said.

Comprehension monitoring includes practice and training techniques as well as skilful instructions. This is when children are able to convey their lack of understanding to the interviewer, who in turn can rephrase questions, so the children can then show significant improvement in accurate recall (Saywitz and Nathanson, 2004).

Diagnostic assessment process

The purpose of interviewing parents and primary caregivers is to obtain a context for the individual child and form a base for the diagnostic assessment. The child's development, personality and behaviour are explored with changes tracked. Interactional features of relationships are explored as are the hypotheses about the child's current presentation. The consistency between parent and child reports is noted and any records collected. The child behaviour checklist (Achenbach,T and Edelbrock,C, 1983) is usually completed by a parent.

Making the child the expert is designed to break down the child's stereotypes around the adult role

Introductory phase – information and training

Informing children is an interactive process, which includes checking their understanding and countering suggestibility. The specialists ensure understanding of their roles in terms of how they help and talk to children. Children are not obliged to participate if unwilling. The individual child's role as the expert is emphasised, along with the notion that the specialist was not present in the child's life experience and therefore does not know about it. Making the child the expert is designed to break down the child's stereotypes around the adult role.

Interviewing rules are explained early in the process. The child's ability to use the concept "I don't know" is checked and practised, as is the concept "I don't understand". This assists the child to resist suggestions and to avoid making false positive statements to please the specialist. Children are reminded not to guess and to correct the specialist if they make a mistake, and to ask for questions to be repeated if necessary.

Rapport building

Many child clients initially present with high levels of anxiety, which must be managed by the specialist through the assessment relationship and rapport-building. Until the anxiety abates, children are often unable to relate well through language.

The process of building rapport occurs throughout all the phases and rapport is built by using the child-centered approach. The use of talking, playing and other activity is interspersed to prevent the sessions becoming overly intense for the child. Specialists attune themselves to developing an assessment relationship with individual children.

During the introductory phase, the child's ability to provide narrative elaboration is assessed and enhanced with open-ended questions about neutral topics such as the child's favourite television programme or an account of their school day. While some children may not find it so easy to recall their previous birthday, most children remember an aspect of it. Memories of concrete items such as presents, visitors and the birthday cake may be recalled more easily. A routine activity, such as a game at preschool, can also be explored.

The child's ability to order events can be assessed during the elaboration. For instance, what happened first at the birthday party, and what happened until the birthday cake was eaten, can be assessed. This type of free narrative practice may then serve as a precursor for later ability to elaborate on topics of concern.

Activities

Frequently the child is asked about their family and to draw the members while the child and interviewer talk. Although there is evidence to suggest that contextual drawing, matching the interviewing subject matter, may assist children's recall and possibly serve to reinstate context (Butler, Gross and Haynes, 1995), drawing is not used as a memory aid or prop during interviewing. Drawing is usually confined to obvious themes, such as a family picture and the family home, if this is where the child is living. Drawing freely while the child and interviewer talk may help children to focus on the interviewer's questions and the details in drawings can be validated independently if necessary.

Children frequently show preferences for playing in sand and appear to find this a relaxing activity. They enjoy the variety of the playroom, some appearing more comfortable with cognitive tasks while others choose free play. The use of a playroom normalises the interviewing components because the child can participate in the playroom atmosphere as well as talk. The toys in the playroom resemble those in their preschool settings with normal connotations, such as a doll's house, vehicles and puzzles. Layered body puzzles facilitate the use of names for body parts.

It is important that the specialist interacts as little as possible in the content of the child's play, but is available to assist the child when required. Frequently the child is engaged at a table with neutral activities so that the specialist can talk with the child in this more controlled setting. This method of talking with the child most closely resembles the interviewing procedures. However, unlike a single videotaped interview, multi-session interviewing takes up a smaller proportion of each session, instead recurring across sessions. Multi-session interviewing is preferable to repeated interviewing within a session when following non-suggestive protocols (Poole and Lindsay, 1998).

Cognitive assessment

An informal assessment begins in the first session when the specialist observes the child's ability in language through observing the sentence length and vocabulary used, as well as the child's numerical, printing and drawing skills. The young child's ability to represent themselves may be assessed.

The specialist aims to recognise the child's understanding of causality and temporal concepts, their ability to order events and to reason, and their use of appropriate vocabulary or idiosyncratic language. The child's development at mentalising or reflecting and commenting on aspects of their reasoning requires assessment. This is especially true of the child's ability to understand and recognise the source of their knowledge.

Walker (2004) and Saywitz (2004) both emphasised that, generally, cognitive development in young children has not attained the full degree of competence required for a forensic interview until children reach ten to twelve years of age. Therefore the specialist's analysis of the child's level of functioning is required to modify lay adult expectations.

Forensic assessment results

The diagnostic assessment report summarises the assessment sessions proposing the relevant hypotheses to explain the child's presentation and discussing the evidence for each. As part of the reporting process, the parents and social workers receive feedback about the findings. The forensic report differs from a Family Court report, conducted by a court-appointed specialist report writer, which is commissioned by the Family Court to answer broader questions about access, custody and risk. The diagnostic assessment may be complementary to the Family Court report and can be conducted in partnership with a court-appointed psychologist. Diagnostic assessments are primarily assessments of the child rather than the parents. Although the parents provide the contextual background to the child, their information must be analysed in relation to the child's behaviour. Parental variables, such as inadvertent coaching or hypervigilance, may also be assessed. The scientist-practitioner model is employed, basing conclusions on the child's statements, behaviours and presentation across repeated sessions and analysis of these observations in terms of the contextual information and research literature.

Parental variables, such as inadvertent coaching or hypervigilance, may also be assessed

At SSU Puawaitahi, in the two years between mid-2001 and mid-2003, 44 per cent of the 38 clients assessed by this method made statements about child sexual abuse. Since many diagnostic assessments are inconclusive, further referrals may be recommended, such as skill and psychological assessments of the parents. The diagnostic assessment considers the safety of the child in conjunction with the results of any investigation so that recommendations can be made around care and protection needs under the umbrella of Child, Youth and Family.

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