

**CHILDHOOD SEXUAL ABUSE INDICATORS (SAI)
FOR DIFFERENTIATING GENUINE FROM FALSE ALLEGATIONS**

**Howard B. Terrell, M.D., Brian E. Terrell, Anthony Capozzi, Esq.,
Hon. Victor N. Papadakis, Ret., Hon. H.N. Papadakis, Ret.,
Kathy Sullivan, Ph.D., Mark Hodges, A.A. Howsepian, M.D., Ph.D.,
Timothy Donovan Esq., Karen Kraus, M.D., and David Fox, M.D.**

Child molestation is a pervasive crime. It typically has lifelong detrimental effects upon the child victim. Allegations of child molestation can also have lifelong effects upon the accused, regardless of whether or not they committed the crime. In this information age, children, parents, school officials, health care professionals and law enforcement officials are more aware of the crime and more inclined to promptly address it when such allegations are made. By the same token, many people are aware that even the mere accusation of child molestation can immediately halt a child custody dispute, turn it to the advantage of the accusing parent and in the process potentially destroy the life, reputation and career of the accused, regardless of any culpability. This article outlines the Sexual Abuse Indicators (SAI) that arose from a multidisciplinary panel study of mental health professionals, legal experts and other professionals who combined have had over two centuries of experience in dealing with sexual offenders and their child victims. The SAI is offered as a new instrument intended to aid the forensic evaluator and other related professionals in delineating the most essential signs, symptoms and findings for assessing genuine versus false allegations of child molestation.

INTRODUCTION

In order to protect society we have an obligation to identify sexual offenders who victimize children, and hold them accountable for their crimes. In order to ensure due process we have an obligation to identify those cases where false allegations appear to have been made. Unfortunately, however, differentiating genuine from false allegations of childhood sexual abuse is an extremely complex and difficult endeavor, even for the most skilled and experienced forensic experts. The physician's obligation to "Do no harm" is always relevant when performing such evaluations. Even the most ethical

forensic expert may be consciously unbiased, yet harbor an unconscious desire to benefit the party who hired him or her.

Courts are always in need of professional information that is scientifically-based. Hence it would be in the interest of justice to develop a scientific test instrument for child sexual abuse that is as objective as possible and free of bias. So far no such instrument has been developed. The Sexual Abuse Indicators (SAI) is a move in the direction of more objectivity in attempting to differentiate false from true allegations of child sexual abuse. We hope the SAI will be an important contribution toward this goal.

BACKGROUND INFORMATION

Much has been written in the literature about genuine versus false allegations of sexual abuse. The McMartin Preschool trial is perhaps the most notorious case of bizarre and incredibly weak allegations that resulted in multiple criminal charges that destroyed the lives of several innocent people. In that case, a student's mother complained to police that her son had been sodomized at the school. The mother's belief was based on her son's painful bowel movements, even though he denied any history of molestation. (1). The accusations of the children in the case were often bizarre and included accounts of teachers who took children on airplane rides to Palm Springs and lured them into a labyrinth of underground tunnels where the accused "flew in the air" and others were "all dressed up as witches." There were claims of orgies at car washes and airports. Children were allegedly flushed down toilets to secret rooms where they were abused, then cleaned up and returned to their unsuspecting parents (2).

In March 1984, Peggy McMartin Buckey, Virginia McMartin, Ray Buckey, and four others were charged with 208 counts of child abuse. The testimony of the children, however, was inconsistent. In 1986, a subsequent prosecuting attorney considered much of the evidence to be weak and dismissed all charges against Virginia McMartin and four other defendants. Peggy McMartin Buckey and Ray Buckey remained in custody awaiting trial. Peggy McMartin Buckey's bail had been set at \$1 million while Ray Buckey was denied bail. The cases went to trial and in 1990 the jury acquitted Peggy McMartin Buckey on all counts. Ray Buckey was cleared on 39 of 52 counts, and released on bail after more than five years of incarceration.

The remaining charges against Ray Buckey were eventually dismissed without further trial.

In January of 1984, after 28 years in business, Virginia McMartin and Peggy McMartin Buckey permanently closed the McMartin Preschool. In March 1985 a group of nearly 50 McMartin Preschool parents arrived at a lot next to the school and began digging for the “secret underground rooms” they believed were the scene of massive sexual abuse of children. A few days later, an archeological firm hired by the District Attorney’s Office began its own dig. No evidence of secret rooms was ever found. The prosecutions of the case cost \$15 million and seven years of court time. In 1991 the McMartin Preschool was demolished. In 1995 Virginia McMartin died at the age of 88 (3).

Of all the contributors on the issue of genuine versus false allegations of childhood sexual abuse the greatest and perhaps most controversial has been the late Richard A. Gardner, M.D. Dr. Gardner was Clinical Professor of Child Psychiatry with Columbia University College of Physicians and Surgeons. His landmark book, *The Parental Alienation Syndrome*, is still hotly debated by forensic experts yet, in our combined opinion, still valuable reading for any expert planning to delve into this subject (4). His Sex Abuse Legitimacy Scale (SAL Scale) (5) was a breakthrough for forensic experts. It provided specific criteria and a numerical scale for assessing the child, the suspect and the accusing parent. Each factor is scored from 0 to 3 points depending upon the findings. The higher the SAL score the more likely the allegations of sexual abuse are true. The lower the SAL score the more likely the allegations are false. Scores in between high and low are deemed inconclusive.

According to Dr. Gardner:

“The Parental Alienation Syndrome (PAS) is a disorder that arises primarily in the context of child-custody disputes. Its primary manifestation is the child’s campaign of denigration against a parent, a campaign that has no justification. It results from the combination of a programming (brainwashing) parent’s indoctrinations and the child’s own contributions to the vilification of the target parent. When true parental abuse and/or neglect is present the child’s ani-

mosity may be justified, and so the parental alienation syndrome explanation for the child's hostility is not applicable" (4).

Although Dr. Gardner's work is still held in high regard by many in the psychiatric community he has had his fair share of critics. His work on the parental alienation syndrome and SAL Scale were considered by some to be pro defense for fathers facing accusations of sexual abuse that were raised during custody disputes.

Berliner and Conte (6) critically wrote:

"Indeed the entire scale (The SALS) and the Parental Alienation Syndrome on which it is based have never been subjected to any kind of peer review or empirical test."

While far from perfect and not typically admissible into evidence by U.S. courts under the Kelly/Frye rule which requires general acceptance in the scientific community, Dr. Gardner's SAL Scale and work on parental alienation syndrome became valuable learning tools for many forensic psychiatrists and psychologists trying to navigate the very complicated and previously uncharted waters of differentiating genuine from false allegations of sexual abuse.

Another criticism of Gardner's SAL Scale is that, to be most reliable, the forensic expert must have an opportunity to interview the child, the parent who brings forth the allegations, and the defendant. In genuine courtroom trials it is very unusual for the forensic expert to have an opportunity to examine all three parties.

Contributions in understanding childhood sexual abuse have also been made by Roland Summit M.D. through his work on the Child Sexual Abuse Accommodation Syndrome (CSAAS) (7). He noted that there are five reactions children can exhibit who have been sexually abused: 1) secrecy, 2) helplessness, 3) entrapment and accommodation, 4) delayed, unconvincing disclosure, 5) retraction. He did not present CSAAS as a forensic diagnostic tool but as an explanation to give clinicians, investigators, and courts an understanding of the coping behaviors of children who have genuinely been sexually abused as well as to dispel myths and prejudice about sexual abuse in children. Dr. Summit's work on the CSAAS has been criticized as a tool

for prosecutors to try and prove a defendant guilty if the child accuses him and even more likely to be guilty if the child later recants the accusations.

Wakefield and Underwager (8) studied the personality characteristics of parents making false accusations of sexual abuse in custody disputes. They assessed the personality characteristics of 72 falsely accusing parents and 103 falsely accused parents to each other and to a control group of 67 custody only parents who were involved in custody disputes, but without allegations of sexual abuse. The parent, usually a female, who promotes false allegations of sexual abuse typically meets one or more of the following descriptions:

- 1) The highly disturbed individual whose personality disorder interferes with functioning, judgment, and sometimes the ability to differentiate between fact and fantasy. Such individuals often have a history of psychiatric involvement and unstable relationships. They are seen as unstable, moody, impulsive, and over reactive. Under the stress of the divorce, they are apt to overreact and misinterpret events and jump to conclusions about abuse.
- 2) The individual who is obsessed over the possibility that her child has been or may be sexually abused. The accusing parent may have been sexually abused or raped herself or may have just overreacted to the media attention to abuse. In either case this parent is now hypervigilant about the possibility of this happening to her child. She may question the child repeatedly, examine her genitals following visits, and take the child to doctor after doctor.
- 3) The individual who reacts fairly appropriately to an ambiguous situation by seeking guidance from a therapist or physician. The child may report that she has bathed with her father and touched his penis or she may make a confused statement which sounds suspicious. The parent, not wanting to handle this by himself, calls a professional.

In California and many other states, physicians, nurses, psychologists, school teachers and many other licensed professionals are “mandated reporters.” Any reasonable suspicion of childhood sexual abuse requires the pro-

fessional to promptly contact child protective services or local authorities. Failure to promptly notify is a crime and can result in prosecution and incarceration of the professional who does not promptly report. Once reported, police authorities interview the complaining witness and frequently thereafter arrest the accused. Police reports are then reviewed by the district attorney's office who ultimately makes the decision whether or not to file criminal charges. In California if charges are not filed within 48 hours the accused is released from custody. Even if the accused is not prosecuted immediately, authorities may wait several years to file charges. In the meantime the life of the suspect may be a living purgatory, not knowing what the future holds. Oftentimes the accused will spend his life savings to raise bail and retain an attorney. Merely being arrested for such a crime may severely compromise his chances of holding employment as a teacher, clergyman, physician, peace officer, or government employee.

Police chiefs, sheriffs and prosecutors are often prone to take sexual abuse accusations at face value and initiate legal action against the accused as is politically expedient. Judges are prone to sign temporary restraining orders (TRO) against the accused with minimal evidence. Being the subject of a restraining order can have an immediate and lifelong impact upon the accused.

Ross and Blush (9) described three personality patterns they observed in falsely accusing parents. These include the histrionic personality, the justified vindicator (which is felt to be a variation of the histrionic personality), and the borderline personality.

It is common knowledge among mental health professionals that the nature of the histrionic personality includes a frequent need to be the center of attention, even at the expense of others. The borderline personality tends to have a multitude of brief, unstable, and overwhelmingly intense relationships where they may love and adore an individual one day then want to humiliate and destroy them the next. The old saying that "Hell hath no fury like a woman scorned" applies more to the borderline than any other personality disorder and can quite appropriately be rephrased to "Hell hath no fury like a borderline."

Few things can be as humiliating and destructive as a false accusation of child molestation. Those falsely accused are at high risk of suffering depres-

sion and anxiety for obvious reasons. They are also at increased risk of suicide. Even those who are guilty of the accusations are at high risk of depression, anxiety and suicide. The way jail and prison inmates treat those accused of child molestation is well known and may result in beatings, homosexual rape, castration, or murder. In prison culture it is considered an honor to assault, severely injure or, even better, to kill a "baby raper."

The estimated incidence of false allegations differs widely between studies. Mikkelsen (10) stated that false allegations are statistically uncommon, occurring in 2 percent to 10 percent of cases. Everson and Boat (11) looked at results from the child protective services' files of 100 county social service agencies in North Carolina. They found the incidence of false allegations to range from 4.7 percent to 7.6 percent, with rates of false allegations rising with the age of the child.

Kanin's (12) extraordinary study on false rape allegations was conducted with the cooperation of a small metropolitan community where 45 consecutive, disposed, false rape allegations covering a 9-year period were studied. The average age of the female victim was 22. No case was considered to be a false allegation of rape unless the woman, herself, admitted that she lied and recanted the allegations. These false rape allegations constituted 41 percent of the total forcible rape cases reported during that period (n=109). These false allegations appeared to serve three major functions for the accusers: 1) providing an alibi, 2) seeking revenge, 3) obtaining sympathy and/or attention.

In their study, McCann and colleagues (13) found that there can be healing of hymenal injuries. We believe, however, when a prepubertal child reports outright sexual intercourse with an adult male, more likely than not, there should be some evidence of ripping, tearing, or scarring of the hymen. Hence, a thorough physical examination by a competent expert with high quality photographic documentation of the child victim is essential when allegations of vaginal or rectal penetration are made.

PANEL SELECTION AND RATIONALE

The decision whether to arrest, prosecute, convict, exonerate, or incarcerate a person accused of child molestation is not the realm of any one expert but typically the combined effort of multiple professionals, including the

arresting officer, forensic mental health experts, prosecutor, defense attorney and judge. The San Joaquin Valley of California, where all of our panel members reside, is a community that is large enough to have a substantial number of accomplished experts in these fields, yet small enough where these professionals often get to know one another. In Fresno it is not at all uncommon to bump into our highest ranking elected officials, judges, prosecutors, police officials, attorneys and physicians at a garden party, fraternal event or at the local hardware store.

The professionals on our panel have had extensive experience in dealing with cases of sexual crimes against children. Every member of the panel has been known by the primary author for many years and held in high regard for their knowledge, skill, experience and forthrightness. They were presented with a number of factors noted in the literature by Gardner (4, 5), Summit (7), Wakefield and Underwager (8), Ross and Blush (9) and other experts, as well as factors considered valuable by the panel members themselves. They were then asked to determine each factor on a scale of 0 (insignificant) to 10 (extremely valuable) in determining whether an accusation of child molestation was likely to be false or genuine.

PANEL CONTRIBUTIONS, METHODS AND RATIONALE

For many of us on the panel who have worked directly with convicted child molesters, it is often noted that they present with an ingratiating and seductive style. We concede, however, that there are many people with ingratiating and seductive styles who are not child molesters.

We have also observed that when older adults (typically age 70 and up) with no prior history of criminal behavior demonstrate totally out of character behavior involving inappropriate sexual conduct with minors, they are often suffering from dementia or other brain disorders. This is especially true when there is no history of grooming the child, and no history of bribes or threats to discourage the child from revealing the “secret.”

Grooming of the victim by becoming their “special friend,” purchasing gifts, giving money and other ingratiating actions is typical for pedophiles and other child molesters. Grooming helps the offender gain the child’s trust and cooperation for the eventual seduction leading to sexual activities. This grooming and “friendship” help to ensure the child’s silence and even the

child's vigorous denial of improper sexual conduct if eventually questioned by suspecting parents, teachers or authorities. We note that there are also many kind and generous adults who contribute their time, money and attention to children for the betterment of society and without any lascivious or malignant intent.

Female sex offenders have been reported as having a high incidence of psychiatric disorders, however female pedophiles are rarely described in the literature (14). Females who molest children reportedly have a higher rate of alcoholism than men who molest children (15). In our panel members' combined experience men are almost always the accused. In the rare cases we have seen of women found to have molested minors (e.g., school teachers having sex with their teenage male students or the adult female trying to sexually educate the teenage boys in the neighborhood), we have observed that they far more often than not are suffering from a serious mental disorder such as bipolar disorder, schizophrenia or a severe substance abuse problem. Bipolar disorder by its very nature often results in hypersexuality, poor impulse control and severely impaired judgment (16). Most of our panel's combined experience involves cases where a man is the accused. Hence, our findings are most relevant to cases in which males are the accused.

For those of us on the panel who have worked directly with parents who have promoted false allegations of sexual abuse, especially the mother who sets the stage for what the late Dr. Gardner would consider parental alienation syndrome, we have found they frequently suffer from severe personality disorders (such as borderline or histrionic personality disorder) or psychotic mental disorders (such as schizophrenia or bipolar disorder).

We have also found that many times a sexual offender will show the child victim pornography in order to desensitize them and convince them that this is acceptable behavior. Perpetrators will also sometimes provide the minors (usually teenagers) with alcohol, street drugs or sedating medications in order to weaken the child's defenses and facilitate the predator's sexual advances. Although many sexual offenders will befriend, date or even marry an adult woman in order to gain access to her children, the exclusive pedophile typically has never married or entered into a serious romantic relationship with another adult because his primary sexual interest is pre-pubertal children.

OUTCOME OF PANEL STUDY FOR SEXUAL ABUSE INDICATORS

These criteria set forth as Sexual Abuse Indicators are listed from “Extremely Valuable” to “Minimally Valuable” based upon the average score from the ten panel members. All co-authors, except the primary research assistant (Brian Terrell, an undergraduate researcher in the early phase of his scientific training), were interviewed by the primary author, Howard B. Terrell, M.D. Responses were recorded, and then ranked. An average score of 9-10 was Extremely Valuable, 8-8.9 Very Valuable, 5-7.9 Moderately Valuable, 4-4.9 Slightly Valuable and 3-3.9 Minimally Valuable.

The most valid use of these indicators requires a professional, open-ended interview by a competent, unbiased and well trained forensic expert with extremely judicious use, if any, of leading or loaded questions. It is also preferred that the initial evaluation be recorded on video or audio in order to obtain and preserve the essential information and also to minimize the emotional trauma upon the child from repeated interrogations.

SEXUAL ABUSE INDICATORS (SAI)

CRITERIA FOR CREDIBLE ALLEGATIONS OF CHILDHOOD SEXUAL ABUSE

Extremely Valuable

- 1) Specific evidence of abuse (suspect’s semen and DNA found in child’s vagina) confirms child’s allegations.
- 2) The child and the accused have the same sexually transmitted disease (e.g., chlamydia, gonorrhea, syphilis, herpes, trichomonas or HIV).
- 3) There is a history of the suspect showing pornography to the child.
- 4) The accused has asked, threatened or bribed others to lie in order to assist in his defense.

Very Valuable

- 1) There is evidence that the victim was given an intoxicating substance by the accused to facilitate the abuse.

- 2) There is evidence that the accused had access to the specific intoxicating substance (other than alcohol) used to drug the victim.
- 3) The suspect is found to be in possession of illegal child pornography.
- 4) The suspect has a history of sexually abusing other victims.
- 5) Medical evidence exists that the child was under the influence of a non-prescribed intoxicating substance while in the presence of the suspect.
- 6) The child provides specific and credible details of the abuse.
- 7) Physical examination generally confirms allegations of abuse (e.g., history of penile penetration of the vagina with findings of a torn hymen).
- 8) The child demonstrates an unusually precocious knowledge of sexual behavior for their age (e.g., a 7-year-old girl talks about oral sex, ejaculation or orgasm).

Moderately Valuable

- 1) The child's account of the abuse demonstrates mood and affect consistent with what is expected of a victim reporting a sexual crime as opposed to a well-rehearsed story.
- 2) History of grooming where the accused has developed a special or exclusive relationship with the child, providing the child with money, gifts, favors or the promises of such.
- 3) The child reports threats or bribes by the suspect to discourage divulgence of the abuse.
- 4) The child's allegations of abuse are consistent over time.
- 5) If the accused is a parent or stepparent, the complaint was not made in the context of a child custody dispute or litigation.
- 6) The child expresses fear of retaliation by the suspect for revealing abuse.

- 7) Feelings of shame or embarrassment by the accusing parent or child over revealing the abuse.
- 8) The child is very hesitant to discuss the sexual abuse.
- 9) Retraction of accusations by the child *with* apparent fear of reprisal from the accused.
- 10) The child demonstrates regressive behavior since making the allegations (e.g., separation anxiety, decreased self care, age inappropriate behavior, thumb sucking or enuresis).
- 11) The accused suffers from dementia, brain tumor or severe brain injuries.
- 12) The child demonstrates depression, withdrawal or psychosomatic disorders.
- 13) The suspect chooses a job or volunteer work that gives him ready access to children of the age and gender he allegedly molests.
- 14) The suspect has a history of being sexually abused as a child.
- 15) The accusing parent initially denies or downplays the abuse.

Slightly Valuable

- 1) The adult suspect has never been married or had a committed romantic relationship with another adult.
- 2) The suspect is unwilling to submit to a lie detector test offered by the police prior to trial or entering into a plea bargain.
- 3) The accusing parent appreciates the emotional trauma to the child from repeated interrogations.
- 4) The suspect is extremely controlling or opinionated.
- 5) The suspect is extremely moralistic.
- 6) The accused is a parent or stepparent and there is no evidence of parental alienation syndrome.

Minimally Valuable

- 1) The suspect demonstrates an unusually charming and endearing nature in his interactions with others.
- 2) The accusing parent appreciates the importance of maintaining some sort of relationship with the accused (if the accused is a blood relative) after revelations of the abuse.

**CRITERIA AGAINST CREDIBLE ALLEGATIONS
OF CHILDHOOD SEXUAL ABUSE**

Extremely Valuable

- 1) The accused has never had the type of physical access to the child that would allow for the sexual abuse.
- 2) The allegations are bizarre and defy the laws of physics or common sense. (e.g., the molester was flying around the room like a witch on a broomstick).
- 3) The alleged victim or the parent who alleges abuse has threatened or bribed others to support the allegations.

Very Valuable

- 1) The alleged victim or accusing parent has made threats to destroy the accused *before* sexual abuse allegations were ever made.
- 2) Physical examination is not consistent with the child's allegations of abuse. (i.e., a 7-year-old female alleges sexual penetration with an adult penis yet there is no evidence of ripping, tearing, scarring or other damage to the hymen).
- 3) There is an obvious motive for the accusations such as child custody, money, revenge or to cover up for someone else's abuse of the child.

Moderately Valuable

- 1) The accusing parent or child who brings forth the accusations demonstrates evidence of a serious personality disorder (i.e., borderline, histrionic, or antisocial personality disorder).
- 2) The child is eager to tell the story of abuse to most anyone who will listen.
- 3) The parent who alleges abuse is eager to tell the story of abuse to most anyone who will listen.
- 4) The complaint was made in the context of a child custody dispute or litigation.
- 5) The accused is a parent or stepparent and there is evidence of a Gardner type of parental alienation syndrome, where one parent or parent surrogate unjustifiably denigrates the other and alienates or “brainwashes” the child to despise the other parent.
- 6) The suspect is eager to submit to a lie detector test offered by the police *before* trial or entering into a plea bargain.
- 7) The interview of the child involved leading questions implicating the accused rather than an open ended, neutral and professional evaluation.
- 8) The child’s description of the abuse is devoid of the emotion and affect (e.g., sad, depressed, anxious, frightened or tearful) that would be expected from a crime victim and appears more like a well-rehearsed story.
- 9) Retraction of accusations by the child occurs *without* fear of reprisal from the accused.
- 10) The accusing parent or child who brings forth the accusations has a history of a serious mental disorder such as bipolar disorder or schizophrenia.
- 11) The child’s account of the abuse changes substantially over time.

Slightly Valuable

- 1) There is no history of grooming the child for future abuse by the accused.
- 2) The parent who alleges abuse does not appreciate the emotional trauma to the child of repeated interrogations.
- 3) The child does not demonstrate evidence of significant depression or withdrawal.
- 4) The child (age 8 or younger) does not show evidence of regressive behavior (e.g., separation anxiety, enuresis, thumb sucking, reduced self care or age inappropriate behavior).
- 5) There is no history of threats or bribes by the accused to discourage revelations of the abuse.

Minimally Valuable

- 1) The suspect does not choose a job or volunteer work that gives him access to children of the age and gender he allegedly molests.

CONCLUSION

Our panel considered assigning a specific number of points to each factor with a numerical scale and calculated score to determine genuine versus false accusations, as was done in the Sex Abuse Legitimacy Scale (SALS) by Dr. Richard Gardner (5). However, we do not believe a specific calculated summation or score would be of value at this time. We believe the most valuable use of these positive and negative sexual abuse indicators will be performed by a skilled forensic evaluator (typically a psychiatrist or clinical psychologist) who is fair, even-handed and highly experienced in dealing with child victims as well as sexual offenders who sexually exploit children and considers the relevant information in light of his or her own knowledge, insight and clinical experience.

It is hoped that these positive and negative indicators will be of assistance to professionals such as psychiatrists, clinical psychologists, peace officers, attorneys and judges who are called upon to consider allegations of

childhood sexual abuse. Our goal has been to attempt to identify and present an even-handed and impartial set of indicators to help professionals differentiate credible from false allegations of child molestation.

Like the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (16), it is anticipated that there will be periodic reviews and revisions of these criteria by highly qualified and impartial experts so it may become more valuable and relevant over time.

CAVEAT

No empirical studies were conducted to establish the reliability, validity, or accuracy of this proposed new instrument. Therefore, the SAI must be used with *extreme caution*, especially for forensic purposes. At the time of article, this instrument could not be said to meet either Kelly/Frye or Daubert evidentiary rules for introduction of scientifically-based or esoteric professional information. The Kelly/Frye standard of admissibility, which exists in California and Washington states among others, requires that a new scientific technique used by an expert witness in a child sexual abuse case be generally accepted within the relevant scientific community. Daubert standards can be found in the United States Supreme Court ruling in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (17). Hence triers-of-fact must be *clearly informed* of the limitations of the instrument.

Future use and research will tell if the SAI ever becomes generally accepted. In the meantime, however, we believe it to be a good starting point for empirical research and knowledge within this very complex area of study. We hope this article will eventually give rise to developing an instrument that is sufficiently reliable and valid so as to gain widespread acceptance within the scientific community.

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REFERENCES

1. Talbot M: The devil in the nursery. New York Times Magazine. January 7, 2001

2. Eberle P, Eberle S: *The Abuse of Innocence: The McMartin Preschool Trial*. New York, Prometheus, 1993
3. Lindsay R: Boys' responses at sex abuse trial underscore legal conflict. *New York Times*, January 27, 1985
4. Gardner RA: *The Parental Alienation Syndrome*. Creskill, NJ, Creative Therapeutics, Inc., 1992
5. Gardner RA: *Sex Abuse Legitimacy Scale*. Creskill, NJ, Creative Therapeutics, Inc., 1987
6. Berliner L, Conte JR: Sexual abuse evaluations: conceptual and empirical obstacles. *Child Abuse and Neglect* 1993; 17:1:111-125
7. Summit RC: The child sexual abuse accommodation syndrome. *Child Abuse and Neglect* 1983; 7:177-193
8. Wakefield H, Underwager R: Personality characteristics of parents making false accusations of sexual abuse in custody disputes. *Issues in Child Abuse Accusations* 1990; 2:3:121-136
9. Ross K, Blush G: Sexual abuse discriminators in the divorced or divorcing family. *Issues in Child Abuse Accusations* 1990; 2:1:1-6
10. Mikkelsen EJ, Guthiel TG, Emens M: False sexual-abuse allegations by children and adolescents: contextual factors and clinical subtypes. *American Journal of Psychotherapy* 1992; 46:4:556-570
11. Everson MD, Boat BW: False allegations of sexual abuse by children and adolescents. *J Am Acad Child Adolesc Psychiatry* 1989; 28:230-235
12. Kanin EJ: False rape allegations. *Archives of Sexual Behavior* 1994; 23:1:81-90
13. McCann J, Sheridan M, Boyle C, Rogers K: Healing of hymenal injuries in prepubertal and adolescent girls: a descriptive study. *Pediatrics* 2007; 119:5:1094-1106
14. Chow EW, Choy AL: Clinical characteristics and treatment response to SSRI in a female pedophile. *Arch Sex Behav* 2002; 31:2:211-215
15. Rada RT: Alcoholism and the child molester. *Ann NY Acad Sci* 1976; 273:492-496

16. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Washington, DC, American Psychiatric Association, 2000
17. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993)

ABOUT THE AUTHORS

Howard B. Terrell, M.D. is a graduate of UC San Diego School of Medicine. He is board certified in psychiatry and forensic psychiatry. Dr. Terrell is also a Distinguished Fellow of the American Psychiatric Association and a Fellow of the American College of Forensic Psychiatry. He holds the rank of Assistant Clinical Professor of Psychiatry with the UCSF School of Medicine and teaches psychiatry residents with the UCSF Fresno Medical Education Program. He has performed thousands of forensic psychiatric evaluations for California superior court judges over the past 20 years.

Brian Terrell served as the primary research assistant on this article. He is a pre-law undergraduate student with the University of California, Davis.

Anthony Capozzi, Esq. is past President of the State Bar of California (2003-2004). He is a former Assistant U.S. Attorney, and former law clerk to a federal judge. He is currently in private practice of criminal law in Fresno, California. He is also a member of the Judicial Council of the State of California.

Hon. Judge Victor N. Papadakis, Ret. is a graduate of Santa Clara University College of Law. He served many years as a criminal defense attorney before becoming a Fresno County Municipal Court Judge and later a Superior Court Judge. He currently serves as Adjunct Professor of Criminology with California State University, Fresno.

The Honorable Judge H.N. Papadakis, Ret. is a retired Fresno County Superior Court Judge with 24 years on the bench. He now sits on assignment in courtrooms throughout the state of California. Prior to becoming a judge he served as a deputy district attorney and as a criminal defense attorney.

Timothy M. Donovan, Esq. is a graduate of Pepperdine University School of Law. He serves as a Deputy District Attorney with the Fresno County District Attorney's Office and is currently assigned to the Elder and Dependent Adult Abuse Unit.

Karen Kraus, M.D. is a graduate of the University of Washington School of Medicine. She is board certified in psychiatry and child psychiatry. Dr. Kraus holds the rank of Assistant Clinical Professor of Psychiatry with the University of California, San Francisco School of Medicine and trains psychiatry residents at UCSF's Fresno Medical Education Program.

Kathy Sullivan Ph.D. is a licensed clinical psychologist and director of the Sullivan Center for Children in Fresno, California.

Mark Hodges is a retired peace officer. He served for two years on the Trinity County Juvenile Justice Advisory Board under the supervision of the presiding judge. He served three and one half years with the Trinity County Sheriff's Department as a patrolman and fifteen years with the California Highway Patrol where he retired as a sergeant. He currently serves as a Masonic Youth Advisor with DeMolay International. DeMolay is the largest fraternal organization in the world for young men between the ages of 12 and 21.

A.A. Howsepian, M.D., Ph.D. is board certified in psychiatry. He is on the psychiatry staff at the Veterans Administration Central California Health Care System and is on the teaching faculty for UC San Francisco School of Medicine. He trains psychiatry residents at the UCSF Fresno Medical Education Program. He holds the rank of Assistant Clinical Professor of Psychiatry. Dr. Howsepian graduated from the UC Davis School of Medicine and from the University of Notre Dame, where he received his Ph.D. in philosophy. His private practice is primarily in forensic psychiatry.

David A. Fox, M.D. is a board certified child/adolescent psychiatrist in private practice and an associate clinical professor of psychiatry at UCSF. A graduate of Harvard University and Yale University School of Medicine, Dr. Fox completed his psychiatry residency and child/adolescent fellowship at Massachusetts Mental Health Center and completed a NIMH Research Fellowship at Boston Children's Hospital.