

The Biases of Child Sexual Abuse Experts: Believing is Seeing

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Experts in clinical evaluations of child sexual abuse were studied using a paradigm that requested them to estimate the likelihood of a 3-year-old child having been sexually molested by her father, as alleged by her mother, when she was two years old. All of the experts claimed special qualifications and experience in the field of diagnosing and treating child sexual abuse victims. Expert-respondents provided two estimates of the likelihood that the child had been molested, the first following a detailed presentation of the clinical case by the actual evaluator of the child (the presentation included opportunities to ask questions *ad libitum* beyond the presentation material), the second following an extensive discussion of the clinical material with other child experts present. The range of estimated likelihoods that the child had been molested was extreme among the expert respondents. The clinical conference format that was used seemed to provide the experts with no apparent means for eliminating or reducing differences in their clinical opinions. Recommendations concerning how the supervising court should regulate further child-father contacts were similarly varied. The implications of these findings for judicial acceptance of expert testimony in cases of alleged child sexual abuse are discussed.

Courts frequently turn to mental health and child development specialists in cases of alleged child sexual abuse. Many such cases arise from ambiguous behavioral circumstances, including verbalizations made by children. Clinicians testifying in such cases face a number of problems, not the least of which is the task of determining the truth-telling/fact-reporting accuracies of the involved

parties, and the task of interpreting the “meanings” of the various circumstances they encounter in such cases. These “meanings” are characteristically imputed to the circumstances through an inchoate process of clinical inference, and they are ultimately channelled toward estimations, or opinions, as to (1) whether molestation has occurred (and, if so, the nature of the molestation); and/or (2) the risk that it will occur/recur.* Since courts rarely seek the opinions of

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*The concept of “clinical inference” in this regard suggests a process that is neither inductive nor deductive in its logic, but is instead an ineffable and intuitive enterprise informed by accumulated experience. It is thus neither pinned to, nor arises from, strictly speaking, a strong empirical base.

mental health experts when the factual evidence is sufficient to yield a finding of defendant guilt, the most common characteristic of cases for which expert opinion is sought is either a paucity of direct evidence (i.e., there is merely an allegation) or the presence of ambiguity or substantially conflicting evidence.

Close study of the various aspects of clinical inference has exposed significant shortcomings on the parts of persons typically regarded as clinically qualified to render estimates as to the likelihood that certain events (e.g., sexual abuse) have occurred based on circumstances and characteristics described during clinical evaluation. For example, empirical studies of young children's recollections of experienced events have, with few significant exceptions, demonstrated a general unreliability of child informants in a variety of circumstances.¹⁻⁴

Rational solutions to the problem of inherently unreliable children's testimony do not, as some activists contend, turn on simply the commitment to "believe the children," a shibboleth heard 300 years ago in Salem as well as today. The problem of children's testimony, even in the face of emerging evidence that young children sometimes do deceive⁵⁻⁷ is not fundamentally a problem of truth-telling *per se*, but rather a problem of accuracy and specificity in recall. Few presumptions are safe to hold in this regard other than what common sense and cumulative experience teach, namely, that the reliability of children's statements concerning specific events of the past is inherently questionable.

As it is, the deception-detecting abili-

ties of various experts, including mental health specialists, has been empirically demonstrated to be decidedly poor.⁸ In any search, therefore, for solutions to the problem of determining the accuracy or truthfulness of young children, the accuracy/truth-discerning shortcomings of the expert must be considered as well.

Studies of expert classificatory reliability in cases of alleged child sexual abuse have demonstrated predictably high rates of error (Horner-Guyer predictions) on the part of clinicians using clinically derived data to classify individuals as abusers/nonabusers. Rates of false positive classification have been shown to be many times greater than the rates of false negative classification.⁹ Failures by experts and courts to account for the diagnostic sensitivities and specificities of interview procedures constitute the most significant basis upon which experts and courts are likely to err in cases of alleged abuse.¹⁰

The Horner-Guyer predictions are made from the standpoint of rational decision-making theory. Since cases in which ambiguous or conflicting factual circumstances exist, and in which competing assertions are made, constitute a large proportion of the suspected abuse cases that are referred to clinical experts, it would be extremely difficult to study empirically the actual classificatory performances of such experts against a scientific standard of independent verification. One way, though, to test empirically the Horner-Guyer predictions would be to present an actual case of an alleged child sexual molestation to a series of mental health and child develop-

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ment specialists, and then elicit their opinions as to whether or not, on the basis of the obtained clinical evidence, the child in question had indeed been molested as alleged. Whereas an obtained consensus of opinion would in no way affirm that that consensus was in fact correct (for example, they might all have reached the same erroneous conclusion), an obtained broad range of opinion would surely affirm that a sizable majority of the individual opinions were *incorrect*. An obtained array of divergent opinions would certainly weigh heavily against individual experts' claims of an objective standard called expertise.

Studies employing mental health specialists from various disciplines and possessing varying degrees of professional experience have in fact shown expert opinion formation to produce highly subjective and variable estimates of the occurrence of a specific event.^{11, 12} Using an actual case of alleged child sexual abuse, a total of 129 mental health specialists in child psychiatry, clinical psychology, clinical social work, and allied disciplines have been asked to estimate the likelihood that a child alleged by her mother to have been sexually molested had in fact been molested. † Ninety-eight of these clinician respondents have provided, during the course of a case presentation, two such estimates, each termed First Estimated Probability and Second Estimated Probability, respectively.

† For a detailed presentation of this case see Horner Goyer, and Kalter.

¹¹ For a synopsis of this case see the Appendix of this article.

The *First Estimated Probability* (FEP) was solicited following an extensive and detailed case conference given by the evaluating clinician, in which respondents were given (1) opportunities to view videotaped segments of the child interacting with each of the parents; ‡ (2) detailed histories and descriptions of the child as elicited from the parents, Protective Services, police investigators, and previous evaluators; (3) detailed histories of each parent as elicited by the evaluating clinician, including the eval-

‡ Key among the segments that were shown to the expert respondents were segments that showed Melissa rebuking her father, calling him a "probeby" (sic), a "fucking guy," and a "mean Daddy", and her once admonishing him not to hit her, and they were shown segments that illustrated Melissa's affectionate and spirited interactions with her father and that showed her sadness at having to end the session. (Respondents were shown all of the videotape's segments that could possibly implicate the father as a feared or otherwise disliked parent; but, because so much of the tape was characterized by positive interchanges, only a representative sampling of the positive segments were shown.)

Respondents were aware at the time of the presentation that Melissa and her father had had, as instigated by Melissa's mother, four months without any type of contact, which in turn had been followed by nearly three months of weekly hour-long contacts supervised by the Department of Social Services. They were thus aware that Melissa's derogatory verbalizations were separated in time by 7 months from any period in which the alleged molestations could have occurred, and that said period of Melissa's vulnerability to abuse by her father had ended at least one year earlier. It therefore could have occurred, if indeed it did, no later than when she was just beyond two years of age.

Even at the point at which respondents observed the videotaped interactions between Melissa and her father we encountered across all of our studies striking diversity of impression and opinion among respondents as to the implications of the behaviors portrayed. Some experts have commented on the negative implications, others on the positive implications, and most found themselves able to "explain" any contradictions or ambiguities they observed. A small number of experts actually commented that they found the videotaped segments painful or uncomfortable to watch, whereas others commented that they found the segments highly representative of a three-year-old's spirited albeit compromised (i.e., she had been deprived of contact with her father for a long period of time) interactions with her father.

uating clinician's appraisal of each parent's mental status; and (4) the mother's and father's separate interpretations of the child's behaviors that had caused the mother to allege sexual abuse. The *Second Estimated Probability* (SEP) was solicited following an extensive discussion of the case by the respondents, in which opportunities to argue specific interpretations of the findings were present.

Across all of our studies, clinician-respondent estimates at both points of solicitation have consistently ranged from .00 to 1.00 (Mean FEP = .46, average SD = .26; Mean SEP = .26, average SD = .23), with data clearly establishing that the ranges were not created by small groups of outliers at either end of the range.^{11, 12} The findings strongly suggest that training and specialization in child mental health and/or development provides a fact finder little real assurance as to the reliability of experts' classifications of persons as sexual abusers and nonabusers.

Considerations of these data prompt the question of whether or not extensive professional training and experience specific to diagnosing and treating children alleged to have been sexually abused is a necessary part of the expertise needed in such cases. Among specialists professing to possess unique training and experience in diagnosing and treating sexually abused children, what would be the range of estimated likelihoods that sexual abuse had occurred when presented with the same clinical information that was used in our studies to assess mental health expertise in general? The present study was undertaken to address this question.

Method

The data records of the 129 specialists participating in the Horner, Guyer, and Kalter studies were reviewed for information that would allow the investigators to classify a subgroup of specialists describing themselves as being uniquely qualified to assess the presence of child sexual abuse. Ninety-eight respondents had completed protocols that contained three questions: (1) Do you have experience evaluating child sexual abuse cases?, (2) Are you an expert in determining whether or not sexual abuse has occurred in children under five years of age?, and (3) Do you routinely treat child sexual abuse cases? The response protocols of all of the respondents who answered "Yes" to these three questions were culled, and their estimates of the likelihood of sexual abuse in the case of "Melissa" examined. §

In all, based on the self-report protocols, eight respondents could be classified as experts using these criteria. Six of the experts were child clinical psychologists, one was a child psychiatrist, and one was a nurse. Six experts were women, two were men.

§ Of the remaining 31 clinician-respondents participating in our studies but not filling out the protocol, we had strong reason to believe that only one (whom we knew, and whose estimate of the likelihood of Melissa's having been sexually abused, and whose recommendation concerning child-father contact, we also knew) would have responded "Yes" to the three questions directed at determining expertise. Most of the 30 remaining respondents would have been graduate students in clinical training (N = 23). The rest (N = 7) were experienced clinicians among whom none but one, based on our personal knowledge of them, could properly have replied "Yes" to all three questions. The one clinician respondent who would have responded "Yes" if given the opportunity to do so (we have verified this with that clinician) has been included in our culled group of clinician-respondents.

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In relation to Melissa, we had presented to all of the respondents in our studies a list of six possible child-father contact arrangements that a custody-deciding court might consider, asking them to select the visitation/custody recommendation they would most prefer to make given the clinical data they received. They had also been asked to comment, if they believed Melissa to have been molested, on the nature of the abusive act(s). (For an account of these latter data with respect to the large groups of respondents participating in our studies, see Horner, Guyer, and Kalter.¹³) As part of this study, therefore, the records of the eight experts (hereafter termed elite experts) were reviewed for the responses they gave to the inquiries made along these lines.

Results

Results fall into three categories: (1) individual estimated likelihoods that

Melissa was sexually abused by her father, (2) individual speculations as to the nature of the putative abuse, and (3) individual recommendations concerning future child-father contact.

Estimated Likelihood of Sexual Abuse As was the case in the previously reported studies, the elite experts provided two separate estimated probabilities that Melissa had been sexually molested by her father. The ranges of the elite experts' estimated probabilities were the same as the ranges of estimated probabilities produced by the larger groups of clinician respondents participating in our studies: Range = .001–1.00 in the case of both FEPs and SEPs. The mean FEP for these elite experts was .47 (SD = .35), while their mean SEP = .41 (SD = .34) (see Table 1).

Speculations as to the Nature of the Imputed Sexual Abuse Six of the eight elite experts either left the inquiry concerning "what had happened" blank (n

Table 1
Estimated Likelihoods of Sexual Abuse and Recommended Child-Father Contact by Respondent

Respondent	Profession	Gender/ Years Experience	Estimated Prob of Abuse		Recommended Child-Father Contact*	
			FEP	SEP	First	Second
1	Child Clin Psychologist	♂/12	.001	.001	5	5
2	Child Psychiatrist	♂/12	.08	.05	None	None**
3	Child Clin Psychologist	♀/15	.10	.10	6	6
4	Child Clin Psychologist	♀/14	.25	.25	4	4
5	Child Clin Psychologist	♀/ 2	.75	.55	2	3
6	Child Clin Psychologist	♀/27	.75	.75	2	2
7	Child Clin Psychologist	♀/ 9	.80	.60	3	3
8	Nurse	♀/16	1.00	1.00	2	1

* Key: 1 = Termination of father's contact rights
 2 = Supervised visits only
 3 = Supervised visits pending further evaluation
 4 = Unsupervised contact, no overnight contact
 5 = Unsupervised contact, including overnight contact
 6 = Custody to father

** This respondent wrote that other options were available but did not specify any that he would recommend.

= 5) or wrote "Don't know" (n = 1). This percentage corresponds roughly to the percentage of respondents as a whole in our studies who elected not to respond to this query.¹³ Not surprising to us, the elite experts who submitted the four lowest estimates of the likelihood that sexual abuse had occurred (all estimates less than .50) elected to make no speculative comment as to what had happened.

Two elite experts, however, did comment on what they believed to have happened between Melissa and her father. One of these, a nurse with a reported 16 years of experience, and who was certain that Melissa had been sexually abused by her father ($p = 1.00$), wrote that Melissa had been sexually abused "probably using objects for insertion." She further indicated that "sexual rubbing of his genitalia in the area of her genitalia" had occurred, as was evident by the reported bruises. She stated that the presence [sic] of the [father's] hair in Melissa's diaper, as well the presence [sic] of blood in Melissa's stool, were "stipulated" [sic] by her state's child sexual abuse laws, and stated as well that the child's statements were most important in determining whether or not sexual abuse had occurred.

The other elite expert, a child clinical psychologist with a reported 27 years of experience, wrote in response to the inquiry item, "Cunnilingus—causing whisker burns; digital penetration of rectum or sodomy while holding child tightly by the legs causing the bruising." Following the discussion amongst the respondents, this expert added "Oral sex

on child plus anal sex or digital penetration of rectum."

Recommendations Concerning Child-Father Contact Made by Elite Experts on the Basis of Estimated Likelihood of Sexual Abuse Unlike the majority of clinician respondents in our studies,^{11, 12} elite experts tended strongly to recommend child-father contact congruent with their estimates of the likelihood of sexual abuse having occurred (see again Table 1). Thus, two of the three lowest estimates of the likelihood of sexual abuse made by elite experts ($p = .001$, $p = .10$, respectively) were associated with recommendations that Melissa's contact with her father be unrestricted. One of these elite experts took the only opportunity recorded in our studies to recommend that Melissa's father have custody of Melissa. The next lowest estimate of likelihood of sexual abuse ($p = .25$) was associated with the minimally restrictive recommendation of unsupervised contact but without overnight contact.

Not surprising, the three elite experts who estimated the highest likelihoods of sexual abuse having occurred also recommended the most restrictive child-father contact options. The elite expert who was certain ($p = 1.00$) that Melissa had been sexually abused recommended first that contacts between Melissa and her father be supervised, then later recommended that they be eliminated altogether.

Discussion

These results reaffirm previous assertions that experts constitute a highly

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variable and therefore unreliable source of opinion formation in cases of alleged sexual abuse.^{9, 10, 11, 12} The findings buttress cautions that have been previously made by both clinical^{9, 10, 14-20} and legal²¹⁻²⁷ commentators concerning the decision-making and opinion-forming limitations (and therefore liabilities) of clinical experts. Said cautions, it appears, must also be raised against persons who present themselves as uniquely qualified by training or experience to opine and pronounce, either definitively or on probabilistic grounds, upon questions of alleged child sexual abuse.

It is noteworthy that the two male elite experts submitted the lowest estimated probabilities that abuse had occurred. One of these male respondents submitted the second most liberal recommendation concerning future child-father contact, i.e., liberal and reasonable visitation. Of all the studies we have conducted thus far in this area, this is the only one to adduce possible evidence of gender-related opinion-formation. The significance of the evidence is somewhat attenuated, though, by the fact that two additional elite experts who submitted very low estimated probabilities of abuse having occurred were women, and that one of these female respondents recommended that custody of the Melissa be shifted to her father.

One need not be familiar with the content of stimulus case that was used in our studies to conclude that, regardless of its specifics, experts deliberating alone or in concert not only do not agree on the significance and implications of particular clinical observations and find-

ings, but are as likely to take diametrically opposed paths both in their inference making and their recommendations as they are to find themselves travelling along common paths of inference toward similar recommendations. Moreover—and we find this most troublesome given the rather broad latitude many experts seem to be given in judicial proceedings—one path upon which some experts seem willing to travel is a path of rather literal reasoning that would take them to an alarmingly certain conclusion, on the basis, essentially, of a reported hair in a child's diaper or a reported bruise on that child's leg, that child had been penetrated with objects (elite expert 8) or subjected to cunnilingus (which, posited, *then accounted* for whisker burns) as well as sodomization (elite expert 7).||

In light of the data accumulated thus far, one might concede that within the large population of experts to which courts routinely turn there exist *some* experts who at least *some of the time* make accurate classifications of children alleged to have been sexually molested. But even knowing this, one is left with the quandary of determining which *some* these experts are. Further, how reliable would such experts be across a series of cases? How is a court, a fact finder, or the public to know which experts are reliable and which are not,

|| For a more extensive assessment and discussion of this kind of reasoning see Horner, Guyer, and Kalter.¹³ For an incisive discussion of how clinicians so frequently convert their hypotheses to given facts, often failing to realize that this is what they have done, see Spence²⁹ or Meehl.¹⁷

when the obvious state of expertise is one of unverifiable claims and unsubstantiated validity?

There is little doubt that on some small, perhaps even random, scale clinical experts are correct in their classifications of abusers some of the time. But this kind of accuracy is hardly rooted in capabilities at divining events of the past or future from the observed or reported conditions of the present. Nor, as the findings of several studies have confirmed, should merely the expert's expressed confidence in her or his opinion be taken as any indication that the opinion is more likely to be correct than opinions more tentatively offered.^{12, 30-32}

On the basis of the accumulated data, then, and no longer simply or solely upon theoretical principles of predictable clinical decision-making accuracy alone, we aver that experts quite routinely err in their classifications of alleged sexual molesters. Moreover, granting that across any array of experts some small portion will indeed be correct in their conclusions, there is no dependable basis on which courts may rely to determine who these experts actually are.¶ Our studies have consistently pointed us

¶ Studies of the manner in which experts acquire, attend to, and process data may disclose systematic patterns of distorted inference-making unique to clinical reasoning. Certainly, clinicians' heavy reliance upon something familiarly called "clinical intuition" would seem to constitute a most problematic mode of reasoning in the face of decisionmaking models that are empirically based and responsive to data rather than intuitions (see, for example, Kahneman and Tversky³³ see, in this regard, Dawes³⁴; Dowie & Elstein³⁵; Meehl³⁶; also Dawes, Faust, and Meehl³⁷; Horner and Guyer.³⁸) For an excellent detailed consideration of the problems and tasks of studying human inference and decision making see Holland, Holyoak, Nisbett, and Thagard.³⁹ For an effective tutorial in decision making theory see Dawes³⁴ or Resnik⁴⁰ among many others.

toward inferences that clinical modes of inquiry provide little in the way (if they provide any at all) opportunities for genuinely clarifying the evidentiary ambiguities and contradictions that so frequently characterize cases of alleged child sexual abuse. The divergent opinions and selections of facts we have consistently observed in clinician-expert groups make it likely that as opinion formers clinicians simply use facts as bases for expounding and rationalizing preconceptions and intuitions arising from particular *Gestalten* of the clinical material that is unique to them as individuals.

The justice system recognizes the inherent fallibility of ordinary witness testimony and attempts to abridge it through its prohibitions of hearsay testimony and conclusory statements, all of which hold great potential of intrusions of personal bias, prejudice, and self-interest. The findings from the present and previous studies suggest that such judicial cautions be similarly applied to the opinion testimony of expert witnesses as well. Burdens should be placed upon experts to demonstrate that they do more palpable good than harm when afforded an occasion to offer opinions concerning ambiguous circumstances and contested findings.

In cases of the sort discussed here, mental health experts as a class can do little more (and perhaps nothing better) than the courts themselves can already do through their established fact-finding procedures. It is clear that experts possess no significant truth-determining abilities unique to their clinical skills and

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practices. The opinions of experts in our studies show as much variability as can ever be ascribed to judges or juries. By virtue of their cognate and technical expertise,¹ experts may provide avenues toward facts that courts do not inherently possess; but as a class of interpreters of facts, they appear no more equipped or specially qualified than any other class of witnesses whose opinions might be sought.

Conclusion

In the 20 years since the late eminent Judge Bazelon wrote on the subject of psychiatric expertise, the mental health specialties have not, it seems, progressed beyond being what he termed "the ultimate wizardry."⁴¹ "My experience has shown," he wrote, "that in no case is it more difficult to elicit productive and reliable expert testimony than in cases that call on the knowledge and practice [of such specialists]."⁴¹

Inherent in our system of justice is a recognition that, owing to the inevitable uncertainty that veils the truth behind alleged acts, the path toward minimizing total error requires that at least some error be accepted. In other words, it is a judicial assumption that decision-making outcomes cannot be correct each and every time. Owing to a legal tradition that can be traced to the English revolutions and beyond,^{42,43} our system of justice is therefore committed to erring in the service of protecting individual liberty against the intrusive and indicting power of the state. The standards of the justice system notably parallel those of rational decision making when they

impose upon the machinery of fact-finding presumptions of unpredictability in the absence of decisive proof, or, as Einhorn⁴⁴ and Hammond, Harvey, and Hastie⁴⁵ have separately demonstrated, presumptions that one must accept error in decision making in order to minimize it. Clearly, as we have previously shown,¹² when prevalence rates of a phenomenon in question are below 50 percent, as is the case with respect to the overall incidence of child sexual abuse, the total rate of judicial error is minimized when one conforms to the presumption of innocence when faced with ambiguous or conflicting evidence.

Appendix: Synopsis of the Stimulus Case (See text, p. 283.)

The mother of a two-year-old girl, "Melissa," alleged on the basis of several behaviors the latter exhibited between 17 and 24 months of age, that Melissa had been sexually molested by her father. The mother and father had been estranged for several months, although the father had continued to have contact with Melissa throughout the period since their separation. The parents had never married.

The mother consulted the child's pediatrician several times with concerns about what she said were nightmares Melissa was having from time to time, a bruise that she had seen on Melissa's leg, traces of blood that she reported finding in one of Melissa's stools, a verbalization by Melissa once that "Daddy hurt vagina," Melissa's resistance to having her diaper changed, her mother's (the maternal grandmother) discovery once of a

hair—she came to believe it to have been a pubic hair—in Melissa’s diaper that, she said, was of the father’s coloration, and Melissa’s recent verbalizations of words such as “vagina” and “penis,” and phrases such as “That’s my tits” and “Where’s my dick?”

In all, four physical examinations were conducted by the pediatrician, a woman, none substantiating sexual abuse. Nevertheless, in response to Melissa’s mother’s insistence, and in order to protect herself from possible sanctions under the provisions of the state’s mandatory reporting statute, to report suspicious conditions, the pediatrician filed a report to the county’s Child Protection Service division of the Department of Social Services. Subsequent Protective Services investigations (which included exculpatory interviews with anatomically accurate dolls) and police investigations (which included two exculpatory polygraphic examinations) failed to substantiate sexual abuse. However, the mother, following the advice of a Protective Services worker who had herself not evaluated Melissa, sought further evaluation and treatment for Melissa at a community hospital which had a special program for treating child sexual abuse victims.

The evaluation that was conducted by the clinical expert whose evaluation served as the clinical material for the respondents in the present study was instigated by the court that was hearing this matter as part of a parental custody dispute. The court, being familiar with the mother’s allegations, the series of investigations that had been conducted,

and the child’s therapist’s report of a treatment that was being conducted for “the trauma of possible sexual abuse” (sic), nevertheless decided to seek additional professional opinions concerning the alleged abuse.

The respondents of the present study were aware from examples provided by the clinician evaluating the case that Melissa’s mother was assiduously keeping a diary of all the things that Melissa was verbalizing and doing that to her “proved” sexual molestation, and they were aware that the mother had secured the addresses of a number of child protection advocacy groups in the event that she needed to conceal Melissa from the courts.

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