PRE-TRIAL THERAPY FOR CHILD COMPLAINANTS OF SEXUAL ABUSE IN THE CRIMINAL JUSTICE SYSTEM: FORENSIC IMPLICATIONS

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Introduction


There is currently much debate amongst professionals across systems in relation to child witnesses receiving therapy prior to a criminal trial for fear of the possible consequences that treatment may have on the quality of the child’s evidence (QLRC, 1998:112). The concerns raised relate to a perception that “children may be susceptible to suggestion through the course of therapeutic intervention, therefore tainting the testimony of the child. There seems to be conflict between the need of a child witness for immediate therapy and the reliability of the child’s evidence after therapy has been received” (QLRC discussion paper1998:113).

This conflict or tension appears to have influenced how and when children access treatment. The QLRC (2000) Report outlines the perception that, “where court proceedings are pending, in order to avoid allegations that the child’s evidence has been contaminated by suggesting or “coaching”, counselling should be deferred until after those proceedings are complete” (p.92). A submission (421) co-ordinated by the Children’s Commission on behalf of a number of non-government organisations summarised that 12 out of 15 organisations who work closely with abused children reported that, in Queensland, “counselling for child abuse victims is commonly postponed until after the trial” …… (QLRC, Report 2000:92).

Others professionals corroborate this view claiming that few professionals offer a counselling service where there is ongoing court action due to the potential allegations that “coaching” has occurred during the course of counselling.

There is a legal basis for this concern according to the Bar Association of Queensland who reported that:

“…. It will be potentially inimical to the integrity of the child’s evidence for there to be intervention which has or may be seen as having an effect or reinforcing the commission of the offence or suggestion as to the content of, or how the content of, that child’s evidence might be presented” (QLRC, Report 2000:90).

The following comments by Queensland defence lawyers also illustrate the assumption that treatment may be linked to contamination:

“Subpoena the entire file of the Child Welfare Department so that the extent and number of conferences between Prosecution operatives in that area can be got on the record. This will be vital in order to show the jury the extent of rehearsing/contamination, which has gone on under the guise of “counselling”. Find out who the Psychiatrist/Counsellor is who the Prosecution have sent the complainant to and subpoena them similarly” (O’Gorman, 1991 in QLRC Dec 1998:114).

“They are getting in their ear (the child) and schooling them up, so that by the time they get in front of the jury they are an engineered, structured witness” (QLD Defence cited in Eastwood 2002:107).
I think that coaching goes on … I think it’s the so-called support groups where the real difficulties arise … well I haven’t come across any case where anyone’s really been caught blatantly coaching. But I’ve had a feeling … (QLD Defence cited in Eastwood 2002:107).

Lengthy delays in bringing a case to trial could potentially mean that children might not be able to access appropriate treatment for an extended period of time.

Eastwood (2002) reports that the average delay between reporting and trial in Queensland was 20.8 months; in New South Wales 16.4 months and in Western Australia 17.5 months. Eastwood stated that “almost two years spent “waiting and worrying” represents a significant proportion of a child’s life at a crucial stage of their emotional, social and cognitive development. This may have significant consequence for children’s psychological well being” (p115). Other issues that where raised in this study by children included harassment from their alleged perpetrators during the waiting period, and the inability to discuss the abuse with those closest to them due to fear of contamination of the child’s evidence.

The UK Crown Prosecution Service has provided a set of practice guidelines to assist in children receiving, as soon as possible, immediate and effective treatment to assist in their recovery. So what does the research literature say about the components of ‘effective’ sexual abuse treatment?

Section 6.9 of these guidelines recommend that “therapists or counsellors should avoid using leading questions or discussing the evidence which the individual or any other witness will give, including exploring in detail the substance of specific allegations made”.

Section 6.11 states that “children may derive therapeutic benefits from talking about their experiences, but any detailed recounting or re-enactment of the abuse may be perceived as coaching. Therapists should recognise that the criminal case is almost certain to fail as a consequence of this type of therapeutic work” (UK Crown Prosecution Service. 2001:11).

So, is it possible for a child complainant of sexual abuse to receive both a fair criminal trial & effective treatment for sexual abuse trauma and related sequelae without subordinating due process and other justice values?

Let’s take a step back and consider more fully the impact of child sexual abuse.

**Definition**

For the purpose of this paper, sexual abuse will be defined as “the involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, are unable to give informed consent to and that violate social taboos of family roles” (Schechter & Roberge, 1976; cited in Swann, 1993: 48).

There is a broad continuum of sexual abuse behaviours, which range from exposing the child to sexually explicit materials or behaviours, having the child touch, fondle or masturbate the abuser, to anal or vaginal penetration of the child.

The majority of perpetrators of child sexual abuse are male (in excess of 95 per cent). Sexual abuse has been documented as occurring on children of all ages and both sexes, and around 80 per cent of the time, the offender is known to the child, and a third of sexual offenders are themselves adolescents (Bagley 1995).
The Effects of Child Sexual Abuse

Much of the research on childhood sexual abuse has raised two important findings.

1. The impact of child sexual abuse is highly variable with no two children reacting in the same way. Variables can range from some children presenting no detectable negative effects whilst others show highly adverse reactions with severe psychiatric symptomatology (Kendall-Tackett, Williams & Finkelhor, 1993).


Saywitz, Mannarino, Berliner & Cohen 2000 argue that it is “not surprising that there is a wide range of symptomatology given the wide range of experiences that constitutes sexual abuse and the disparate context in which it can occur, ranging from indecent exposure in a park, to multiple forms of sexual abuse and other forms of maltreatment, by multiple perpetrators in a chaotic family situation” (p.1040).

Yet, because of the complexities and wide range of reactions by children who have experienced sexual abuse, there is no one identified syndrome. However, research does suggest that more than 50% of sexually abused children experience symptoms that meet either partial or full criteria for post-traumatic stress disorder (eg: McLeer, Deblinger, Atkins, Foa & Ralphe, 1988; McLeer, Deblinger, Henry, Orvashel, 1992). The American Academy of Child and Adolescent Psychiatry [AACAP] (1998) suggest that childhood PTSD may be under diagnosed due to insufficiently sensitive diagnostic criteria. Current PTSD criteria do not take into account developmental factors impacting trauma in children including developmental specific symptomatology (eg: repetitive trauma play, sexualised behaviour). Some researchers (Debliner, Lippmann & Steer, 1996) argue that it is possible for a child to exhibit significant trauma symptomatology yet fail to meet the diagnostic criteria of the DSM-IV.

Research findings emphasize that sexually abused children exhibit more symptoms than non-abused children in comparison groups and the two most common features presented by sexually abused children is the emergence of PTSD and the presence of sexualised behaviour (eg: Browne & Finkelhor, 1986; Kendall –Tackett et al, 1993; Mannarino, Cohen & Gregor, 1989; Wind & Silvern 1994).

Research suggests that between 50 – 66 % of sexually abused children appear to improve over time, but it also indicates that many either do not improve or deteriorate over time (eg: Kendall-Tackett et al, 1993; Oates, O’Toole, Lynch, Stern & Cooney, 1994). There is also some evidence of a sleeper effect in severely abused children where serious symptoms may not present themselves until some time later after disclosure (Mannarino, Cohen, Smith & Moore-Motily, 1991).

Various studies report 21% to 49 % of sexually abused children present with no detectable symptoms, in other words they are asymptomatic (Kendall-Tackett et al., 1993).

Hypothesis for the presence of asymptomatic children include:

(a) A group of children and families who present with a number of factors that may contribute to general resilience (eg: child temperament and functioning pre-abuse, a positive and strong attachment to primary carers, and presence of protective factors such as social & emotional resources),

(b) The child may not have experienced the sexual abuse event as traumatic, although it was exploitative and illegal (Saywitz et al., 2000).
Currently, there is no reliable means of predicting which cases of children will have persistent symptomatology or will develop symptoms later and which children require no or minimal intervention. Regular assessment reviews may be an important component of monitoring potential trauma symptoms and to inform mental health practitioners when it is necessary to begin treatment.

Saywitz et al., (2000:1041) describes four groups of children, identified in the research, to be considered for intervention:

1. **Asymptomatic children.** Kendall-Tackett et al (1993) estimated this group to be about one third of children studied. [Reviews are suggested to monitor ‘sleeper effect’ & possible late onset of symptoms].

2. **Some children have few emotional and/or behavioural symptoms that either do not reach clinical levels of concern or reach clinical levels but are not severe as in the general clinical population.** (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989; Gomes-Schwartz, Horowitz & Cardarelli, 1990; Mannarino et al., 1989; Tong, Oates & McDowell, 1986; Wolfe, Gentile & Wolfe, 1989).

3. **Some children have serious psychiatric symptoms, such as depression (eg: Shapiro, Leifer, Martone, & Kassem, 1990), anxiety (Kolko, Moser & Weldy, 1988), sexualised behaviour (Friedrick et al., 1992; Gale, Thompson, Moran & Sack, 1988; Kolko et al., 1988), substance abuse (eg: Hibbard, Ingersoll, & Orr, 1990; Singer, Petchers, & Hussey, 1987), Aggressivity (eg: Friedrick, Belike, & Urquiza, 1987), self-esteem or identity difficulties (eg: Davaiola & Schiff, 1989; Hotte & Rafman, 1992; Wozencraft, Wagner, & Pellegrin, 1991), shame and cognitive impairments or distortions (Einbender & Friedrich, 1989), and isolated post-traumatic symptoms, such as flashback, nightmares, repetitive play (eg: Conte & Schuerman, 1987; McLeer et al., 1992; Wolfe et al., 1989).**

4. **Some children meet full criteria for psychiatric disorders, most notably PTSD, major depression, over anxious disorder and sleep disorder (eg: McLeer et al., 1988). In addition, co-morbidity (more than one diagnosis) is a significant problem with traumatized children and adolescents (AACAP, 1998). Studies of clinical populations estimate that 55 % of children referred for treatment have more than one diagnosis (Target & Fonagy, 1996).**

**Treatment for Sexually Abused Children and Adolescents**

A number of obstacles are present in measuring the effectiveness of psychological intervention with children and adolescents including a very small number of well-controlled studies involving sexually abuse children. Therefore, any recommendations for service delivery demand reliance of a broad range of literature focusing on intervention with children generally.

The most recent wave of studies has begun to demonstrate statistically significant benefits. These studies used randomised samples, and trials, control groups, standardized instruments, manualised treatments, and adherence procedures. Usually some form of abuse-specific cognitive behavioural therapy was compared with a more non-directive approach.

Deblinger, Lippman & Steer’s (1996) research (seven to thirteen-year-olds) supports abuse-focused professional intervention with both child and non-offending parents for significantly greater improvement in PTSD symptoms, depressive symptoms and improvement in parenting skills.

The Cohen and Mannarino (1996b, 1998b) study (three-to-seven-year-olds) found that “children provided with abuse-focused CBT had significantly greater improvement in PTSD symptoms, sexualised behaviours, and internalising and externalising symptoms compared with those receiving nondirective supportive therapy” (Saywits et al., 2002:1044).
Other studies have identified that in the cases of child sexual abuse, parental belief and support have been found to play a key role in treatment outcome (Cohen & Mannarino, 2000).

It is important to note that generally speaking, studies support behavioural therapy and CBT over non-behavioural therapies, however Saywitz et al (2000) comments that “this does not mean that behavioural approaches are best for all types of children and all types of problems. These approaches may enjoy the greatest empirical support in part because they are the most frequently studied, they are short term and are among the easiest to manualise, standardize and therefore utilize in well-controlled treatment trials” (p.1043). The empirical support for abuse-specific CBT must be viewed in the context of a gap in information about other treatments. These treatments, prevalent in the field and based on well-articulated theoretical frameworks, have not been adequately tested.

It would appear that because the effects of child sexual abuse are so diverse, no single type of intervention is likely to be applicable or effective for all sexually abused children. Difficulties in disentangling pre-morbid presentations (eg: emotional or behaviour difficulties that pre-date the abuse and/or continue there after such as depression, ADD/ ADHD) also continue to challenge clinical practitioners and researchers. An argument is made for a multimodal, integrated model of treatment, based on the clinical presentation of both child and their family to determine how treatment will proceed (Friderich, 2002). Working with the caretakers appears to be essential and specific symptoms need to be targeted with specific treatment strategies.

Generally, treatment incorporates components of both trauma processing and behavioural strategies with a particular focuses on child protection issues such as the prevention of both further victimization, and ‘at risk’ problem behaviours such as sexualised behaviour, suicide and self-harm.

The AACAP indicate that most of the therapeutic interventions recommended for children and adolescent who have developed characteristic symptoms following exposure to a particularly severe stressor, like sexual abuse, are trauma-focused and include some degree of direct discussion of the trauma as an important part of treatment for the reduction of PTSD symptoms.

_So There Lies The Dilemma!_

Saywitz et al (2000:1046) raises the dilemma that is created by the fact that interventions with the most empirical support involve exposure-based treatment.

To put it simply, effective sexual abuse treatment involves some discussion about the abuse.

The following points are raised:

- When abuse is the source of extreme anxiety and avoidance, triggered by remembering, some direct discussion of the abusive event or events is indicated for exposure and desensitisation to be effective;
- When the abuse is the source of distorted cognitions that underlie depression, self-harm, and sexualise behaviour, some direct discussion of the abusive event is often indicated for cognitive restructuring to be effective.

Interestingly, these researchers caution the reader in relation to carefully conducting discussions so to not contaminate the child’s report and the disclosure process, and suggests that at times it may be appropriate to delay direct discussion of the abusive event with a child until the abuse is substantiated by the local child protection service system, but does not mention the postponement of treatment.
So, just how vulnerable are children to suggestion? And is there any current evidence that supports the perception that therapeutic intervention contaminates the testimony of a child?

What other variables may influence a child’s testimony that may also be perceived as a source of contamination? For example what is the impact of a child’s natural maturation on how they present their information. For instance, if a child is 5 when they give their police statement and are 7 by the time they give evidence in court, how much of their own natural development will influence their memory, and communication competencies?

Could the court process in general and cross-examination specifically be a point of contamination given the techniques used by some defence include ridicule of testimony, character attack, questions which permit only a yes or no answer, frequent interruptions and repetitive questioning (Easteal 2001).

It would appear that our exploratory journey takes us to the realm of children’s memories and their ability to not only recall information but also communicate that information in a way that is acceptable to the courts.

**Memory and Suggestibility**

Current research indicates that the quantity of information a child witness reports about an event generally increases with age (Peterson & Bell, 1996). It is generally accepted that pre-school children are particularly vulnerable to being more suggestible than older children and adults but there is more evidence accumulating to suggest that they do not necessarily have poor memories or are unable to resist suggestibility entirely.

The literature states that these abilities are not stable in any population, be it childhood or adulthood, and it is suggested that reliability of memory can depend on a number of factors including:

1. The type of event experienced
2. The type of information to be recounted
3. The conditions surrounding an interview
4. The strength of the memory
5. The language used, and
6. Post-event influences.

(Saywitz, Goodman & Lyon 2002:351)

Consistently the research literature is indicating that free recall is typically the most accurate form of memory report (Saywitz et al., 2002). That is a response to open-ended questions, such as “What happened”, “Tell me more about that”, “What happened next” and can include the more therapeutic line of inquiry such as “What do you think about that” and/or “How do you feel about that”.

One of the problems reported by the literature regarding the use of open-ended questions within an alleged sexual abuse context, is that they may fail to elicit information about genuine abuse as young children tend to not report information freely if the content is embarrassing. In a study by Saywits, Goodman, Nicholas & Moan (1991) children who had experienced genital touch by a doctor during a medical examination omitted this information more than 60% of the time unless they were asked directly about it.
In a ‘scientific case study’ by Bidrose & Goodman (2000), four girls aged between 8 and 15 years old testified about sexual abuse involving 8 adult men. Their testimony was compared with photographic and audiotape records made by the ‘sex ring leader’ of the abuse. This study indicated high levels of accuracy in the allegations the children made. It also highlighted a high level of omission errors (acts that happened but were not reported by the children).

It appears that the amount of information obtained increases when children are asked specifically about an event (Priestly, Roberts & Pipe 1999; Salmon & Pipe 2000 cited in Saywitz et al., 2002). Unfortunately, inaccuracies also tend to increase (Dent & Stephenson, 1979).

Children’s accuracy declines when asked yes-no questions, the accuracy of responses to these questions do increase dramatically with age (Saywitz et al., 2002), however this is a significant issues given that yes-no questions are a technique often used in cross-examination.

Saywitz et al 2002 summarise three reasons why young children are particularly susceptible to suggestions:

1. Young children tend to rely on cues from adults to help them construct their narratives, including the adult’s perception and interpretation of events; and
2. Young children are still learning the skill of sourcing information. That is developing the skill to identify the sources of their beliefs. For example, young children may be more prone to confuse what they have been told with what they have actually seen or experienced.

Intimidation can also add to young children’s suggestibility about abuse-related events, and younger children appear to be more easily intimidated. Once again, could it not be argued that intimidation under cross-examination may also increase the likelihood of a child’s suggestibility? Westcott & Page (2002) suggest that the dynamics present in cross-examination may resemble dynamics present in abuse. They go on to say that “In both, the social rules of acceptable adult-child interaction are broken, but in cross-examination these transgressions are socially sanctioned by the court and by the adults present” (p.138).

Comments made by defence lawyers in a research study into “The Experiences of Child Complainants of Sexual Abuse in the Criminal Justice System” included the following, “if in the process of destroying the evidence it is necessary to destroy the child – then so be it” (Eastwood, Patton & Stacy 2000:169 cited in Eastwood 2002). Such behaviour could be perceived as abusive in its own right.

**Trauma and Memory**

Research is inconclusive regarding children’s memory and suggestibility for stressful events, for example several studies of children’s memory for stressful events are consistent with the view that core features of stressful events are retained especially well in memory and have greater resistance to suggestion (Goodman, Hirschman, Hepps & Rudy 1991 cited in Saywitz et al., 2002). On the other hand, some researchers report a decrease in memory others find mixed results even in the same study (Peterson and Rideout 1998).

In summary:

- Research indicates that even young children can, under certain conditions, provide accurate testimony, especially when interviewed in a supportive manner that does not involve highly or multiple suggestive accusatory questions. (Case example of three-year-old Susie - Walker-Perry & Wrightsman 1991:10-13).

- Young children (under 4’s) can be expected on average to make more errors in their statements than older children and adults.
Substantial individual differences exist at all ages.

Children may have particularly vivid memories for traumatic events, such as invasive genital touch, but may need to be asked specifically about such touch to reveal that it occurred.

False memories, misperceptions, and errors in reporting of traumatic events also can occur.

Preschoolers are often more susceptible to error and pose greater challenges for interviewers in attempts to obtain accurate and complete reports.

(Saywitz et al., 2002:355-356).

Children’s Communicative Competence

Child development is a crucial part of understanding children’s memory, and communicative ability. “It is through the spoken word that children typically are required to express their memories. So even when a child’s memory is accurate and strong, efforts to elicit reliable reports from children may be frustrated by developmental limitations on communication” (Saywitz et al 2002:357).

Only gradually do children learn the skills of communication. Mastering skills such as articulation, vocabulary, grammar, sentence construction, comprehension & clarification takes time and often children depend on familiar adults (eg: parents & teachers) and familiar environments (eg: Home, Kindergarten, School) to learn how to structure their conversations.

The forensic context, with its unfamiliar setting and highly complex use of language is often poorly matched to the child’s developmental stage of language development and comprehension skills. Even professionals at times may find it difficult to communicate at their optimal level of functioning under such stressful and unfamiliar conditions.

Recent studies are indicating that many types of grammatical constructions are not mastered by young children but are common in the courtroom. One study refers to lengthy compounded sentences used in questioning as legalese. This study found that the length, complexity and grammatical constructions are beyond the comprehension and memory of most children less than 8 years of age. Serious miscommunications resulted and when children where asked abuse related questions in legalese, error rates where found to increase substantially (Carter, Bottoms & Levine 1996).

Could one not argue that this type of questioning constitutes a form of contamination of a child’s testimony?

Vocabulary used in courts are unfamiliar to children which may lead to misunderstanding or failure to comprehend the true meaning of the word or sentence (eg: Many school age children do not understand what it means to “swear” to tell the truth. It is language that has no context for them. More developmentally appropriate language such as “do you promise to tell the truth” has been suggested by some as being more child-friendly (Lyon, 2000).

Another issue is that children under 7 years of age are still developing their abstract thinking. Concepts such as time, depth, height, under and over, before and after may be concepts that the child simply has not developed yet. This type of information requested in questions is often used to determine the accuracy and reliability of a child’s responses.

In summary, it would appear it is not so much a question about the competence of a child to give evidence but studies suggest that the quality of a child’s report depends more on the competence of the questioner to ask questions in language children can comprehend and about concepts they can understand and with mechanisms available to the child regarding issues of non-comprehension.
Conclusion

In conclusion, it appears that both the legal and mental health system need to work in collaborative partnership more consistently to meet both the needs of children, whilst they are required to testify in an adversarial court system, and ensuring the rights of the accused. Is it possible to ask that the legal domain recognise therapeutic as well as legal goals whilst mental health practitioners educate themselves in the area of legal principles?

It is no longer appropriate to suggest that it is not the business of law to consider its impact on the emotional life and psychological well-being of its participants (Wexler, 2000).

Therapeutic jurisprudence is an emerging field of law and social science inquiry that explores the role of the law in fostering therapeutic or anti-therapeutic outcomes (Casey, P; Rottman, D 2000:445). “The field of therapeutic jurisprudence is one source of guidance as courts think through the philosophical and practical issues associated with changes to their role and in what the public expects of the courts” (Rottman & Casey, 1999 cited in Casey et al., 2000:446). It provided a theoretical framework for researchers to begin to address the inherent problems of a win-lose system.

This perspective proposes that the legal domain be sensitive to the fact that their actions and decisions have psychological consequences. It asks, “whether the law’s anti-therapeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating due process and other justice values” (Wexler & Winick, 1996, p. xvii cited in Wexler 2000).

Therapeutic jurisprudence is informed by research and literature from psychology, psychiatry, clinical behavioural sciences, criminology and social work to see whether those disciplines can provide insights and be incorporated into the legal system.

This perspective raises the awareness, recognises and acknowledges that the law itself, know it or not, like it or not, sometimes functions as an anti-therapeutic agent. This is highly relevant to mental health issues of children who have experienced child sexual assault and are being instructed by the legal domain not to talk about it with people they love and trust in a time that they need it the most. Families feel paralysed to seek professional assistance and access appropriate, best practice sexual abuse treatment prior to trial. It begs the question-

“What is in the best interest of the child”? 
References


