The Interpretation and Limits of Medical Evidence in Child Abuse Cases

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UPCM-PGH Child Protection Unit

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The UPCM-PGH Child Protection Unit (CPU) is a multidisciplinary clinic dedicated to the diagnosis and treatment of abused and neglected children. Its staff of specially trained pediatricians, social workers, and child psychiatrists strive to meet the medical and psychosocial needs of maltreated children and their families.

Part of our commitment to the long-term safety and well being of these children is the education of fellow professionals in the medical aspects of physical and sexual abuse. It is our hope that this lecture and the accompanying materials will inform your management and adjudication of the complex child abuse cases presented before your respective courts. Should you have any questions regarding medico-legal aspects of child abuse, please feel free to contact our staff at telefax 526-8418, via email at cpu@advisory.ngo.ph, or in person at the unit, Ward 11, Philippine General Hospital, Taft Avenue, Ermita, Manila.

The Differential Diagnosis of Physical Abuse

Because some injuries may be either accidental or inflicted, diagnosing abuse is not as simple as diagnosing, for example, appendicitis. Effective differential diagnosis, the process of distinguishing abusive from accidental injuries, relies upon a clinician's ability to make the connection between the injury history described by child and/or caretaker, the type of injury observed, and the mechanisms recognized by medical research to produce such an injury. This process is not so unlike a judge or attorney weighing a defendant's testimony, the physical evidence/witness reports, and existing case precedent.

The two-way arrows above symbolize the necessary correlation and agreement between these three "packets" of information. As long as there is no discrepancy between what the parent says, what the physician observes, and what the physician knows about the biomechanisms normally producing such injuries, then the physician assumes that the story is true. Once abuse is remotely suspected, either because of physical or behavioral signs, it is the physician's responsibility to carefully review and question the links between the history given, the injury sustained, and known biomechanics of such an injury.

CASE EXAMPLE

A two-year-old child presents to the emergency room with severe burns to the top (dorsum) of both hands. Her father explains that the child reached out and touched a boiling pot of rice. This seems unlikely since the burns are not on the palms of her hands, the usual place for accidental "exploring" burns on toddlers.

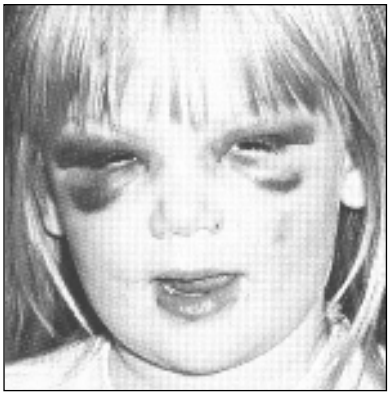
A full physical exam of the child reveals a series of clearly demarcated circular burns, all exactly 5 mm in diameter, on her thighs and calves. The father explains that these are splash marks from the rice pot which the child spilled (though earlier, he said she just "touched" the pot). As splash marks tend to be highly irregular, most severe at point of impact and less severe as water trickles down the body and cools, this too seems unlikely. Also, upon close examination, the burns have the classic "halo affect" (a perfect ring of lighter skin around a hyperpigemented circle) left on the skin by cigarettes which are 5 - 7 mm in diameter.

Diagnosis: Suspicious for physical abuse. Physician needs to interview the child without the father present.

A Layperson's Guide to Injury Specificity

Some injuries are more suspicious than others for abuse especially when correlated with an unlikely story. Physicians often talk about the "specificity" of an injury *per se*. If an injury, in and of itself, is "specific for abuse," then it is 1) an injury almost always associated with abuse and 2) an injury difficult to sustain accidentally. If an injury is "nonspecific" then it means that the injury per se could be abusive or accidental. In such cases, the physician relies upon the history and child's disclosure to make a differential diagnosis.

Specific Injuries	
Bruises	• Two black eyes without a broken nose (see right) • Bruises in recognizable shapes (e.g., belt, tool) • Circumferential injuries of wrists, ankles, neck • Adult bite marks
Skeletal injuries	• Multiple skull fractures, absent major accidental trauma • Long bone fractures in a non-ambulating child • Posterior rib fractures • Metaphyseal avulsion fracture • Two or more fractures in different stages of healing
Head injury	• Skull fracture ascribed to a routine fall (see p. 4) • Evidence of Shaken Baby Syndrome (see p. 5)
Burns	• Multiple cigarette burns, perfectly circular 5 – 7 mm • Immersion burns with clearly demarcated borders



Bilateral periorbital bruising, sometimes called "raccoon eyes," without bruising or swelling of the nose, as above, indicates a multiple blow etiology. This child could not have received two black eyes without a broken/swollen nose from "walking into a door" as claimed. Double black eyes is a fairly specific injury.

Abuse versus "Discipline"

Although the law (specifically RA7610) does not clearly define physical abuse, many people believe that anything harsher than spanking with the palm of the hand is "crossing the line." Corporal punishment in varying degrees is a widely accepted form of child punishment in the Philippines. The best argument against parents' inflicting physical pain for the purpose of child "discipline" is that it doesn't work! Countless studies of spanking and other physical punishments versus granted rewards and withdrawn privileges show that the non-violent paradigm is the better method of teaching children proper behavior. A child who has suffered any of the specific injuries listed above at the hands of a parent or caretaker is not being disciplined. He or she is being abused.

Head Injuries from Routine

Physicians suspect abuse whenever a child presents with a serious head injury, with or without a skull fracture, as a result of a reported fall from a bed, sofa, or crib. Courts should not accept – without police investigation or other corroborating evidence – such explanations (e.g., baby fell off bed) for a serious head injury or death.

Several studies of such short-distance falls have determined that children almost never suffer skull fractures, cerebral edema, retinal hemorrhages, subdural hematoma, or epidural hemorrhage due to such routine accidents. Only intense trauma, such as a car accident or a severe beating at the hands of an (armed) adult, could explain a bilateral or branched skull fracture or any skull fracture greater than 1 mm in width. Results of selected head injury studies are summarized below.

Author	Year	Findings
Helfer et al.	1977	Studied 246 children under 5 years of age who fell out of bed. Of the 85 who fell from distances of approx. 3 feet, only one had a skull fracture (without serious sequelae), 57 had no apparent injury, and the remainder suffered only minor cuts, bumps, or bruises.
Nimityongskul & Anderson	1987	A study similar to Helfer's concluded that children are not seriously injured in short falls.
Smith et al.	1975	Studied long falls of children from buildings and found that the shortest falls that resulted in death were from the four-story level (about 30 feet).
Snyder et al.	1977	Studied 100 falls of children and adults and concluded that life-threatening injury required at least a 15-foot fall. They found just one child death after a presumed 10-foot fall.
Williams	1991	Reported on 106 infants and children whose injuries resulted from falls that were witnessed by a second person. Only one death occurred, resulting from a 70-foot fall. There were falls of up to 15 feet with no injury, and minor injury and simple fractures were found in 77 patients.

Shaken Infant Syndrome

- Shaken infant or shaken impact syndrome is responsible for at least 50% of the deaths of children caused by non-accidental trauma. It also yields the most severe sequelae of abuse such as cerebral palsy and profound mental retardation.

- **The diagnosis of Shaking Infant Syndrome describes a typical constellation of injuries – subdural hematoma, skull fracture, retinal hemorrhaging – that are sustained when a baby is violently shaken and/or slammed into a solid object (e.g., a wall, the floor, a door, even a firm mattress).**

- **Swelling of the brain (edema) and the other injuries listed above are not caused by slight shaking of a baby. They require significant forces of acceleration and deceleration (like the "whiplash" effect produced in a car accident) that any competent caretaker or onlooker would recognize as extremely dangerous.**

- Children under two years of age are especially prone to severe brain injury during severe shaking with or without impact because of the disproportionate size of the head compared to the body, weakness of cervical (neck) musculature, and the higher water content of their brains.

- The caretaker who violently shakes a young infant, causing unconsciousness, may put the infant to bed, hoping that the baby will later recover. Thus the opportunity for early therapeutic intervention is often lost. When brought to medical attention, the shaken infant typically is convulsing or comatose, not sucking or swallowing, unable to follow movements, and not smiling or vocalizing. The comatose state may be unrecognized by caretakers and even by some medical providers who may assume that the infant is sleeping or lethargic. Such infants often have respiratory difficulty, progressing to respiratory failure and death.

- Because there are often no external signs such as bruising to the head or bloody lacerations to the body, physicians have to use a CT scan, an ophthalmoscope (to see inner eye hemorrhage) and other technologies to visualize the internal damage and, thus, diagnose Shaken Infant Syndrome. For "shaken babies" who are dead-on-arrival (DOA) at the emergency department or die soon after admission to the hospital, only a post-mortem CT scan or autopsy will reveal the subdural hematoma (the collection of blood under inside their skull) that caused their death.

Child Deaths Likely from Abuse

In its first seven months of operation, the PGH-CPU encountered three abuse-related child fatalities in which an autopsy was necessary to confirm or dispel suspicions of abuse and neglect. Due to confusion over the competing rights of the state (i.e., attending PGH physicians) which sought to determine the cause of death in the name of justice, and of the parents who exercised their apparent rights of custody by refusing to permit an autopsy, the abuse-related deaths went uninvestigated.

We believe that, by law, the body of a child who dies under suspicious, probably abuse-related circumstances requires a medico-legal autopsy, a procedure which renders the corpse the property of the state until the cause of death has been determined, at which time the body is returned to parents for burial.

The circumstances surrounding the three germane CPU cases, and the confusion that arose as to which agency does or does not have the authority to order an autopsy, illustrate the dilemma. One case involved a child who was brought to the emergency room dead-on-arrival (DOA); the other two cases involved critically injured children who died after admission to the hospital and a consultation with a CPU physician. In all three cases, the injuries sustained were strongly indicative, if not pathognomonic of abuse; without disclosure from the child, however, a pathological examination of the corpse would have been necessary to either dispel or confirm our physicians' strong suspicions of child abuse. In all three cases parents, themselves under suspicion for causing the children's deaths, refused to permit an autopsy.

Unsure of how to proceed, CPU physicians contacted the National Bureau of Investigation (NBI), whose medico-legal officers are authorized by Republic Act 157 to perform medico-legal autopsies, and were informed that NBI would be unable to perform the autopsy without parental consent. Informal inquiries to the Department of Justice elicited the opinion that the DSWD was the body capable of authorizing such an autopsy, the underlying logic being that the DSWD has the right to terminate parental rights and take children into involuntary protective custody. When pressed on this issue, however, DSWD explained that it would not claim emergency custody of a dead child, nor of a child for which no evidence has been gathered of parental unfitness. This inaction presents a paradox, for without permission to perform autopsy, we can supply DSWD with no evidence as to the presence or absence of abuse or neglect.

DSWD's reluctance to claim custody of the dead children also raises the question of "ownership" over the corpse of a child. While this seems a macabre issue, it is surely one that must be addressed. It is obliquely addressed in Article 327a of the Civil Code, which dictates termination of parental authority under certain conditions, including "upon the death of the child." Yet, in practice it appears that the terminated "parental authority" of Article 327a somehow excludes the right of a parent to dictate the burial of his or her child's body over physicians' orders. Do parents, therefore, retain the right to refuse an autopsy by right of their kinship relation to the dead child? Even under extraordinary circumstances in which they themselves may be criminally implicated?

In *Legal Medicine*, a secondary forensic text written by Atty. Pedro B. Solis (Quezon City: R.P. Garcia Publishing Co, 1987), the author differentiates between a hospital, or non-official, autopsy and a medico-legal, or official, autopsy. It the CPU's belief that the autopsy of a child believed to have died due to physical and/or sexual abuse and/or neglect falls into the latter category and, thus, that the state's interest in justice overrides the parents' wish for an immediate burial. As Solis explains:

> **"In cases which require a medico-legal autopsy, the dead body belongs to the state for the protection of public interest until such time as a complete and thorough investigation into the circumstances surrounding the death and the cause thereof have been completed. The physician entasked [sic] to perform such autopsy is considered to be the authoritative agent and representative of the state who has the 'property right' of the dead body" (164).**

Uninvestigated Due To Autopsy Dilemma

It is standard practice in the Philippines for an attending physician who wishes to order an autopsy (or for a forensic pathologist who will perform an autopsy) to request the consent of the parents of the deceased child. Often, religious beliefs and the custom of open-casket funerals may dictate that a child's body not be desecrated by an autopsy; but at other times, as in the three cases I have discussed, it may appear that parents are trying to protect themselves or a known perpetrator from incrimination by refusing the autopsy.

In some European countries and in a dozen states in the USA, all sudden deaths of children under suspicious circumstances are subject to a routine review by a team of physicians regardless of parental objections.[1] The purpose of the review, which may entail an autopsy, is not solely to punish a possible abuser for having killed the child; it is also to supply evidentiary grounds to remove other children at risk from the household of this abuser or, in cases of non-abuse, to gather information that may prevent future accident-related child fatalities.

At present, no specific law codifies the right of Filipino physicians to perform autopsies on children who die under suspicious circumstances. Several existing laws, however, prescribe actions required in the case of suspicious deaths (of children or adults, though age and legal standing of the deceased are not specified).

To wit, Chapter XXI. Disposal of Dead Persons. Section. 91f. of The Sanitation Code, otherwise known as Presidential Decree 856, pertains directly to the responsibility of attending physicians who are issuing a death certificate. It states that:

> **"If the person who issues a death certificate has reasons to believe that the cause of death was due to violent crime, he shall notify immediately the local authorities concerned. In this case, the deceased shall not be buried until permission is obtained from the provincial or city fiscal."**

Therefore, if a physician suspects that a child died due to abuse-inflicted injuries – a "violent crime" as described in the Sanitation Code – he or she should contact the local fiscal or police department. The child should not be buried until an official medico-legal autopsy has been performed or the provincial or city fiscal has determined an autopsy to be unnecessary.

Section 38, RA 409, as amended by RA 1934 states that authorized individuals (e.g., medico-legal officers, medical examiners):

> "may investigate cases of sudden death, which have not been satisfactorily explained and **when there is suspicion that the case arose from unlawful acts or omissions of other persons, or from foul play, and in general victims of violence, sex crimes, accidents,** self-inflicted injuries, intoxication, drug addiction…"

Certainly the sudden deaths of otherwise healthy children who display signs of abuse or neglect fall into this category of victim. Due to confusion among governmental agencies as to the legality of overriding parental wishes, however, it has been impossible for CPU physicians to order the autopsies of such children. It is evident that clarification of the law is necessary in order for justice to be served and children protected.

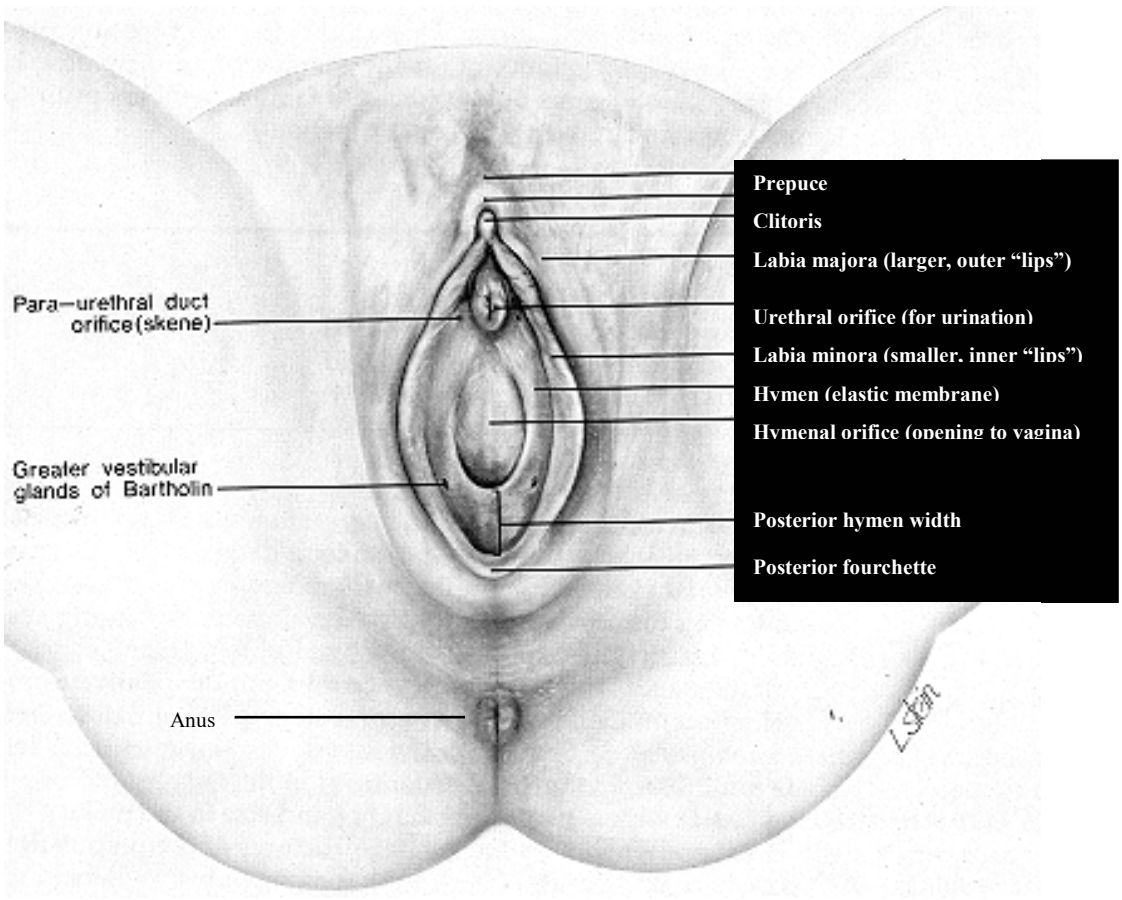
[1] Kaplan, Sarah R, JD. *Child Fatality Legislation in the United States*. Volume 1 of 1997 Publications of the Child Maltreatment Fatalities Project of the American Bar Association's Center on Children on the Law and the American Academy of Pediatrics (Washington DC: ABA, 1997).

Medical exam of the sexually abused child

The findings of a sexually abused child's medical exam depend, to a certain extent, upon the following:

- Invasiveness of the sexual contact (digital versus penile penetration, force used, position of child)
- Elapsed time between the last sexual contact and the exam
- Age and development of the child *(which makes hymenal tissues progressively more elastic and less likely to be marked)*
- Expertise of the physician performing the exam (training, experience, knowledge of normal genitalia)
- Equipment used by the physician (e.g., a colposcope to magnify and photograph the genitalia)

Normal Female Genitalia



This diagram is included so that you may be better able to understand anatomical terms that physicians use in medical records and testimony in child sexual abuse cases. Remember, however, that normally female genitalia is not exposed as it is in this examination position. It is protected by two sets of "lips" (the labia) so that if a child falls off a bicycle, for example, these "lips" may be bruised but the internal structures will likely go unscathed. Another important point is that the hymen is a membrane of tissue with an orifice or opening through which a penis, finger, or other object may pass. It is a highly elastic structure that expands to accommodate these objects' entry into the vagina so it may show no signs of penetration.

Classification of Medical Findings

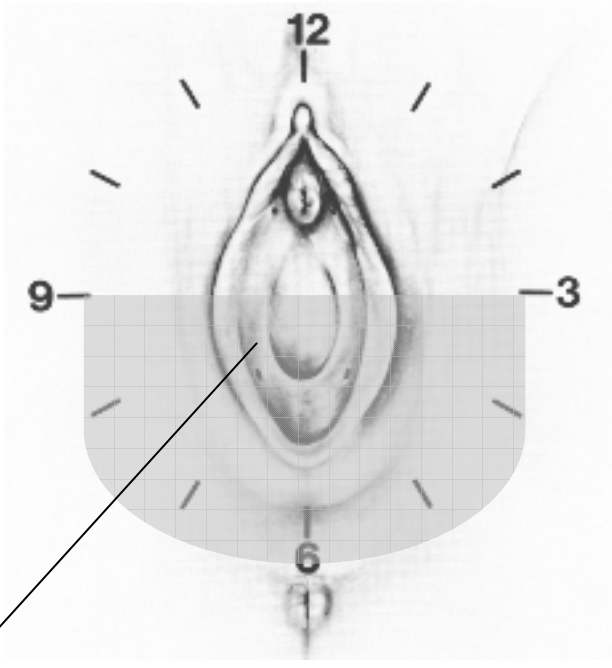
Class	Significance	Examples
Normal	The exam reveals normal anatomy. As 80% of exams of children who have been abused but only disclose after time elapses are normal, **a normal exam does not mean that no abuse occurred.**	• A cleft – a slight irregularity in the hymen - thought to be a scarred injury turns out to be a normal variant.
Nonspecific*	These are conditions that might be caused by sexual abuse, but also occur in non-abused children.	• Generalized reddening of the hymen and surrounding area
Suspicious or specific	These are conditions that are usually caused by abuse though it is *possible* that a history of non-abusive trauma might account for them.	• STDs like Herpes or Chlamydia • Scars or "notches" of the hymen • Attenuated posterior hymen width
Definitive evidence	This is conclusive evidence of sexual abuse. Even with no disclosure from the child, these findings **prove** sexual contact has occurred.	• Hymenal or vaginal tears or lacerations • Presence of sperm or semen • Syphilis or gonorrhea (non-neonatal) • Complete loss of hymen tissue • Pregnancy
Unrelated to abuse	Exam shows non-normal findings due to an identifiable cause that is not abuse-related.	• Hematoma on the labia caused by an accident witnessed by a reliable person

** A nonspecific finding may become a specific finding when a child gives a clear history of recent sexual abuse.*

Clock face as reference

When physicians discuss their medical findings from the female genital exam, they often make reference to the numbers of a clock face. At right, you see a clock face superimposed onto the female anatomy. The hymen, the circle of elastic tissue which may be damaged in sexual abuse, surrounds the vaginal opening.

In general, any irregularities such as lacerations, tears, abrasions that are found on the posterior hymen – between 3 and 9 o'clock, the bottom half of the clock – are more suspicious. Because of the biomechanics of fingering and vaginal penetration, injuries between 3 and 9 are more specific for abuse than other injuries.



Injuries to the posterior hymen, meaning between 3 and 9 o'clock, are inherently more suspicious.

Sexually Transmitted

- STD, a common stimulus to the evaluation for child sexual abuse, may be the only physical evidence of sexual abuse in some cases.

- **The increased recognition of STDs in children parallels the recognition of child sexual abuse in general. Non-sexual transmission of STD is rarely an issue in adults, but when STDs occur in children sexual abuse must be suspected** (Royal College of Physicians, UK, 1991).

- The identification of a sexually transmissible agent from a child beyond the neonatal period always *suggests* sexual abuse and demands investigation. (Centers for Disease Control: Sexually Transmitted Diseases Treatment Guidelines - 1989. MMWR 38, Supplement S-8:40, 1989).

- Full penetrative sexual intercourse (vaginal or anal) is not necessary for infection. Orogenital sex and intercrural contact may transmit pathogens.

- The inability to document a specific STD in a possible or suspected perpetrator does not rule out the possibility that this individual was the source of the child's infection.

- **Only about 3% of children who are sexually abused will actually have an STD. Absence of an STD, therefore, in no way rules out sexual abuse!**

Significance of STDs in prepubertal children

STD	*Incubation*	*Indicator of sexual abuse?*
Gonorrhea	**2 - 7 days**	**Certain ***
Syphilis	**10 - 90 days**	**Certain ***
Chlamydial infections	Variable	Probable *
Human papilloma virus	1 - 9 months	Probable *
Trichomoniasis	4 - 20 days	Probable *
Herpes-1 Herpes-2	2 - 14 days 2 - 14 days	Possible Probable *
Bacterial vaginosis	7 - 14 days	Uncertain

** Unless perinatal transmission is documented in an infant*

Physical Findings

Unless children who have been raped or sexually assaulted are brought to the emergency room immediately following the incident, there is usually little likelihood that sperm or seminal fluid will be recovered upon the physician's exam. As children usually do not disclose sexual abuse right away, fleeting evidence like sperm is scarce. There are, however, other reasons why the exams of sexually abused children do not reveal physical evidence of the perpetrator that might be used in a court of law:

- A victim's first response after a rape or sexual assault is to bathe, thus washing from herself all traces of the event – including evidence such as ejaculate. Even urinating and defecating will remove traces of blood and other telltale perpetrator fluids from the child's body. *(Dejong & Finkel, 1990; Paradise, 1990; Tipton, 1989).*

- Many perpetrators experience sexual dysfunction when assaulting their victims and thus do not leave behind ejaculate. *(One American study, Groth and Burgess, 1977, of confessed and convicted rapists found that 34% - 58 of 170 - had experienced erectile or ejaculatory dysfunction during their assaults.)*

- While sperm and associated fluids may remain detectable on clothing for months and even years (see table below), the Philippines does not, at present, have facilities or professionals to process this evidence.

Persistence of forensic evidence

Site	Type of evidence			
	Motile sperm[1]	Nonmotile sperm[2]	Acid phosphatase[3]	P 30[4]
Pharynx	½ - 6 hours	6 hours (?)	6 hours (?)	No data available
Rectum	½ - 8 hours	24 hours	24 hours (?)	No data available
Vagina	½ - 8 hours	7 - 48 hours	12 - 48 hours	12 - 48 hours
Clothing	< ½ hour	Up to 12 months	Up to 3 years	Up to 12 years

1 Rarely persist more than a few hours at any site. Lack of cervical mucous decreases sperm survival in prepubertal girls.

2 Limited data on pharyngeal persistence. May persist indefinitely on clothing if kept dry and not washed.

3 This is an enzyme secreted by the prostate gland and found in seminal plasma or liquid portion of the semen. Limited data on pharyngeal and rectal persistence. It may persist indefinitely on clothing if kept dry and not washed.

4 P30 is a protein manufactured in the prostate gland that is secreted into the seminal fluid. It may persist indefinitely on clothing if kept dry and not washed.

Limits of the Medico-legal exam

In a population of sexually abused children examined by qualified physicians more than 72 hours after the last incident, 80% will have normal findings. Only 20% will have suspicious or definitive findings of abuse (Bays & Chadwick, 1993). This is extremely important. It means that, in about three-fourths of sexual abuse cases, the medico-legal exam will not provide police officers, attorneys, and judges with the hard evidence they seek to "prove" or "disprove" abuse. The corollary is that we often have to rely upon the child's disclosure and other corroborating evidence (e.g., crime scene investigation, witness interviews) to make legal decisions (e.g., whether to file a complaint or pursue a case). This means that investigative support and the forensic interview must be in place.

Even with a confession of penetration by the perpetrator, the examination is often normal. Studies of children whose sexual abusers have confessed prove that the 20% findings rule is correct (Kerns & Ritter, 1992; Murain, 1989). This seemingly low percentage of physical findings in all exams of sexually abused children may be explained in three ways:

1. Elasticity of hymen prevents injury.

The hymen is elastic and penetration by a finger or penis, especially in an older child with estrogenized tissues, may cause no injury or may only enlarge the hymenal opening. Indeed, the rate of findings is usually lower in children above age 13. This is because at puberty, secretion of the hormone estrogen stimulates the hymen, causing thickening and elasticity of the tissue. This fleshy, elastic hymen both resists and obscures injuries (McCann et. al., 1992).

2. Delayed disclosure is the rule not the exception.

The sooner the examination occurs after the abusive event, the more likely it will reveal positive findings. However, most children are not examined immediately following an episode of abuse. They are examined once they have disclosed, which may be days, months, or even years after the abuse. [In two studies comparing timing of examinations, 36% of children examined within 24 hours of a penetrating sexual assault had evidence of genital trauma whereas 13% seen after 24 hours had positive findings (Rimza & Niggemann, 1982).]

3. Ano-genital injuries heal rapidly.

Hymenal healing occurs in 6 to 30 days and may be complete. Teixeira (1981), who examined 500 patients for sexual abuse, found single, partial hymenal tears healed as soon as 9 days after injury, while extensive tears took up to 24 days to heal. Finkel (1989) followed seven children with acute genital and anal trauma. Six children healed with no residual trauma in 7 to 13 days. Others have also reported complete healing of acute anal and genital injuries from sexual abuse (McCann, 1988; McCann et. al., 1992).

Common Questions answered

Can a child contract a sexually transmitted disease by merely sharing the same bed, toilet seat, or towel with an infected individual?
No. Almost without exception, sexually transmitted diseases are contracted through sexual contact.

What does "intact hymen" on a medico-legal certificate imply?
The diagnosis "intact hymen" is almost meaningless. Medically, it is more precise to state that the hymen looks normal and is not lacerated. Even full penile penetration, however, may not rupture or leave any marks on the hymen. Fingering or fondling often leave no signs of trauma. Therefore, "intact hymen" does not rule-out abuse.

Does successful insertion of an object into a child's vagina prove that it could or could not have accommodated a penis or finger?
Whether or not an object can "fit" in a child's vagina is *irrelevant* to determining previous digital or penile penetration. The vagina is, by design, elastic and distensible. This means it stretches to accommodate objects (like a penis or a baby) and returns to its original shape. A medical exam cannot determine what object or what size object was or was not inserted into a sexually abused child; it can, however, reveal the injuries caused to the child's genitalia from which the physician draws conclusions about whether penetration occurred.

Can bicycle riding or gymnastics injure the genitalia? Can these activities lacerate the hymen?
Injuries to the genitalia may occur with physical activities. When such injuries involve the vagina, however, the event is usually a very dramatic "straddle injury" and will be reported immediately. Unless an object enters the vagina, then none of these activities could abrade or lacerate the hymen. The hymen is an internal structure of the vagina that is protected by the labia minora and major.

Can a child be born without a hymen?
There is not a single documented case of an infant girl born without a hymen. Between two studies (Jenny et. al., 1987; Mor & Merlob, 1988) 26,199 newborn girls were examined and all had hymens. Congenital hymen absence is a myth. Any prepubertal child with complete loss of hymen has suffered abusive penetration.

Can excessive masturbation or the use of tampons explain abnormal vaginal findings?
Masturbation and tampons do not cause injury to the hymen or internal genital structures. There is no evidence that use of tampons causes trauma to the hymen (Dickinson, 1945; Cowell, 1981; Stewart, 1990). Masturbation in girls usually involves clitoral or labial stimulation and does not cause hymenal injury (Hobbs, Wynne, 1989; Tipton, 1989).

Children who masturbate excessively or insert foreign objects into body orifices usually show no genital or anal injuries. Hyman et al. (1990) examined 97 mentally retarded individuals between 11 months and 21 years old whose behaviors included excessive masturbation and insertion of foreign objects into various body orifices. None had evidence of genital or anal injury.

Limiting Multiple Victim interviews

Many individuals who work with child abuse victims believe that their having to retell their story to a large number of professionals - physicians, socialworkers, police officers, and attorneys - is among the most traumatic aspects of the justice system. In addition to traumatizing the child, multiple interviews conducted at different sites by interviewers of different abilities may compromise a child's credibility. The Jalosjos case is a good example of how a victim's repeated interviewing over a period of nearly one year by manifold individuals resulted in a courtroom argument over the dates of her multiple rapes and, by extension, over the victim's credibility as a witness. More generically, an authoritative uniformed male police officer in a busy stationhouse may elicit only a partial disclosure on the day following an episode of sexual abuse, while a friendly female social worker in a quiet and private playroom may strike up a real rapport with the child and elicit an entire account of chronic abuse over several years.

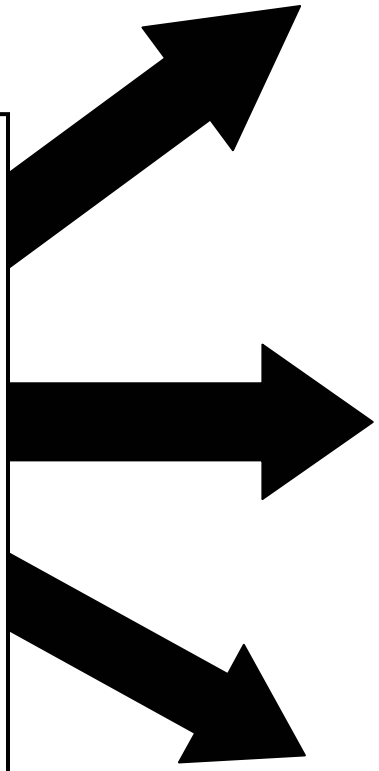
Proposed Solutions

1. **Conducting some form of joint interview of abuse victims with interviewers from two or more of the agencies involved (e.g., a pediatrician, a DSWD social worker, and an NBI/PNP officer)**

2. **Collectively devising a standard interview protocol that meets all needs; then requiring the best-qualified interviewer to furnish other agencies with a copy of a definitive interview transcript**

3. **Videotaping the child's first statement and distributing it to colleagues working on the case**

The crux of all of these "solutions"- which are not mutually exclusive - is collaboration between multidisciplinary professionals in devising a standard interview that will meet the goals of all parties involved – including the child! - and be accepted without need for re-interviewing.



Requires multidisciplinary collaboration

Joint Interviewing

As it is widely recognized that a child's initial interview is the best, most "unrehearsed" disclosure of the abuse, having members of several agencies involved in the first interview may prove fruitful. One model places the child and two interviewers, a social worker and a physician, for example, in front of a one-way mirror while a police officer and prosecutor, for example, observe and listen. At an intermission, the observers may communicate to the interviewers questions they wish to be posed to the child. There are logistic and ethical questions to answer if implementing this method of interviewing:

- Who does the interviewing and who does the observing?
- How many people may reasonable and non-traumatically interview the child at once? Sequentially?
- Do the observers get a chance to speak to the child directly? Or only convey their questions through the interviewers?
- Is the venue for the interviewing convenient to all parties?
- Who is responsible for scheduling the interviews and making sure all can come?
- Will the child be informed who is behind the mirror and why they are observing? What if s/he objects?

Multi-Purpose Interviewing

Like "joint interviewing," this strategy aims to have one or two interviewers pose the questions that a broad range of professionals need answered to fulfill their role in child abuse case management. The goal is to have one interview that meets the basic needs of the physician, the social worker, the police officer, and the prosecutor. While future, shorter and more specialized interviews may be needed to assess the child's need for psychotherapy, for example, the core medical and investigative information has been gathered. While the greatest barrier to this method is acceptance of the interview by all involved agencies, some questions to reflect on are:

- Who will conduct the interview? (The obvious answer is the person best qualified in forensic interviewing of children.)
- Has this individual been trained in atraumatic investigative interviewing techniques?
- Is the interviewer attune to all the purposes of the interview?
- Are other professionals involved confident in the interviewer's abilities?
- Does the interviewer know how to avoid leading questions?
- Will he or she be able to withstand severe cross-examination?
- Will the interviewer be able to adequately meet all the needs of the interview without tiring the child?

Videotaped Interviewing

To avoid repeated interviews and preserve the child's statement for future use, many jurisdictions in the United States, the United Kingdom, and Europe, use videotape to record the child's first statement. Before instituting videotaped child interviewing, the community of professionals involved must collectively consider the following questions:

- At what point in the investigation will the videotape be made?
- As children do not always disclose completely during their first interview, should subsequent interviews be taped as well?
- What are the procedures for preserving the chain of custody of the videotape?
- Who owns the videotape? Who may obtain copies (police, prosecutor, defense attorney)?
- How can the videotape be shielded from the media? *(RA6710 mandates the sanctity of such information)*
- Legally, is it necessary to obtain the child's informed consent before videotaping an interview?
- Ethically, is it desirable for the child to know that his or her interview will be videotaped?

Assessing the Credibility of

As only 20% of exams of sexually abused children will provide physical findings,

General rules

- Children cannot fantasize about sexual acts of which they have no experience.
- Children do not learn distinguishing sensorimotor details (e.g., the bitter taste of semen or the feeling of a " knife in my bum") from watching sexually explicit material on television or seeing pornographic materials.
- The more detail that children recall, the more likely the disclosure is truthful. Remember, however, that children may be ashamed or embarrassed to reveal explicit details and need to be reassured that they are not at fault.
- Children's memory is no less accurate than adults' but children tend to recall less peripheral detail, especially with the passage of time. (Please see p. 18)
- Children can place events in correct temporal order yet may need chronological "anchors" such as "before dinner" or "after school" to orient themselves.
- Children relate events within the limits of their language and understanding. A basic understanding of children's age-determined developmental abilities should inform your assessment of each disclosure.
- Children may be silenced by fear, coercion or anxiety.
- Ensuing recantations are often scripted by adults with vested interests in the child's silence; these statement often use incongruous language or adult rationales.
- Children realize that their disclosure of abuse precipitates a crisis for the family. This may keep them silent until the situation becomes unbearable.

For details on evaluating children's testimony regarding past episodes of abuse, please refer to p. 18 and enclosed research briefs from the Education Development Center's Child Abuse Victims as Witness Series. They discuss the accuracy of children's memories of abuse, their credibility as witnesses, and techniques judges employ to improve children's testimony.

ChilD's disclosure of Abuse

carefully assessing a child's disclosure is essential to evaluating a civil or criminal case

Features of child's account that increase its

- Explicit and/or sensorimotor details
- Idiosyncratic and/or contextual details
- Description from child's point of view, perspective
- Vocabulary, sentence structure congruent with child's age and typical speech
- Affect either appropriate or predictable given child's coping style
- Consistency in core elements
- Psychological response to abuse (e.g., fear, guilt, low self-esteem)
- Disclosure to a trusted individual when child feels safe from perpetrator
- Element of secrecy
- Coercion and threats by the alleged abuser

Findings that corroborate a child's oral disclosure

- Physical findings consistent with abuse
- Sexualized themes in drawings and play (e.g., with anatomically correct dolls)
- Behavioral changes consistent with abuse (e.g., nightmares, fear of men)
- Child's statements to others about the abuse
- Precocious and/or explicit knowledge of sexuality
- Sufficient access of alleged perpetrator
- Evidence of violence, substance abuse, etc. in perpetrator's background
- Absence of motivation or undue influence to fabricate

No single element of a child's disclosure of sexual abuse, present or absent, is definitive. The same tenet applies to corroborating evidence or the lack thereof. The child's disclosure and medico-legal findings (even when "normal") must always be considered in tandem.

Children's Testimony

Judges and attorneys often have qualms about abused children testifying if court. While young victims certainly pose challenges as witnesses because of their still-developing linguistic and cognitive abilities, recent psychological research demonstrates that children may give accurate and reliable testimony. The best way to elicit truthful, complete statements from abused children – whether in a forensic interview or a courtroom – is to understand and accommodate them. Three factors that impact a child's statement of "what happened" - memory, recall, and suggestibility – are discussed below.

Memory

Contrary to popular belief, children have good memories. What they remember is effected by how much of what they see and hear "registers' – that is, what their brain is able to process meaningfully. What registers is in turn effected by their limited knowledge, experience, and tendency to view the world egocentrically. While children's memories naturally fade over time, as do adults', for extremely stressful events directly involving the child – such as abuse to their person – the core elements remain.

Recall

Recall is the ability to recollect or retrieve memories and, in the case of giving a statement, articulate those memories to others. Children, especially ones under five, are less able to freely recall events without any prompts or cues. If asked on direct examination an open-ended question such as "what happened?" a raped child might give a brief, incomplete, and for the court's purposes a relatively unenlightening answer: "I got hurt." While adults would give a narration of all the pertinent facts, children simply say the first thing they freely recall and although this is generally accurate, it may serve the not meet the needs of the interviewer. To elicit more complete statements, one may give the child cues or prompts in the form of more focused questions.

Suggestibility

The fear of overly focused questions is that they may lead a suggestible witness into making an incorrect statement. Children are neither overwhelmingly nor invariably suggestive. Like adults posed suggestive questions, they are less likely to give inaccurate statements regarding central (as opposed to peripheral) details of an event. When they are directly involved in an event – e.g., when they are the victim of an abusive act – they are even less suggestible. A rule of thumb is to move along the continuum of suggestiveness shown below. Begin by asking children open-ended questions and then proceed to more focused and potentially suggestive questions if the child needs prompting to give a complete statement. (Please see *Pacific Law Journal,* Fall 1996 for more details.)

OPEN-ENDED ➡	**FOCUSED** ➡	**SPECIFIC** ➡	**LEADING**
What happened?	*Where were you when you got hurt?*	*Was Jose there?*	*Jose hurt you more than once, right?*

Questioning Children

Too often questions are phrased in grammar and vocabulary too advanced or complex for children to comprehend. All interviewers must carefully match the form and the content of their questions to the child's stage of language development. Below are simple guidelines for talking to English-speaking children under seven to eight years of age, extrapolated from the research on child development. These were adapted from Karen J. Saywitz's "Children in Court. Principles of Child Development for Judicial Application" in *A Judicial Primer on Child Sexual Abuse* (ABA Center on Children and the Law, Washington DC, 1994).

- **Use short questions and sentences.**
- Avoid long, compound utterances.

- **Use one to two syllable words.** *point to, explain, show me*
- Avoid three to four syllable words. identify,
- Avoid legal jargon. *petition, allegation, testimony, recantation*

- **Use simple grammatical constructions.**
- Avoid complex constructions, such as embedded clauses, double negatives.

- **Use simple tenses.** *Where were you? What happened next?*
- Avoid multi-word verbs. *Might it have been the case that...?*

- **Use concrete, visualizable terms.** *gun, jeepney*
- Avoid hierarchical, categorical, more abstract terms. *weapon, vehicle*

- **Use the common meaning of terms.** *"strike" means to hit, "charges" are made with a credit card*
- Avoid the legal terminology. *striking words, filing charges*
- Ask children to define or use terms to check their understanding. *What is a defendant?*

- **Use proper names. Clarify nicknames.** *Anna, Lito, "Boy-Boy"*
- Avoid pronouns. *him, her, they, he, she*

- **Use active voice**. *Did Marie hit Jose? Did he chase you?*
- Avoid passive voice. *Was Marie hit by Jose? Were you chased by him?*

- **Repeat the name of the antecedent.** *When did the red car arrive at your house?*
- Avoid unclear references. *When did that happen? (those things, this, it, that)*

- **Use stable terms**. *in the front of the room, in the back of the room; a lot, a little*
- Avoid words whose meaning varies with time or place. *here, there, yesterday, tomorrow*
- Avoid relational terms. *more, less; did it happen more or less than two times?*

- **Use several short questions to replace one overloaded question.**
- Avoid questions that list several previously established facts before asking the question at hand. *When you were there, on Sunday the third, and Lito entered the bedroom, did Anna say that she was leaving?*

Understanding Inconsistencies

Inconsistencies in children's statements may be explained by developmental, linguistic, or emotional characteristics of the young abuse victim. Inconsistencies should not immediately lead you to discredit the child's statement or doubt her reliability or truthfulness. First, clarify that you understood the "change" in the statement and then try to understand the discrepancy. Some of the reasons for apparent inconsistencies in children's statements are discussed below. These explanations aside, if a child suddenly changes a statement dramatically (e.g., alters the identity of the perpetrator), you should investigate possible motives or pressures to do so (e.g., family wants to blame a stranger instead of a relative).

Children may change their answers under repeated questioning.

As a general rule, repeated questioning implies– even to adults – that the initial answer was incorrect or unacceptable. Out of respect and obedience, children try to give the "right" answer, the answer they think that adults want. So if an adult, especially a prosecutor or judge, asks the same question again, the child may think a different answer is required. They may also be anxious to finish their testimony so if a question is repeated sarcastically or disbelievingly on cross-examination, for example, they may just give in to be able to sit down.

Differently phrased questions, posed by different interviewers, on different dates may elicit different details.

Children are very sensitive to the following interview conditions: the rapport the interviewer develops with the child (e.g., supportive versus accusatory), the physical environment of the discussion (e.g., a crowded, noisy police station versus a private and quiet interview room), the time of the interview vis-à-vis the incident(s) (e.g., immediately following the incident vs. a few days later vs. two years later), and the language level of the questions (e.g., overly complex versus developmentally appropriate).

The very nature of children's disclosures of abuse may give the appearance of inconsistencies.

Because of the shame, embarrassment and confusion that abused children experience, they often disclose the abuse haltingly over time. That is, they may initially give only a partial disclosure, often telling a trusted adult only the least invasive event or least explicit details. For example: "Something bad happened with Lolo in the bathroom. He hurt me." Over time, with support and understanding, children may be able to give a more complete disclosure. Thus, the initial statement becomes: "Lolo put his penis in me in my bedroom and then hit me in the bathroom until I promised not to tell anyone." Here, the location of the sexual abuse has seemingly changed from the bathroom to the bedroom; but when you compare the statements, you see that the first statement referred to the physical intimidation not to the sexual assault of which the child was much more ashamed.

Anne G. Walker's *Handbook on Questioning Children: A Linguistic Perspective (* American Bar Association Center on Children and the Law. Washington, DC, 1994) discusses some of the other reasons for children's apparent inconsistency. The text is available for reference at the CPU library but we definitely need an analog for Tagalog-speakers. This would make a good project for a Filipino law student or doctoral candidate.

Preparing Children to Testify

One of the best ways to elicit reliable and accurate statements from children is to prepare them to testify. This doesn't mean "coaching" or "scripting." Instead, it means that a judge may give instructions to the child when s/he takes the stand to clarify the purpose and procedure of their testimony. In addition to guiding the child, it may allay some of their anxiety. The effect of fear and stress on children's ability to testify should not be underestimated. Older children may benefit from an explanation of the judge's and jury's role as well as the basic judicial process. The child's attorney may explain this before the child comes to court or a judge may explain it at the beginning of the session.

Sample Instructions on testifying

- "Your job is to tell what you remember the best you can-to tell the truth." "Tell what you saw and what you heard."
- "Tell me everything you remember, even the little things that you might not think are very important."
- "You may not understand all the questions. Some may be easy and some may be hard to understand. I am used to talking to other adults, not children. When you don't understand a question, tell me that you don't understand. You can say, 'I don't get it' or 'I don't know what you mean.' Then I will do my best to explain."
- "I may ask you some questions more than once. Sometimes I forget that I already asked you that question. You don't have to change your answer, just tell me what you remember the best you can." *Repeated questions pose problems because the child may try to give you the "right" answer that you seem to want the second time.*
- "Sometimes you may not know the answer to a question. That's okay. No one can remember everything. If you don't know the answer, then say, 'I don't know,' but do not guess or make anything up. It is very important to tell only what you really remember, only what really happened. And if you know the answer; tell the answer."
- "I want to write down what we say because what you're telling me is important. Later, if I forget what we said, I can look it up." *Children are naturally curious about the court stenographer or about the judge's note taking.*

Sample Explanations of court proceedings

- When asked, "What is the job of the judge in court?" in research studies, young children under seven typically respond, "He wears a robe and sits up high; that's it, he watches." Children need to be instructed not only that the judge is in charge, but that he or she will ensure that no one gets hurt, that the proceeding is fair, and that the bailiff will help keep order.
- Children need to understand why they are in court and how the proceeding relates to the previous investigation. They need to understand the flow of information from the investigation to trial. Young children may believe that a courtroom is merely a room you pass through on the way to jail. They may have no concept of a trial. They are surprised that information provided to investigators in perceived confidence is now public information in court.
- Children may benefit from a brief outline of what will happen in the courtroom, including instructions about the mechanics of testifying (e.g., "Talk into the microphone," "You cannot nod your head; you must say yes or no out loud"). Even so, they may need reminders throughout their testimony if it extends over hours and days rather than minutes.
- Children need to understand that they are a team player, that their testimony is only one piece of information to be considered, and that many factors are beyond their control. Children should not be made to feel responsible for the outcome of the case. A child needs to hear that the adults, and not the child, have the responsibility and authority to make decisions.

Accommodation syndrome

When a child is caught up in sexual abuse, that child develops an adjustment pattern to the abuse that is widely known as the accommodation syndrome. An understanding of this "normal" behavior pattern is vital to understanding why a child victim is behaving in a particular way, especially if s/he keeps the abuse secret for a long time, recants a previous statement, or casts blame on herself for the abuse. The accommodation syndrome is often considered as a progression of five stages:

Secrecy

Children are told not to tell. Threats of physical violence, but often promises of withdrawal of love and affection, are all that are needed to secure a dependent child's silence. The child fears disapproval or punishment. Attempts to tell often confirm their worst fears. Retaliation certainly occurs.

Older children understand the implications for the family of a police investigation: possible imprisonment of family member, loss of income, shame and the possibility that they may be held responsible. The logical solution for most children is to maintain the conspiracy of secrecy and silence.

Helplessnes

Children are unable to stop the abuse in most cases. Although they may resist at least initially, they find that it is less trouble to lie still, pretend to be asleep and "switch off." In this way they attempt to protect themselves.

Children will not cry out or struggle to protect themselves and this is often misinterpreted as willing compliance, both by the abuser and society at large. The cost that the child pays for the abandonment of active resistance is insecurity, victimization, and a loss of psychological well being.

This behavior is often reflected in the ease with which CSA victims are medically examined. During the examination, some children even go to sleep.

Accommodation

In a position of helplessness and secrecy, the child feels utterly trapped. The only active role the child can play is to hold herself responsible and, in sensing the wrongness of what is happening, attempt to make amends herself.

Self-blame and guilt are feelings shared almost universally by sexually abused children.
In addition the child faces other pressures:

- The need to protect other children, siblings
- The need to protect the other parent
- The need to protect the family home and integrity of the family

The child has the power to destroy the family, but the responsibility to keep it together. Parent and child roles have, in effect, reversed.

Once in this pseudo-adult position, child may be viewed as a consenting and willing participant in the abuse. The parent, in a child-like position, may simply deny the child's statements if later the truth is revealed. The child who is able to accommodate effectively to the abuse will cover up the reality in order to protect the parent, but also to allow herself space for survival.

It is not unusual, for example, for children to flourish at school where they feel protected and safe, effectively splitting off that part of their life from the threats and insecurity of home.

Why did she keep it secret for so long? **Shame, confusion, and fear prevent children from disclosing abuse. Don't punish her for her silence. Now that she speaks, listen.**

A Child's Recantation

The first impulse, when a child recants a disclosure of sexual abuse, is often relief. It is easier to accept that a child fabricated the story than to accept that such things really happen. The actual rate of false allegations, however, is extremely low, especially in young children. Retraction of a disclosure, therefore, should be understood as part of the Accommodation Syndrome and a function of the pressure placed on the child from her family and society. When a child learns that RA7610 imposes a mandatory death sentence on her uncle, for example, she may be forced by her family or her conscience to recant. Likewise, if a child is told her family will disintegrate if its primary breadwinner goes to jail, she may think it wiser to just pretend nothing happened. Often a family will file a writ of desistance once the case has already begun because it is then that pressure mounts and the consequences of sentencing loom. Because child abuse is a public crime under RA7610, however, the state may still theoretically pursue a criminal case against the perpetrator.

Delayed disclosure

It is likely that many children never disclose their sexual abuse. They may attempt to within the family or (less frequently)outside the family. Disclosure is favored by:

- Overwhelmingly impossible situation at home
- Presence of a sensitive friend, teacher or counselor
- Absence, temporary or permanent, of the abuser
- Educational initiatives, telephone "hotlines" (e.g., Bantay Bata 163)

Many disclosures seem to arise almost by chance. Incidents where a chance remark is made by a child when defenses are down, picked up by a sensitive listener and carefully expanded upon are common.

Contrary to the popular view that children are more likely to disclose upon entering adolescence, experience has shown that disclosure is not particularly favored at any age.

Disclosure is, however, often delayed. The abuse will have been going on for some time and the child fears that he or she will not be viewed sympathetically. The disclosure, therefore, may sound unconvincing, and includes details of only one or two incidents. The types of activity described will often be the less intrusive and upsetting ones for the child. Ambiguities may exist that the child can not readily resolve.

Retraction

Whatever children say about sexual abuse, there is a strong likelihood that they will reverse it under pressure, especially the pressure of a cross-examination in an intimidating courtroom. **This pattern is most clearly seen when the abuser is a trusted caregiver, parent or parent figure.**

For the child, sexual abuse is laden with ambivalence, guilt and self-doubt. A hostile response by family members or the community soon lets children know that they had better recant their disclosure and claim they fabricated the whole thing.

The fact that children cannot and do not readily make up stories of explicit sexual activity is quickly forgotten by all concerned as the threat of the child's disclosure recedes. The retraction reassures, encourages disbelief of the original disclosure, and may lead to inaction.

While retraction should be viewed as a normal and expected part of the psychological adjustments of sexually abused children, overly quick acceptance of retractions should also reveal that people are happier to believe that children lie than that they are sexually abused.

Children may lie to get *out* of trouble, but they don't often lie to get *into* trouble.

Please remember this when considering disclosures of sexual abuse.

A Court-Ordered Child Evaluation

Screening, assessment, and therapy with child psychiatrists are treatment services offered by the PGH-Child Protection Unit to abused and neglected children. All of our patients are screened for any dysfunction or psychopathology provoked or exacerbated by maltreatment. The psychiatrist assesses their mental health and ability to function following the trauma and may recommend further therapy sessions, individually or with other family members, to help the child recover and return to normalcy.

The police and the court system often refer child victims to the CPU psychiatrists for evaluation. The psychiatrist then becomes a consultant to the court, a role that may, at times, be at odds with her role as mental caregiver to the patient. As some confusion exists over the purposes and limits of the court-ordered psychiatric evaluation in child abuse cases, we have clarified the procedure below. The primary message is: psychiatrists are not forensic lie detectors! Their job is to cultivate the mental health of the child and promote her long term rehabilitation.

A court-ordered psychiatric evaluation of a child usually takes at least three visits. While the court may wish to expedite a case, it is often counter-productive to rush an evaluation as a pressured child may be inclined to shut down and become uncommunicative. Over the span of a few weeks, the evaluating psychiatrist attempts to answer three primary questions.

1. Is the child psychologically and intellectually capable of providing reliable testimony?

This addresses the issue of a child witness' competency. The psychiatrist tries to determine whether the child is cognitively capable of understanding her role in a court trial and developmentally competent to provide reasonably coherent testimony. In cases of mentally retarded or very young victims, a psychometric evaluation often proves invaluable in managing the court's expectations of what information the child can and cannot reasonably provide.

2. Is the child suffering from any psychopathology due to the abuse?

The psychiatrist considers the child's behavior, reaction to the alleged abuse, coping style, ability to interact with others, and, using the *Diagnostic Statistical Manual* as a reference for standard mental illness symptomology, may make a diagnosis of some psychopathology. On pages 22 –23, we discussed the Accommodation Syndrome as a set of behaviors often manifest in sexually abused children. Like a diagnosis of Post-Traumatic Stress Disorder, it does not prove that a child was abused. It does, however, help explain to the court why an abused child might behave in a certain way and may bolster a child's credibility if she is attacked as a witness for not reporting the abuse right away, for example, or recanting or altering her initial statement.

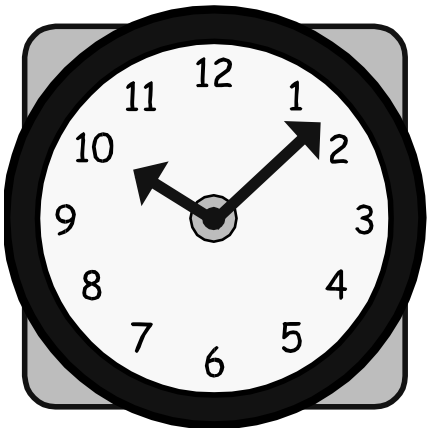
3. Was the child abused as alleged?

A child psychiatrist cannot force a child to disclose, nor can she detect with certainty whether a child's disclosure is true or false. She can evaluate the child's basic psychology, the child's capacity and motives for honesty or fabrication, and the psychological effects of the alleged abuse. Some abused children will, miraculously, survive relatively unscathed and mentally healthy; others may be unable to function even on a basic level and may be scarred for life (see pp. 26-27). Because of the subtlety and complexity of children's responses to abuse, a psychiatric evaluation coupled with other evidence provides insight into the truth sought by the court.

Children's Sense of Time

Courts must recognize children's difficulty with time. Although many children can relate a story with a decent grasp of event chronology, children under seven have enormous difficulty recalling precise dates or even approximate times of particular incidents. In *In re K.A. W.* [104 NJ 112, 515 A 3d. 1217 9(1986)], the New Jersey Supreme Court took judicial notice of children's inability to pinpoint the time of an event explaining that "[u]nlike adults, their lives are not controlled by the clock or calendar." Thus, a six-year-old may not know what day of the week an incident occurred, but he can say with certainty that an assault occurred after Christmas but before Valentine's Day because these are meaningful references for a child of his age.

In *People vs. Jones*, the California Supreme Court noted that young children's difficulty with date and time specification is exacerbated when they are abused repeatedly or chronically over an extended period. The court wrote that a young victim allegedly "molested over a substantial period by a parent or other adult residing in his home, may have no practical way of recollecting, reconstructing, distinguishing, or identifying by 'specific incidents or dates' all or even any such events"[*Jones*, 51 Cal. 3d 294, 792, P 2d 643 (1990)].



Although a child's inability to provide an exact time and date of alleged offence(s) undeniably frustrates the defendant's ability to assert an alibi, the Pennsylvania Supreme Court observed that if children "are to be protected by the criminal justice system, a certain degree of imprecision concerning times and dates must be tolerated" [*Commonwealth v. Groff,* 378 Pa. Super. 352, 548 A.2d 1237, 1242 (1988)]. Indeed, if an alleged molester has frequent access to a child, as if often the case since molesters tend to be trusted acquaintances or relatives of the child, the alibi defense as well as the mistaken identity defense are impractical.

To protect the defendant's rights, the prosecution must make a good faith effort to narrow the time frame of the incident through investigation and efforts to elicit points of reference that the child can corroborate with reasonable certainty (e.g., "after school but before dinner," "right before I entered 3rd grade," "after my parents left for the movies").

Note: John E.B. Myers two-volume series entitled *Evidence in Child Abuse and Neglect Cases* (New York: Wiley Law Publications, 1997) contains an excellent discussion of the judicial implications of children's developing sense of time. This text is available for reference from either the Philippine Judicial Academy or the Advisory Board Foundation.

What Determines the Impact

Type of sex act	• Penetrative abuse is considered more harmful than non-penetrative abuse. • Percentage of women traumatized according to the type of act: Clothing contact, unwanted kissing 22% Touching of unclothed genitals, breasts 36% Vaginal intercourse, oral or anal intercourse 59% • The victim's perception of the abuse and the harm that results are closely and etiologically related.
Frequency duration	• The balance of evidence favors the view that harmfulness is related to frequency and duration. • However, chronicity is likely to lead to accommodation, which may be associated with fewer symptoms in the short term but greater long-term psychological harm. • In chronic abuse, the child is more likely to suffer long-term distortion in development.
Degree of force and violence	• Society perceives physical force or violence as abusive, whereas more subtle inducements resulting in the same outcome are often not viewed in the same way. • The degree of violence, according to research studies, remains an important factor although it will certainly interact with other variables. • While initially force will be immediately traumatizing there may be some solace for the victim who is able to perceive later the wrongfulness of the experience and his/her own lack of involvement. • Children who are tricked, bribed or seduced rather than physically forced to comply may feel complicit in the abuse. Their view of themselves may be distorted in other ways. They often feel more intensely that they are at fault and should have stopped the abuse.
Relationship to offender	• Abuse by close relatives, especially if in a parental or caring role, is generally felt to have the most harmful effects. However, no straightforward connection between the closeness of the relationship and the effect on the child has been established.
Age of Child	• This is an important and complex factor. With young pre-school children the view that the child does not understand or perceive the wrongfulness of the act is often quoted to indicate that less harm will result. However, many young children exhibit signs of emotional disturbance indicating that, whether or not they have an understanding of right and wrongfulness, the negative effects have been perceived and responses have occurred. • In developmental terms, the effects are likely to be related to the developmental processes occurring at the time of the abusive incident(s).

Of Sexual Abuse on a Child?

Multiple abusers	• Abuse by multiple perpetrators results in the child becoming convinced that the blame for the abuse lies within herself, rather than with the offenders. • The harmful effects of abuse are compounded and patterns of revictimization into adulthood may result.
Effects of disclosure	• Children are harmed not only by the abuse, but also by the response of the family and professional system. • Disbelief or denial by someone (e.g., mother or father) in a position of responsibility regarding the child is clearly a major source of harm to a child already suffering the effects of sexual abuse. • Even when a disclosure is believed, the immediate effects of disclosure on the family may be extremely traumatizing. • A positive response and support of disclosure may be therapeutic in assisting the child and may have effects on such outcomes as the attitude to men following abuse. • Many children still receive little in the way of therapeutic help or positive support. The most common reaction, even when the abuse is acknowledged and acted upon, is for the child to forget about everything as quickly as possible or behave as though it never happened.
Iatrogenic harm	• Professional interventions, while seeking to secure protection and support for the child, must avoid themselves adding to the child's distress. Possible sources of iatrogenic harm are listed below. • Overzealous professional intervention--the crusader who may end up alienating parents and children alike • Repeated interviewing, multiple interviews, pressured interviews • Repeated or insensitive physical examinations, physical examinations conducted against the child's wishes • Defensive decision making – the refusal to take any risk leading, for example, the unwarranted removal of the child from the family. It is preferable when possible to remove the perpetrator, leaving the child at home. • Attendance in court – there is evidence that this adds to the harm experienced by a sexually abused child. (Flint and Bull 1989; Goodman et al 1989. *Emotional effects of criminal court testimony on child sexual assault victims.* Final report submitted to US National Institute of Justice, Grant number 85-IJ-CX-0020.)
Birth to 5 years	• Abuse occurring in the early stage of a child's life (from birth to five years of age) is more likely to lead to major and fundamental changes in normal development and from what we have seen so far to have life long consequences. These children have been deprived of trust and security within a relationship. Furthermore, they have come to regard human relationships in a distorted way -- a distortion that they are at first not aware of and that cumulatively grows. • As they grow older and reach the age of around nine years they become clearly aware of the taboo which exists about incest and withdraw in shame and guilt, or turn to aggressive or abusive behavior themselves.
Teens	• Adolescents have also been considered to be especially vulnerable psychologically to sexual abuse. • Sexual identity is at the height of its development and will be distorted by sexual abuse. • The perpetrator may also enforce isolation from peers.

Attached reference articles

- *Accuracy of Children's Memories, Children's Credibility as Witnesses,* and *Techniques for Improving Children's Testimony* by Debra Whitcomb. All three articles reprinted by permission of the Education Development Center from the Research Briefs: Child Abuse Victims as Witness Series, 1992.
- "Responsibilities and Effectiveness of the Juvenile Court in Handling Dependency [Child Abuse] Cases" by Mark Hardin. *The Future of Children.* Winter 1996, pp. 111-125.
- "Statutory Exceptions to Hearsay" and "Streamlining the Adjudication Process." *When the Victim is a Child* by Debra Whitcomb. Second Edition. 1992, pp. 85-101 and 135-145.
- "Prior Acts Evidence in Child Sexual Abuse Proceedings" by Mark Horowitz. Reprinted from American Bar Association's *Juvenile and Child Welfare Law Reporter.* Volume 11, 1992, pp. 159-60.

Additional References Available at the CPU Library

- *Evidence in Child Abuse and Neglect Cases* by John E. B. Myers. Third Edition, volumes 1 and 2. Wiley Law Publications, New York, 1997.
- *The Prosecution of Child Sexual and Physical Abuse Cases*, Submitted to the National Center on Child Abuse and Neglect by the American Bar Association Fund for Justice and Education on Behalf of the ABA Center on Children and the Law, Washington, DC, 1994.
- *Child Sexual Abuse Judicial Training Manual: A Curriculum for Judges*, American Bar Association Center on Children and the Law, Ed. Josephine Bulkley, Washington, DC, 1993.
- "Psychological Research on Children as Witnesses: Practical Implications for Forensic Interviews and Courtroom Testimony." John E.B. Myers et al. *Pacific Law Journal.* Fall 1996. Vol 28. No. 1
- *Handbook on Questioning Children: A Linguistic Perspective.* Anne G. Walker, Ph.D. American Bar Association Center on Children and the Law. Washington, DC, 1994.
- *Early Termination of Parental Rights: Developing Appropriate Statutory Grounds*, American Bar Association Center on Children and the Law, eds. Mark Hardin and Robert Lancour, Washington, DC, 1996.
- *Working with the Courts in Child Protection,* National Center on Child Abuse and Neglect, Washington, DC, 1992.

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