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Expert Issues in Child Sexual Abuse Cases

Use of Experts

1. Explain things that are counterintuitive (Late Disclosure; Sexual Acting Out, etc.)
2. Educate the jury on rejecting common misconceptions
3. Talk about client's problems so they don't have to.

Uses for Experts

- Psychological Diagnosis and Treatment
- Multi-Trauma Clients
- Substance Abuse
- Late Disclosure
- Economic Damages
- Respond to Defense Experts

Two Types of Cases

Cases with Minor Victims

- Victims may not have manifested many of the sequelae of abuse
- Difficult to diagnose children with mental illness
- Childhood acting out may not be obviously relatable to abuse

Cases with Adult Victims

- Late disclosure
- Delay in seeking treatment or misdirected treatment
- Subsequent confounding trauma

Psychological Diagnosis and Treatment

WHO DO YOU GET FOR EXPERT

Retained Expert

Treating Provider

Strong Qualifications

Knows client

Not committed to a diagnosis

Credibility

Expensive

Treatment v. Court Ready

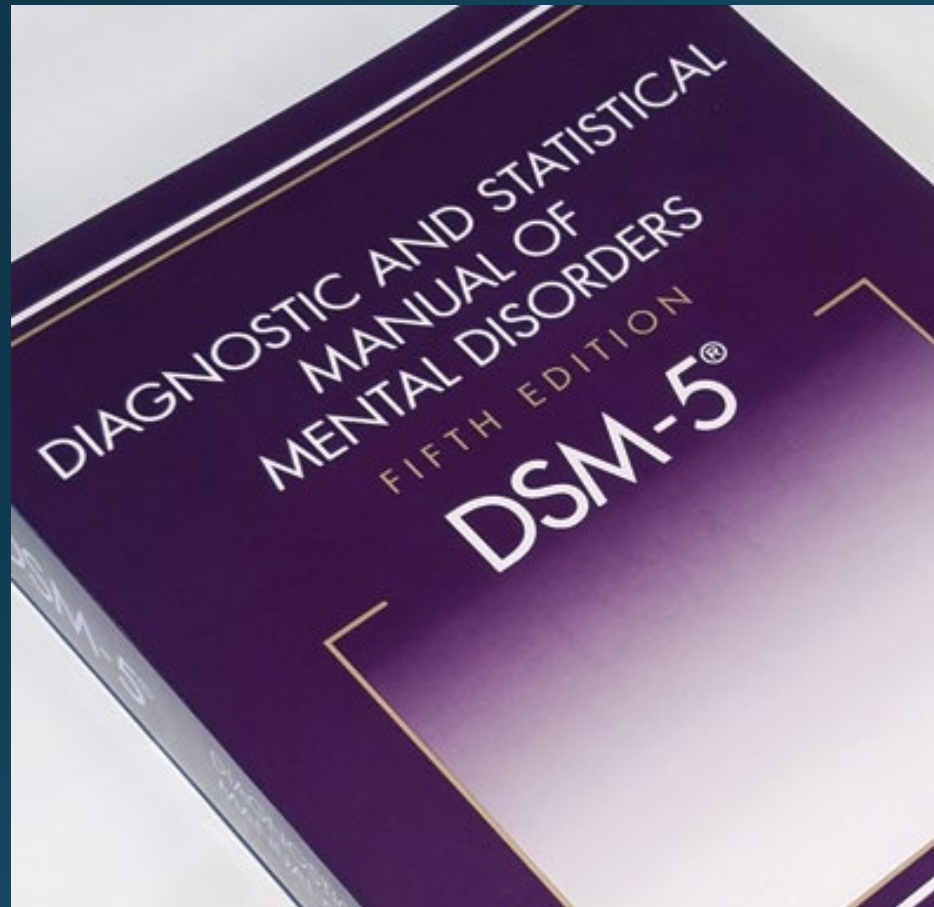
Bias

Less impressive qualifications

Post-Traumatic Stress Disorder (PTSD)

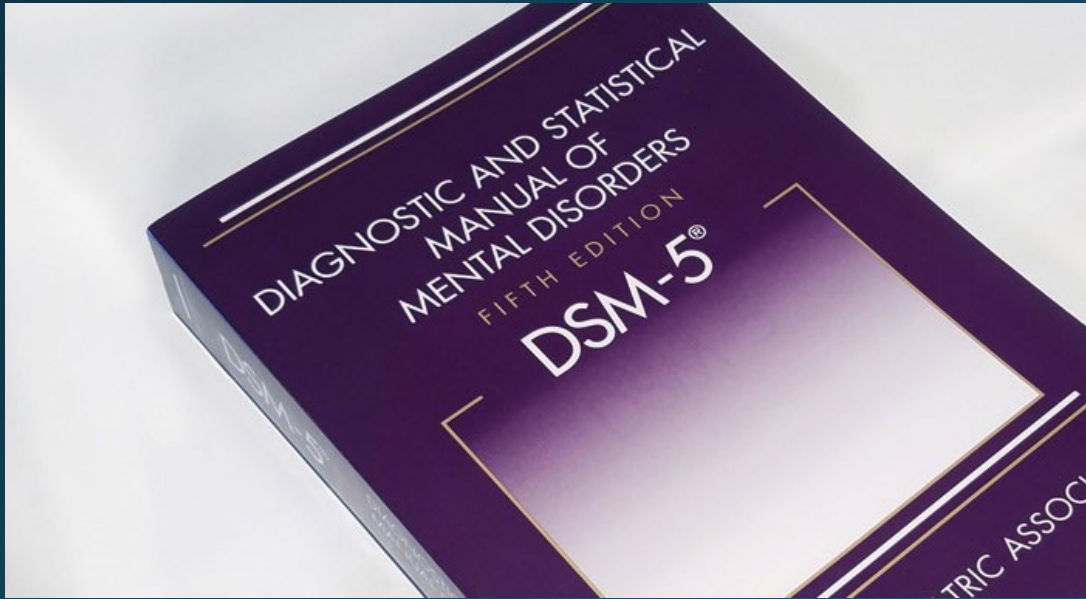
- Recognized as Mental Health Diagnosis since 1980
- Public opinion of individuals with diagnosis has waxed and waned.
- Quickly diagnosed by providers without strict adherence to DSM Criteria

Post-Traumatic Stress Disorder (PTSD)



trauma	Actual or threatened violent death, serious injury or accident, or sexual violence
A. Exposure	Via any of the following: <ol style="list-style-type: none"> 1. Directly exposed to trauma 2. Eyewitness (in person) to others directly exposed to trauma 3. Learning of direct exposure to trauma of a close family member or close friend 4. Repeated or extreme exposure to aversive details of traumatic event (eg, trauma workers viewing human remains or repeatedly exposed to details of child abuse), in person or via work-related electronic media
Symptom groups B to E (symptoms beginning or worsening after the traumatic event)	
B. Intrusion	<p>≥1 <i>intrusion symptoms</i>:</p> <ol style="list-style-type: none"> 1. Recurrent, involuntary, distressing trauma memories 2. Recurrent, distressing trauma-related dreams 3. Dissociative reactions/flashbacks related to trauma 4. Intense or prolonged psychological distress to trauma reminders 5. Marked physiological reactions to trauma reminders
C. Avoidance	<p>≥1 <i>avoidance symptoms</i>:</p> <ol style="list-style-type: none"> 1. Avoidance/efforts to avoid distressing internal trauma reminders (memories, thoughts, feelings) 2. Avoidance or efforts to avoid distressing external trauma reminders (people, places, activities)
D. Negative cognition and mood	<p>≥2 <i>negative cognition/mood symptoms</i>:</p> <ol style="list-style-type: none"> 1. Amnesia for important parts of trauma exposure 2. Persistent, exaggerated negative beliefs about self, others, or the world 3. Persistent, distorted trauma-related cognitions leading to inappropriate blame of self/others 4. Persistent negative emotional state (eg, fear, horror, anger, guilt, shame) 5. Loss of interest or participation in significant activities 6. Detached/estranged feelings from others 7. Persistent loss of positive emotions (eg, happiness, satisfaction, love)
E. Hyperarousal	<p>≥2 <i>marked alterations in trauma-related arousal and reactivity</i>:</p> <ol style="list-style-type: none"> 1. Irritability and angry outbursts with little/no provocation (eg, verbal/physical aggression toward people/objects) 2. Reckless or self-destructive behavior 3. Hypervigilance 4. Exaggerated startle 5. Concentration problems 6. Sleep disturbance (eg, difficulty falling or staying asleep, restless sleep)

Post-Traumatic Stress Disorder (PTSD)



One of more:

Intrusion symptoms (intrusive thoughts, nightmares, etc.)

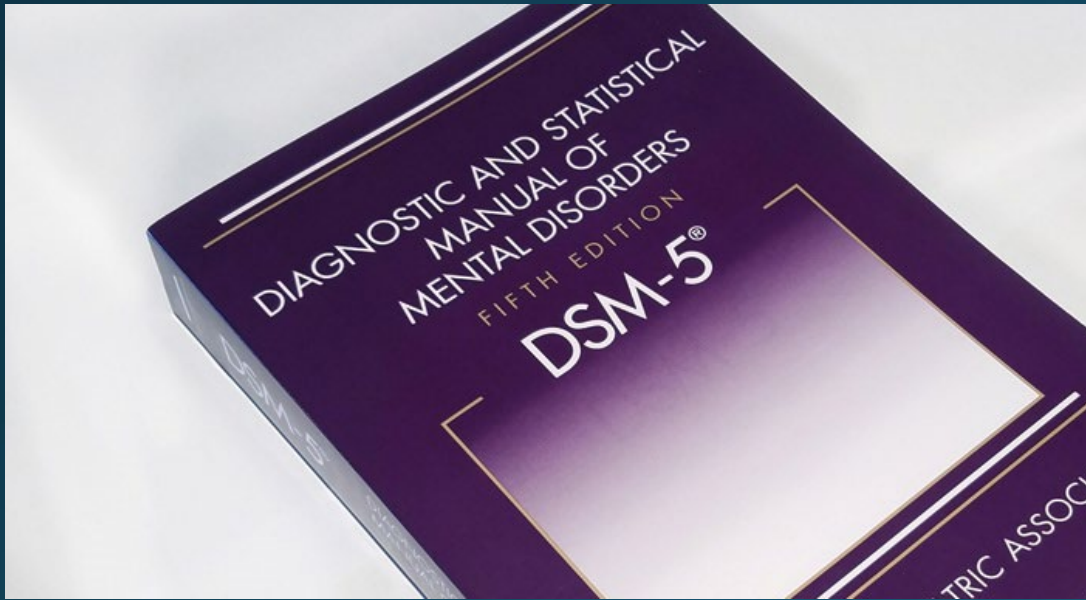
Avoidance Symptoms (internal or external reminders)

Two or more:

Negative cognition/mood symptoms (amnesia, distorted thoughts, negative emotional state/loss of positive emotions)

Hyperarousal symptoms (Hypervigilance, outbursts, startle response, sleep disturbance)

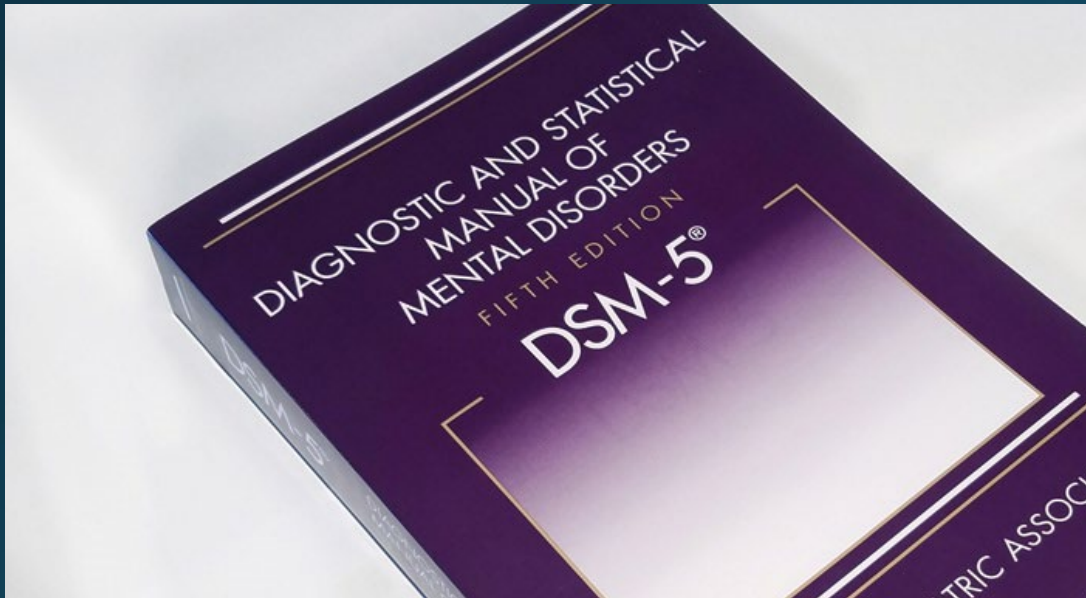
Post-Traumatic Stress Disorder (PTSD)



- Need to present for more than one month
- Significant impairment of activities
- Can't be explained by other causes (other illnesses or D & A abuse)

Post-Traumatic Stress Disorder (PTSD)

- Need to go through criteria
- Need to exclude other causes for symptoms



CHILDHOOD TRAUMA IS A BRAIN INJURY

The effects of childhood trauma are known to cause shrinkage of several areas of the brain including the hippocampus essential for learning and emotional processing, the prefrontal cortex necessary for judgement, assessing situations and insula, which is an area of the brain that supports social interaction. Children with PTSD have been shown to have global brain shrinkage of 10-20% as compared to unaffected children.

De Bellis, Michael D. "Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy." *Development and psychopathology* 13.03 (2001): 539-564.

Substance Abuse

- Multi-factorial- lots of reasons may contribute to client's substance abuse
- Genetic Components
- Public Perception that substance abuse is a character flaw
- Commonality in population

Substance Abuse Disorder

- Addiction is a disease.
 - 11 substance use disorders in the DSM-V.
 - None address underlying cause of use.

Substance Abuse Disorder

In the National Survey of Adolescents, teens that had experienced physical or sexual abuse/assault were three times more likely to report past or current substance abuse.

Devries, K. M., Mak, J. Y., Child, J. C., Falder, G., Bacchus, L. J., Astbury, J., & Watts, C. H. (2014). Childhood sexual abuse and suicidal behavior: a meta-analysis. *Pediatrics*, peds-2013

Bi-Polar/Depression Conundrum

There are a lot of mental health diagnoses and they are easily thrown around

Bi-Polar/Depression Conundrum



Pooh: **Attention Deficit Hyperactivity Disorder.**

Piglet: **Generalized Anxiety Disorder.**

Eeyore: **Depressive Disorder**

Owl: **Dyslexia.**

Tigger: **Risk-taking behavior Disorder.**

Rabbit: **Narcissism.**

ONE CARTOON- SIX DIAGNOSES

Bi-Polar/Depression Conundrum

Correlation between bi-polar disorder and CSA.

- Maniglio ([2013](#)) reviewed 20 studies, including 3,407 young and adult patients with Bipolar Disorder across 10 countries and three continents, concluding that, compared to healthy individuals, patients with Bipolar Disorder report higher rates of child sexual abuse.

Bi-Polar/Depression Conundrum

Conclusions from the literature:

- The prevalence of child sexual abuse among subjects with bipolar disorder is high (>24%);
- There is an association between childhood trauma and an earlier age at onset for BD;
- There is an increased severity of symptoms risk for suicide attempts in BD population with CSA history;
- There is increased comorbid substance misuse;
- Causality between child sexual abuse and bipolar disorder cannot be determined.

Bi-Polar/Depression Conundrum

Victims of CSA get BD

- More frequently
- Earlier
- More Severely

Bi-Polar/Depression Conundrum

Consider possible misdiagnosis?

- Overlap in Symptomology with PTSD.
- Bipolar diagnosis may predate disclosure.
- Substance Abuse Disorder confounds BD diagnosis.

Delayed Disclosure

WHY DIDN'T YOU TELL ME?

Number one thing that is difficult for people to understand about CSA is the failure of so many victims to disclose at the time of the abuse

Delayed Disclosure

- Credibility
- Damages
- Limitations Period

Kids Don't Tell When They are Kids

- Studies show a significant majority (55-80 %) of CSA victims did not disclose during minority
- In a study of over 1,000 survivors, the average age at the time of reporting child sex abuse was about 52 years.

Delayed Disclosure

Expert can explain:

- 1) the prevalence of delayed disclosure;
- 2) the psychological factors for a delay in disclosure;
- 3) partial disclosure

Reasons for Dealyed Disclosure

- Age - Younger children are at a higher risk for longer delays.
- Gender - Males are more reluctant . A study of male victims found that on average it took 21 years from time of victimization to disclosure.
- Intellectual Ability
- Fear, Shame, Embarrassment
- Cultural Norms and Race - Minority groups or collectivist cultures increase disclosure delays.
- Dysfunction in Family
- Relationship to Perpetrator

Defense Experts

Attacks on Credibility

Credibility is traditionally reserved for the fact finder and not subject of expert testimony.

Two Defense Tactics

1. Medical Experts assessing credibility under the guise of evaluating for PTSD
2. “False” Memory Experts

False Memory “Science”

- Memories are not reliable
- Most people have fundamental misconception of how memory works
- People are susceptible to implantation of false memories

Responding to False Memory “Science”

- Get your own expert?
- Know to what is science and what isn't science.

Responding to False Memory “Science”

- Almost exclusively experimental
- False Memory Experts rely on the assumption that the details are as important as the theme
- False Memory Science is about the trees and not the forest.
- Central v. Peripheral details

Central v. Peripheral Details

Dr. Christine Blasey Ford could not remember:



- Street address
- Whose house
- 2-4 boys in the room
- Day, month or year,
- Her grade in school
- How she got home

Central v. Peripheral Details



**BUT SHE
REMEMBERED THE
SEXUAL ASSAULT**

Central v. Peripheral Details

Central details are recorded by the brain more than peripheral details.

- We remembered WINDOW because we remembered the central theme of the list.
- Observed and followed the Hershey's kiss, even though we missed other events.

Central v. Peripheral Details

- More focused on Central Details in trauma
- Central Details become more important and become engrained in long term memory.
- Initial memory is more important.