DISTINGUISHING BETWEEN TRUE AND FALSE ALLEGATIONS OF CHILD SEXUAL ABUSE IN DIVORCE CASES: RESPONDING TO CRIMINAL CHARGES

by

Charles E. Bridges
Bridges, Nichols & Seibel
200 North Second Street
St. Charles, Missouri 63301

TABLE OF CONTENTS

I. Introduction

A. This article will focus on those procedures which may lead to false allegations of sexual abuse. By focusing on false allegations, I will be emphasizing what I believe are the weaknesses in the present system of identifying sexual abuse in children. My personal opinion is that the vast majority of sexual abuse allegations are true and that the dedication of the experts that I am critical of in this article has resulted in the conviction of sex offenders who might otherwise have gone free to abuse other children. So much deserved praise has been given these experts that I do not feel the need to say more. However, there has been so little deserved criticism of these experts that I do feel the need to criticize those procedures that can lead to false accusations of sexual abuse. False accusations can be devastating both to the innocently accused and to the child incorrectly diagnosed as a sexual abuse victim.

B. Wakefield and Underwager have recently written a book which is the most exhaustive study of accusations of child sexual abuse which I have found. The following excerpts from that book clearly define some of the issues I will discuss:

"Prior to the first official contact, the parents, if they suspect abuse or have been informed that abuse was reported, will question the child . . . Retrospective description of this first interrogation begins when the investigating official first talks to the reporting adult and gets the information that led to the report. If the investigating official has the bias that children must always be believed and that all accusations are true, the initial contact with the child will be based upon the prior assumption that the alleged abuse really happened. This bias markedly affects the outcome of the investigation.

. . . Social workers, police and physicians often make their initial decision that alleged abuse is fact on the basis of a

preconceived version. The result was that the main determinant for obtaining accurate accounts was whether or not the interviewer had a preconceived notion of what happened.

. . . In any situation where it is evident that (1) a professional very quickly reached a decision that abuse had occurred; (2) the decision was made on the basis of limited data; and (3) disconfirming data was ignored and no alternative options were examined, the probability of a false positive (allegation) is increased." (1)

A vicious circle may develop. The police and DFS workers have learned which hospital has a bias towards finding evidence that children have been sexually abused. The child is referred to that hospital. The professionals in that hospital may reach a decision that abuse has occurred and they may reach that decision on the basis of limited data. Disconfirming data may be ignored and alternative options might not be examined. The professionals at the hospital advise the police, DFS workers and parents that based upon their examination of the child they believe the child has been sexually abused. This finding strengthens the bias of subsequent interviewers. The hospital personnel or DFS workers refer the child to a therapist who has the same bias. In my experience, the therapist does not do an assessment to determine if in fact the child has been sexually abused because the professionals at the hospital have already reached this conclusion. Therapy sessions with the child are highly suggestive because the therapist assumes the child has been sexually abused and, if the child continues to deny abuse, the therapist exerts more pressure on the child to disclose.

If the child continues to deny abuse, more therapy sessions are necessary to get the child to open up and express anger against the abuser. Ultimately, the child admits the abuse and this admission is then used to validate the professionals and therapist's initial conclusion that the child had been abused.

The police and DFS workers tell the parent or parents that this hospital's experts are the best in the field and are not mistaken in their diagnosis. The hospital recommends an "excellent" therapist (in my experience the therapist recommended is not a psychologist or psychiatrist) and the therapist advises the parent or parents that the experts at the hospital could not be incorrect in their diagnosis. No one in this "circle" will criticize or question the methods and opinions of the others in the circle.

If the child is referred to someone outside this circle, either a doctor or psychologist, and if that doctor or

psychologist does an unbiased, independent assessment of the medical or psychological evidence, any weaknesses in the initial assessment of sexual abuse can be exposed. The earlier an unbiased doctor or psychologist is involved in the assessment process the less likely the chances are that all subsequent interviews will have the built-in bias.

To demonstrate my opinion that professionals and experts in our metropolitan area are sometimes diagnosing sexual abuse on the basis of limited and sometimes incorrect data and they are ignoring disconfirming data and not examining alternative options, I will use as examples testimony from the doctor who is considered by many in our area to be the leading authority on diagnosing sexual abuse. If the leading authority in our area is sometimes diagnosing sexual abuse on the basis of limited data and not examining alternative options, then it is likely that less experienced and less qualified experts are doing the same. The likelihood of this occurring in less-qualified experts is even greater since this "leading authority" is training the less-qualified doctors.

The "expert" in St. Louis has testified that he considers three factors when he makes a "diagnosis" of sexual abuse. Those factors are:

A. What the Child Reports

B. The Medical Findings

C. The Psychological Changes or Behavioral Indicators of Sexual Abuse

II. <u>What the Child Reports</u>

A. In criminal cases you often do not have an opportunity to hear firsthand what the child is reporting until the preliminary hearing or in depositions after your client has been indicted. At this point, the child has often been subjected to numerous interviews by relatives, DFS workers, police officers, nurses at SAM clinics, therapist, etc. If these previous interviews were not videotaped or at least tape recorded, it is very difficult to prove that the child's allegations are the result of influences and suggestions made in the interviews. Since it is my belief that this is such an important part of distinguishing false allegations from true allegations, I want to spend some time discussing this point.

There is substantial psychological evidence in the psychological literature that if a young child is asked a leading

or suggestive question the child may give an affirmative response to the answer even though the correct response is negative because (1) the child believes from the way the question is phrased the correct answer is an affirmative response, or (2) because the child believes the interviewer wants an affirmative response and the child wants to please the interviewer or (3) for other reasons (1, 2, 3). Even if the child gives the correct negative response to a question that is leading or suggestive, the child may later report those suggestions made in the questions as facts. The psychological studies report that the suggestions made in the question distort the child's memory and the child later remembers what was suggested in the question and the child's memory for what actually occurred or did not occur is lost (1, 4). Not only is there substantial psychological studies to support these findings, but the two most comprehensive law enforcement studies into false allegations of sexual abuse also support this finding (5, 6).

It is important for lawyers to understand how little suggestion is required to effect the reliability of the child's response. Lawyers and others involved in the interrogation of young children must be aware of the suggestibility of young children. For example, as reported by Dale, Loftus, and Rathbun (7), the use of the word "the" as opposed to "a" can effect the reliability of the child's answer. These psychologists investigated the effect of the form of questions on the memory of preschoolers after they had viewed films. They found that the syntax of the question had no effect if the question concerned something which was actually present in the film. However, if the object was not present in the film, children were more likely to answer "yes" incorrectly when questions were worded as follows:

1. "Did you see the . . . ?"
2. "Did you see any . . . ?"
3. "Didn't you see some . . . ?"

This same study found that the question is less likely to induce a false positive response if the following question is asked?

4. "Did you see a . . . ?"

As noted in Wakefield and Underwager's book, leading questions not only elicit information but also provide it. When one asks, "Did you see the broken headlight?", one is essentially stating, "There was a broken headlight. Did you happen to see it?" (1) Some other forms of leading or suggestive questions that can contaminate or distort the child's account of the alleged

abuse are set forth in Appendix A.

If the child has been questioned, it is likely that the child has been subjected to such leading and suggestive questioning. In the interviews of 15-20 children in cases that I have been involved in, the interviews by the police, DFS workers, nurses and therapist are much more leading and suggestive than the questions referred to above. However, I have yet to find a police officer, DFS worker or nurse who will admit that they asked a leading or suggestive question. In Appendix B, I have set forth a portion of an interview by a therapist and in Appendix C a portion of an interview by two police officers. In both of these interviews, the interviewers suggest answers to the child. However, the therapist and police testified they did not suggest answers.

If the interviews in Appendix B and C had not been videotaped or tape recorded, the police officers' and therapist's testimony which was a totally inaccurate account of the interview would not have been refuted. Wakefield and Underwager's review of over 100 taped interviews of children found that this is a common misleading behavior of interviewers. They explained this behavior as follows:

"Frequently interviewers introduce a statement, a topic, a question, to which the child either gives no response, a denial or a minimal response. After repeated questioning, the child may nod or answer yes. But in the report of the interview, the interviewer claims that the child said the statement rather than only affirming the interviewer's statement. Also, denials which may have preceded the eventual affirmation are seldom mentioned.

When tapes of interrogations are examined, children often do not say what the interviewer reported they said. A false description by the adult interrogator may be either a deliberate misrepresentation or a misperception. In view of what is known about interviewer bias, it is more likely that the prior beliefs and bias of the interrogator lead to the false statement rather than a deliberate choice to mislead.

The most likely interpretation of this discrepancy is that the bias and belief of the interviewer that the child was abused created a situation of cognitive dissonance when the child denied it. For the child to deny that daddy did it, when the interviewer believes that daddy did it, doesn't fit. Cognitive dissonance theory then predicts what happens in this situation. The interviewer reduces the dissonance by misperceiving the reality.

Interviewers also may reduce dissonance by explaining the denial in a way that enables them to maintain the belief that daddy

did it. There are three explanations interviewers use when the child denies or refuses to admit that abuse happened. They are (1) the child is scared by some threat; (2) the child is frightened or ashamed and it is hard to talk about it; and (3) the child has a secret too scary to tell. When a child does not produce the desired response affirming abuse but denies it, interviewers may use one or all of these explanations. They repeat the question and the putative explanation for the `wrong' answer until the child finally catches on to what is wanted. The child gives the desired response, and then gets social reenforcement for producing the `right' answer. In this manner the child is taught to produce the explanations for the initial denial of abuse." (1)

As a consequence of knowing that (1) the interviewers are going to ask leading and suggestive questions; (2) the interviewers are going to denythat they asked leading and suggestive questions; (3) the interviewers will inaccurately report what the child reports; and (4) the suggestions made in the questions will distort the child's memory and the child may report those suggestions as fact, I always file a motion with the court requesting that all interviews of the child be videotaped. When there is a case in juvenile court, I have been successful in convincing the juvenile judge to order that no one -- police, DFS workers, therapist, etc., can interview the child unless that interview is videotaped or tape recorded. I argue that the best interests of the child require that all interviews be videotaped because (1) if the interview is videotaped and properly conducted that videotape can be used in court instead of the child's live testimony; and (2) the videotape will show if leading and suggestive questions which distort the child's memory are being used by the interviewer. False allegations resulting from improper interviewing techniques can be as psychologically damaging to a child as actual abuse. (1)

Many therapists, prosecutors and DFS workers refuse to acknowledge that children will report an allegation of sexual abuse as a result of leading and suggestive questioning. However, in my experience, jurors are very receptive to the idea that a young child can be led into believing he or she has been sexually abused by improper and repeated interviews. In many criminal trials, the jury has to consider two options as to each witness: (1) the witness is telling the truth or (2) the witness is lying. If you are going to be successful in defending your client from false allegations of sexual abuse, you have to give the jury a third option: (3) the child may be neither lying nor telling the truth. The child may say what he or she believes is true, even though it is not the truth. A psychiatrist, Dr. Lee Coleman, writes:

"At first blush, this seems a rather unlikely possibility, to say the least. A child believes in sexual abuse which has not taken place. I would certainly be skeptical of such an idea if I hadn't had a chance to see how children are being manipulated by adult interviewers -- sometimes by a police officer or protective service worker, sometimes by a mental health professional -- who have been trained to believe that those who really care and are sufficiently skilled at their work will help the child talk about sexual abuse." (8)

In order to educate the jury on the substantial evidence that exists that a child can believe he or she was sexually abused as a result of the interviewing process, I would recommend that you call an expert (I have used both psychiatrists and psychologists) to testify how leading and suggestive questions can distort a child's memory and how what the child is now reporting was first suggested by the interviewer and not the child. I would also recommend that through discovery you question every person that questioned the child and you attempt to show what questions were asked in each interview. By then demonstrating to the jury (I do this by printing the leading and suggestive questions on a large chart) that what the child is now reporting was first suggested by an interviewer, reasonable doubt may be established. (See Appendix D for a detailed explanation of how this was demonstrated in one case.)

Of course, probably the most effective way to demonstrate to a jury that a young child can be led to make false allegations of sexual abuse is to lead the child into making false allegations when you question that child. If you have evidence that a particular child has been subjected to interviews where leading and suggestive questions were asked and the child has incorporated the misleading information supplied in the questions into his account of the allegations of abuse, you may want to use the same type of questioning technique to demonstrate that fact. If an attorney takes the time to learn what type of questions are most likely to lead to false allegations and what type of interviewing techniques are most likely to lead to false allegations, the attorney can elicit false allegations from the child.

In one case I was involved in, seven four year old boys had allegedly been sexually abused by a man. According to the parents of three of the seven boys, their children indicated that numerous other people were also involved in sexually abusing them. In this case, the therapist and other experts testified at the preliminary hearing that children are not capable of making false allegations of sexual abuse and that it is absurd to believe that a child would make a false allegation of sexual abuse as a result of leading and suggestive questions. Since the State was introducing

the hearsay testimony of these children and did not intend to call the children at the preliminary hearing, I had subpoenaed the children as witnesses so that I could question them and demonstrate that these children were capable of making false allegations if they were subjected to leading and suggestive questions. I agreed I would only call three of the children at the preliminary hearing and that their testimony would be taken outside of the courtroom setting on videotape. I carefully prepared a set of questions for each of the three children. I made certain that I did not use any interviewing technique that was any more suggestive or leading than the interviewing technique used by the nurse at the hospital where these children were interviewed. By using questions that were less leading and suggestive than those questions previously asked these three children, I was able to elicit from these three children the following false allegations:

1. Each of the three children positively identified the assistant prosecutor who filed the charges as either sexually abusing them or being present when my client sexually abused them. One of the three recanted that testimony while the other two on cross-examination by the prosecutor refused to recant that testimony despite the leading and suggestive questioning by the prosecutor. These three children identified the assistant prosecutor from a photographic display that I showed to them.

2. Of the three children, one positively identified the chief of police's home as the place where the sexual abuse occurred while another positively identified the investigating detective's home as the place where the abuse occurred. The child that identified the chief of police's home as the place where the abuse occurred also selected from the photographic display the chief of police's picture as a picture of a person who was present when the abuse occurred.

3. One child identified a Missouri Supreme Court judge and a doctor on the Missouri Arts Council as the man and woman who he and two other four year old boys "killed" in the presence of my client. He testified both on direct and cross-examination that he was positive that this man and woman he had identified were the same man and woman that were killed. This child had previously advised his mother that he and two other four year old boys were with my client when they went over to a house. This child told his mother that when they were at the house, he and the other two four year old boys climbed upon the roof of the house while my client remained inside the house. While on the roof of the house, a man and a woman walked by the house and the boys pushed a ladder onto that man and woman, striking them on the head. They then climbed down and my client came out of the house and assisted them in tying the hands and feet of this man and woman. The child had

told his mother that the man and woman were dead and my client and the three four year old boys dragged them to the trunk of my client's car, put them in the trunk and then took their bodies to another house. On cross-examination, the prosecutor could not get the child to change his mind that this occurred at the house identified as the chief of police's home and that the man and woman involved in this incident were a Missouri Supreme Court judge and a doctor on the Missouri Arts Council. (By the way, the judge and the doctor are still alive and well.)

4. One child selected the photograph of a movie actress and testified that that actress and my client engaged in sexual activities in the child's presence.

The false allegations in this case did not stop after my interview of these three boys. According to the mother of one of the boys, her son had indicated that there were over 40 adults involved in his abuse. This boy recognized one of these people when he was at Dierberg's. The allegations he made against a man he saw at Dierberg's, who had no connection to my client, included the following: that man took him to his house and made him type the letter "g" on his typewriter all day; that man made him catch beautiful butterflies; that man tied women up and made the child kiss their breasts. This boy had driven through town and identified four different houses as places where he had been sexually abused. None of these people were charged with any offenses.

When one of the therapists in the case decided that there most be some ritualistic or satanic abuse involved in the case, the allegations then became allegations of mutilation of animals, torture of children, groups of Chinese chanting and taking drugs, people dressing up as bears, etc. According to one child, my client, his wife, his two children, his mother and at least 40 other people were involved in this ritualistic abuse.

When I deposed some of the other children, one boy testified that my client took a large needle approximately a foot long, stuck it in one of the child's ears, through his head, and it came out the child's other ear and that he stuck a needle through the top of the child's head and it came out through the bottom of his chin. One child testified that my client took him to Grant's Farm and threw him in a snake pit. He testified that he was bitten by five to ten snakes and was saved by the zookeeper. Another child testified that my client had a friendly blue monster that was approximately a foot tall and it was alive, had three eyes and it talked to him. The child testified that when the child snapped his finger, the blue monster turned into a statue and when he snapped his finger again it turned back into a live blue monster.

He indicated that this blue monster stayed over at my client's house and when the child went to my client's house, he and the blue monster and other boys would go into the back yard of my client's house and the blue monster would play freeze tag with the boys. The child said the blue monster talked to him and drove him around town.

For over a year, I tried to convince the prosecuting attorney's office that these children were making these allegations as a result of the leading and suggestive questions used by their parents and therapists. It was only after the prosecutor sent all police reports, parents' statements and therapists' reports to an FBI expert, a psychologist in New Jersey and a psychologist in Atlanta that the prosecutor finally believed that the leading and suggestive questions of the parents and therapists had distorted these children's memories. The State's own national experts concluded that these children were in fact making false allegations and that those false allegations resulted from the parents, police and therapists' interviewing techniques. (The State's local experts still refuse to admit this occurred.)

B.

" . . . Faced with such problems, police and child protection workers naturally hope for a way to resolve these special difficulties which may protect the child molester in one case and falsely accuse an innocent person in another.

Not for the first time and undoubtedly not for the last, we have turned to doctors to relieve us of the uncertainty. And so great has been our desire for resolution, for "science" to come to the rescue, that we have been only too happy to accept whatever the doctors have offered. With few exceptions little thought has been given to whether the doctors' offerings are legitimate medical evidence, or something else." (9)

III. Medical Findings

A. In nearly every metropolitan area "law enforcement and child protection workers quickly learn which examiners are more likely to make findings supportive of an allegation of molest. Most often those examiners are attached to a `sex abuse team'" (9). Likewise, in the St. Louis metropolitan area, the police and Division of Family Services workers have learned which

sex abuse team is more likely to make findings supportive of an allegation of molest.

B. The most important motion an attorney can file when faced with medical findings consistent with sexual abuse is to attempt to have the child examined by another doctor. It is not unusual for one expert to examine a child and report physical findings of molestation and another expert to examine the same child and find none (9, 12).

In a criminal case, no Missouri statute or rule authorizes a trial court to order a physical or mental examination of a prosecution witness and appellate courts have upheld trial courts' refusals to order mental examinations. State v. Clark, 711 S.W.2d 885 (Mo. App. E.D. 1986); State v. Wallace, 745 S.W.2d 233 (Mo. App. E.D. 1987). However, in State v. Johnson, 714 S.W.2d 752 (Mo. App. W.D. 1986), the Western District disagreed with the Eastern District's ruling in State v. Clark that a trial court never has authority to order a mental examination of a prosecution witness. The Johnson case suggests that Missouri trial courts have authority to order such an examination ("We note only that the thoughtfully wrought decisions of virtually all jurisdictions which have considered the essential question recognize just such a discretion in a trial court to protect the integrity of the fact-finding in a criminal case -- the want of a rule or statute notwithstanding.") State v. Johnson, supra at 758 fn. 6. The same analysis should apply to a physical examination. (See State v. Johnson at 757-8 for a discussion of cases from other states).

Missouri Supreme Court Rule 60.01(a) allows a court in a civil case to order a party, or a person in the custody or under the legal control of a party, to submit to physical or mental examinations. Consequently if a juvenile court proceeding or domestic relations case is pending that involves the child a physical examination can be ordered.

C. To date, there are only two studies which report the incidence of various genital and anal findings in normal non-abused children. Both of these studies are considered authoritative studies and are very useful in cross examining experts who claim they have found evidence of sexual abuse. If lawyers become familiar with these two studies, they can demonstrate to judges and juries that "experts" are reporting as "findings of sexual abuse" findings which commonly occur in children who have not been sexually abused. The two studies that report what findings occur in the genital and anal area of young children who have not been sexually abused are: (1) Emans, Woods, Flag, Freeman, "Genital Findings in Sexually Abused, Symptomatic and Asymptomatic Girls." Pediatrics, V. 79, No. 5,

May 1987 and (2) A study done by Dr. McCann, Dr. Voris and Dr. Simon which is not in print yet but which was presented at a meeting in St. Diego in January, 1988 sponsored by the Center for Child Protection of San Diego Children's Hospital. Dr. McCann's findings as presented at that meeting are contained on audio cassette tapes and will soon be published (11).

Dr. Lee Coleman has recently written an article entitled "Medical Examination for Sexual Abuse: Are We Being Told the Truth?" In that article he summarizes some of the findings of the Emans and McCann studies:

"Emans, et al.attempted to compare three groups of girls: abused (Group 1), asymptomatic and non-abused (Group 2) and symptomatic and non-abused (Group 3). This study has serious flaws. The examiners were not blind to which category each girl belonged; no information is given on how certain it was that alleged molest victims were true victims; and examiners were not randomly assigned. Instead, the lead author was the exclusive examiner of girls assumed to be molested.

Nonetheless, the authors deserve credit for at least addressing what has been ignored by so many others. They concluded from their literature search, just as I have from my own, that `no previous study has reported the incidence of various genital findings in girls . . .'

Presence or absence of 20 genital findings were recorded on each child. These included hymenal clefts, hymenal bumps, synechiae (tissue bands), labial adhesions, increased vascularity and erythema (redness), scarring, friability (easy bleeding), rounding of hymenal border, abrasions, anal tags, anal fissures, condyloma accuminata (venereal warts). These are the kinds of findings which are being attributed to sexual abuse in courts across the land, despite their having been `no previous study.'

Their findings: `the genital findings in Groups I and III were remarkably similar . . . there was no difference between Groups I and III in the occurrence of friability, scars, attenuation of the hymen, rounding of the hymen, bumps, clefts, or synechiae to the vagina.' These findings, in other words, are not specific to molest.

Emans, et al. do claim that only the abused group showed hymenal tears and intravaginal synechiae. Doubts about this, however, are raised by the results of the only other research effort done so far. It is not yet in print, but Dr. John McCann has recently discussed the findings. McCann, Voris and Simon have taken a different approach from Emans group. They have taken on the very

necessary task of trying to establish the range of anogenital anatomy in normal children. Without such data, the `findings' so regularly attributed to molest are essentially meaningless. That there are as yet no published data on this is itself highly significant.

At a meeting in San Diego in January, 1988, sponsored by the Center for Child Protection of the St. Diego Children's Hospital, McCann reported on this research. Three hundred pre-pubertal children were examined, and it was found that many of the things currently being attributed to molest are present in normal children. Here are some conclusions:

- - vaginal opening size varies widely in the same child, depending on how much traction is applied and the position of the child. Knee-high chest position leads to different results from frog position.

- - 50% of the girls had what McCann calls bands around the urethra. He has heard these described as scars indicative of molest. So have I.
- - 50% of the girls had small (less than 2 mm) labial adhesions when examined with magnification (colposcope). Twenty-five percent had larger adhesions visible with the naked eye.

- - Only 25% of hymens are smooth and contour. Half are redundant, and a high percentage are irregular.

- - What are often called clefts in the hymen, and attributed to molest, were present in 50% of the girls.

- - `We were struck with the fact that we couldn't find a normal (hymen). It took us three years before we found a normal of what we had in our own minds as a preconceived normal . . . You see a lot of variation in this area just like any other part of the body . . . We need a lot more information about kids . . . We found a wide variety . . .'

- - ` . . . in the literature, they talk about . . . intravaginal synechiae and it turns out that . . . we saw them everywhere . . we couldn't find one that we couldn't find those ridges.'

- - When does normal asymmetry become a cleft? I don't know.'

Anal examination were equally revealing of a good more variation among normal children than the `experts' have so far been recognizing.

- - 35% of children had perianal pigmentation.

- - 40% had perianal redness. The younger the age group, the more likely this finding.

- - One-third of the children showed anal dilatation less than 30 seconds after being positioned for the examination.

- - Intermittent dilatation, said by Hobbs and Wynne to be clear evidence of molest, was found in two-thirds of the children.

Recall that Emans found that while abused (by `history' at least) girls were remarkably similar to non-abused but symptomatic (infections, rashes, etc.) girls, hymenal tears and intravaginal synechiae were said to be found only in the abused group. We now see the McCann's group finds that it cannot be sure what is a tear and what is a normal asymmetry, and that they `saw intravaginal synechiae everywhere.'

What little research exists, then, shows that a small group of self-appointed `experts,' given credibility by an all- two-eager law enforcement and child protection bureaucracy, has misled the courts, falsely `diagnosed' sexual abuse, and damaged the lives of countless non-abused children and falsely accused adults." (9)

D. Have the "experts" in our metropolitan area reported findings which occur in non-abused normal children as proof that a child has been sexually abused? The answer is a definite yes. To illustrate, I will take testimony from the "expert" in our metropolitan area and compare it to the recent studies referred to above. The medical finding that I will use as an illustration is an anal tag. An anal tag is defined "as a mound of skin on the anal verge which may be associated with or have resulted from a fissure." (12)

The following testimony was given by the prosecution's "expert" at a preliminary hearing:

Q: What physical findings must be present before you can specifically conclude based solely upon the physical findings that the child has been sexually abused as regards the anus?

A. Tags and tears. Dilation. And these children, the history becomes very pertinent and your behavioral indicators. You need to show dilation, and I think -- you should ideally if at all possible, dilation and tears and tags and funneling. They are all physical findings.

Q. What I'm asking you is, is based solely on physical findings what do you have to observe before you can conclude positively that

that child has been sexually abused through anal intercourse?

A. Any of the things I mentioned.

(Objection made and overruled.)

Q. What physical evidence must you have, or must any pediatrician or expert in this field have before they can conclude based solely upon the physical finding that the child has definitely been anally penetrated?

A. Nothing else.

Q. With nothing else --

A. After a kid's physical exam?

Q. Yes.

A. And I had no other input but that physical exam, if I saw a tear or a tag I would say this child would be very likely to have been sexually abused, getting some history, getting some --

Q. But you're still not answering my question --

A. But I have answered your question.

Q. My question is what physical findings must you see before you can conclude positively that this child has been anally penetrated not knowing any other behavioral indicators or background?

A. Dilation.

Q. Let me stop you there.

(At this point the expert testifies on the significance of dilation of the anus. According to McCann's study, dilation can be a normal finding in children who have not been abused. Since I am only discussing anal tags, I will not discuss this any further).

Q. Other than dilation what other physical findings must you see for you to determine that without a doubt this child has been anally penetrated if you have no history or no background on the child or any behavioral indicators?

(Objection made and overruled).

Q. Other than dilation is there anything else as far as physical findings where you can look at the anus of a child and determine based solely upon the physical findings that that child has been anally penetrated?

A. Yes. Tags.

Q. And how many tags do you have to find before --

A. One is sufficient.

Q. So when you find one tag you can conclude that that child without a doubt has been anally penetrated.

A. Yes.

According to this expert's testimony, he can make a positive diagnosis of sexual abuse without obtaining any history on that child if he observes one anal tag. According to the two studies of "normals," this is not possible because anal tags are found in "normal" non-abused children (10, 11).

In the Emans study, the percentage of anal tags found in sexually abused girls did not differ significantly from the percentage of anal skin tags seen in girls with other genital complaints. The Emans article notes that some children are born with anal skin tags. (Yet the "expert" above can see a tag and without a history conclude the child has been sexually abused). According to Emans, "anal tags were seen in all groups; when known congenital tags were specifically excluded, group 1 (sexually abused girls) was slightly more likely than group 2 (normal girls with no genital complaints) to have tags."

Similarly, the McCann study found that normal children have anal skin tags (13).

A comprehensive study of the significance of medical findings of sexual abuse in young children in England had the following to say about the significance of finding anal tags: "They (anal skin tags) would not appear in themselves to be grounds for suspicion" (12).

According to the testimony of the expert in St. Louis, not only are they grounds for suspicion but anal tags can be diagnostic of sexual abuse. I have been unable to find any source that agrees with the St. Louis expert.

I never got the opportunity to impeach this expert at trial with the above materials because the charges against my client

were dismissed just before trial. However, in depositions, this "expert" retreated from his original claim that observing an anal tag is proof of sexual abuse. In my experience with the expert, I have seen him attribute other "normal" anal and vaginal findings to sexual abuse.

E. Differential Diagnosis: Those experts who find evidence of sexual abuse more often than other experts often do not consider alternative causes of a particular finding. It is important for a defense attorney to show that the finding that the expert is relying on to conclude that this child has been sexually abused could have been the result of causes other than sexual abuse. If the defense attorney can show that the particular finding could be the result of causes other than sexual abuse, you may be able to establish reasonable doubt. If the expert is one used by the prosecution, that expert may not admit that the finding has many causes.

How do you get the State's expert to admit that the finding has many causes? Again, I will illustrate this through testimony in a case I handled. This testimony occurred at a preliminary hearing where I cross-examined the State's expert:

Finding: Small scars and dimples on child's anus.

Testimony: Isn't is true that passing large stool can cause small scarring?

A. Yes.

Q. What else can cause small scars other than passing large stool and sexual abuse.

A. I don't think of anything else.

Q. You don't know of anything in the literature that would cause small scars?

A. I'm sure there must be something. Turns to judge: He must have found something.

After the preliminary hearing but prior to trial, I had to disclose what authoritative sources I intended to use at trial. The State's expert apparently read some of those sources because when he testified at trial on direct examination he testified as follows:

Q. By prosecutor: Now, what other things can cause scars in a

child's anus like this?

A. Very few things. But you can get anal trauma and anal problems with chronic constipation. You can get it with severe diarrhea, explosive diarrhea in which people have. And you can also get it with chronic colonic disease.

To prepare for my cross-examination I spent several hours at the St. Louis University Medical Library to obtain authoritative sources which discuss the various causes of scars on a child's anus. After spending only a few hours at the medical library, I had obtained authoritative sources that indicated any of the following could cause scars on a child's anus:

1. Constipation.

2. Any trauma to area: ranging from the child acidentally sitting on a sharp object to intentional injuries.

3. Scratching induced by eczema or other perianal condition; i.e., child does not wipe himself thoroughly.

4. Crohn's disease.

5. Anal stenosis.

6. Crypt abscess.

7. Juvenile polyps.
8. Perianal inflammation.

9. Inflammatory bowel disease.

10. Improper insertion of anal thermometer.

11. Insertion of finger, either child's or adults while wiping child.

12. Diarrhea.

13. Giving a child an enema - if not done properly can cause a small scar.

At the trial this "expert" was then asked, on cross-examination, questions such as the following:

Q. And you have previously testified that Nelson's Textbook on Pediatrics is an authoritative source, isn't that correct?

A. On pediatrics, yes, sir.

Q. Let me ask you if you agree with this statement in Nelson's Textbook on Pediatrics: "The causes of most anal fissures and scars are often not evident but may be secondary to constipation with passage of large stools, scratching induced by irritation from enterobius vermicularis or eczema or other perianal conditions."

A. This child did not have eczema. And eczema doesn't usually attack that area. But if Nelson said it, I guess it's feasible.

Using this same approach with each of these causes the State's expert admitted that every one of the items in the above list can cause small scars on a child's anus similar to the one he allegedly observed on this child's anus.

I then finished this part of my cross-examination with the following questions:

Q. Doctor, there's other things besides which I have listed here that can cause scars in a child's anus, aren't there?

Q. When you attended the summit conference in California, wasn't that a recommendation and isn't that what they use in San Diego, that a doctor does not get to hear the history before he examines the child because if you hear a history that has a biasing effect on any normal individual?

A. I guess that's feasible, but I think that the history is important too.
Q. Before you examine the child?

A. Yes, sir, I believe that is. I'd like to believe I wouldn't be biased by that.

F. In the above example, we saw that the expert initially claimed a particular finding could only be caused by two things -- constipation and sexual abuse (in this case forcing a stick into the child's rectum). The expert claimed he asked the parents if the boy had ever been constipated and when they denied constipation he concluded the small scar on the anus was "consistent with sexual abuse as stated by child." He then advised the police and parents of his opinion.

This expert did not tell the police or the parents that this small scar could have fifty other causes. Nor did he inquire into the child's medical history to determine the likelihood of these other causes. The parents and police interpreted this expert's conclusion that the small scar was consistent with sexual abuse as medical proof that the child was sexually abused. From that point on, any hope for a neutral investigation was lost forever (9). Everyone who then interviewed the child, including his psychologist, admitted they assumed the child was a victim of sexual abuse because of this expert's findings -- the investigation into the truth or source of the allegation stopped.

This expert's phrase that the physical examination of the child showed evidence "consistent with" sexual abuse means very little. Dr. Coleman describes the term "consistent with" as a pseudofinding:

"Likewise, it might seem obvious that a normal ano/genital examination is no help in establishing molest. Such normal examinations are, nonetheless, frequently termed "consistent with" sexual abuse. Rarely have I seen this followed by a statement indicating that a normal examination is equally consistent with no abuse . . .

Given that many victims of molestation show no physical

results, it follows that every child's anatomy is `consistent with' molest because normal anatomy is also consistent with non-traumatic molest."

Not only can this "pseudofinding" stop the truth-seeking process, at times it can start a false allegation. If a parent, police officer or DFS worker is told that the expert found medical findings consistent with sexual abuse it often is only a matter of time before the interviewer's bias (in this case a belief that there is medical proof of molest) results in the child affirming the interviewer's belief.

G. I began this section with a recommendation that you always attempt to obtain a second medical examination of the alleged victim. The case I have been discussing in this section is a good example of why a second examination is important.

In his medical report and at the preliminary hearing, the State's expert did not indicate the size or shape of the small scar he claims to have observed on the child's anus. In depositions he testified as follows:

Q. Was this small well-healed scar at six o'clock as large as a millimeter?

A. I don't recall.

Q. Was it smaller than a millimeter?

A. I don't recall.

At trial in this case this "expert" gave the following testimony on direct examination regarding the size of this alleged scar:

Q. Well, first, about how big was this scar?

A. . . . I din't measure it. It's hard to say, but I know it would be at least a centimeter. Maybe longer. (Note: A centimeter is 10 times longer than a millimeter).

On cross-examination this expert admitted that he did not document the size of the scar by either photographing it, drawing it in the medical report or indicating the size in his medical records. He also testified that he had no records that would refresh his recollection as to the size of the scar. He was then confronted with the testimony he had given approximately 10 months earlier:

Q. Have you ever given different testimony as to the size of that

scar in this case?

A. Not that I recollect. Again, I didn't measure it. It's hard to say. I might have given different sizes. I might have said something other, but my recollection at this point is that that would be about it.

Q. Well, you wouldn't be mistaken and be off as much as 10 times the length, would you?

A. I don't think so.

When this expert was confronted with his previous testimony that he did not recall if the scar was smaller or larger than a millimeter (but he now remembered it was at least a centimeter), he testified as follows:

Q. Well was your memory better a year ago or is it better today?

A. I don't recall it. I didn't recall then and again I said I would think. I didn't say it was one centimeter. I said I would think it would be at least that length.

I had requested that this child be examined by another expert but this request was denied. In the hearing on the motion for a second examination, I introduced evidence that the State's expert had on previous occasions observed evidence of sexual abuse that other experts failed to observe when the child was seen by a second expert. If a second opinion had been ordered at least the size of the scar would have been determined and the size of the scar would not have grown from the depositions to the trial.

H. Even when you cannot obtain a second examination of the alleged victim, you may still be able to contest the existence of a particular finding. This can be accomplished by obtaining a complete history of any medical complaints made by the child (through a deposition of the child's parents and through the pediatric records of the child) and demonstrating how the medical history is inconsistent with the allegations being made by the child. For continuity, I will again use the child with an alleged small scar on his anus as an example. In this case the State charged the defendant with forcing a stick into the child's rectum. According to the father of the child, the child said the Defendant held onto the stick with both hands and made three quick thrusts with his hands when he forced the stick into the child's rectum.

In depositions of the child, the child at first said there was no pain when the stick was forced into his rectum and then he

said it hurt just a little. However, at trial when the State asked the child if this was one of the child's most painful experiences, the child answered in the affirmative.

The State's expert testified that this small scar on the child's anus (size disputed) was consistent with the child's allegation that a stick had been forced into his rectum. The nurse who worked with this expert had not told him that while she was interviewing the child he took her scissors and told her the defendant had also stuck those scissors into his rectum. However, when I pointed that out to this expert, he said the small scar was also consistent with pointed scissors being forced into the child's rectum. His testimony on this is as follows:

A. . . . I examine the child and I see a scar. And I say that scar is consistent with what the child says.

Q. And if you didn't see anything, no findings at all, that also is consistent with what the child said, isn't it?

A. It can be, yes, sir.

Q. And in fact, no findings at all are consistent with what the child said?

A. That's feasible. Besides, 50 percent of children who are sexually abused show no findings.

Q. So there is nothing that is inconsistent with what the child says according to you, is there?

A. According to everyone who works in the field.

- -

Q. Let me ask you if you agree with this statement in the Medicine, Science and the Law by Dr. Paul. "Fissures, scars, and anal verge, hematoma can both result from the passage of constipated stools so great care must be taken in the interpretation of such a solitary finding. History of any sudden change in an infant's bowel habit is of great importance. A child previously potty-trained and regular in his bowel habits who suddenly resents being pottied or refuses to have his bowels helped is frequently found to have some injury to his anal verge. Such a history is associated with a history of an alleged sexual assult and with clinical findings of anal verge injury is good corroboration. Any child who has been the victim of anal penetration will experience pain on defecation for sometime afterwards and this discomfort will persist even in the absence of

an anal fissure or scar. If a fissure or scar is present, the discomfort may persist for as long as two weeks. So specific is that the doctor should view with great suspicion any history where there is no complaint of pain on defecation. Such a history is inconsistent with penetration."

A. I don't know if I agree with that entirely.

- -

Q. Let me ask you if you agree with this statement in Nelson's Textbook on Pediatrics regarding fissures and scars. "Pain on defecation and frequently refusal to defecate are the principle manifestations of an anal fissure." Do you agree or disagree with that?

A. Fissure, oh, yeah, anal fissures are common. They don't often, they usually don't scar.

Q. Because they're less severe than what causes a scar?
A. Breaks in skin. You get little fissures on the lip the same way. A break in the skin. Tender, heals, doesn't leave a scar.

Q. So it's not severe?

A. Has to be deeper to leave a scar, yes, sir.

Q. So a principle manifestation of what the child would have shown because of this scar would be pain on defecation and refusal to defecate?

A. Does Nelson list in there sex abuse as a cause of scars?

Q. No, he doesn't.

A. Then he's not complete either, is he?

Q. I'll get to the American Medical Association Diagnostic list in a minute. Now, Nelson, that's a national publication, textbook?

A. Yes, sir, it is.

Q. You've also told me that another book which is in pediatrics is Current Pediatric Diagnosis and Treatment, ninth edition, edited by Kempsey and Silver; is that correct?

A. Yes, sir.

Q. And that's an authoritative source, isn't it?

A. It's considered, yes, sir.

Q. Let me ask you if you agree with this statement as to what findings the child will have if they've had a small scar or fissure on their anus. And it's in Current Pediatrics Diagnosis and Treatment. "The infant or child cries with defecation and will try to hold back stools. Sparse bright red bleeding is seen on the outside of the stool or the toilet tissue following defecation. Fissure can often be seen if the patient is held in the knee-chest position." Do you agree with that?

A. Yes, sir.

Q. So again we have --

A. That's why it's a vicious circle. Children who are sexually abused can have, get a history of chronic constipation.

Q. And did you ask his parents if the child ever had a history of pain on defecation?

A. I don't recall if I did. I don't think I did.

Q. Doctor, are you familiar with the medicine, American Medical Association's journal where the council on scientific affairs has listed a diagnostic list of factors you look for to determine if there's been child abuse or child sexual abuse?

A. If that's it.

Q. Yes. Are you familiar with the AMA diagnostic and treatment guidelines concerning child abuse and neglect?

A. Yes, I think I have seen that.

Q. Okay. Let me ask you a specific question about that.

A. Sure.

Q. There is a list of approximately 16 items, signs of sexual abuse, physical signs. Let me ask if you agree with these, any of the following physical signs may indicate sexual abuse: Difficulty in walking or sitting.

A. Sure.

Q. Did you have any history of that --

A. No, sir.

Q. - - from the child?

Q. Did you have any history of torn, stained or bloody underwear?

A. No, I did not sir.

Q. Bruises or bleeding of the perianal area, did you find that?

A. No, sir.

Q. Recurrent urinary track infections, gonococcal, syphilis, herpes, sperm or acid toxilate, lax rectal tone. Did you find any of that?

A. No, sir.

Q. Is there anywhere on this list put out by the American Medical Association scientific affairs published in 1985 that says that small scars on the anus are physical findings of sexual abuse?

A. Well, I don't think it's a complete list. They listed, the most uncommon thing is not there. It just doesn't, that's not the complete list either. I think that's incomplete.

Q. So they left out --

A. If they left out scars, I think that's an oversight on their part. They also left out normal findings as a finding too. So I think that's an incomplete list.

Q. This is the Journal of American Medical Association, isn't it?

A. Yes, sir, it is.

In cross-examination of the parents, it was brought out that this child had never been constipated, had never had complaints of pain on defecation and had never made complaints of pain to his anal area (except once approximately two weeks <u>after</u> his removal from the school where the abuse allegedly occurred). Further, his parents had never observed any blood on his underwear or blood in his stool. The child's pediatric records were introduced to show that this child was never taken to his pediatrician for any complaints of pain or injury to his anus or rectum. Thus, the child's history was "inconsistent with" a small scar being on the child's anus.

The defendant's expert testified among other things (1) that a small scar on the anus could not properly be identified as a scar by simply looking at the scar as was done by the State's expert, (2) that the State's expert's failure to "document" the scar by photographing the scar or at least describing the size and

shape in his medical report was not consistent with standard medical procedure, (3) that if in fact the child had a small scar on his anus there should have been a history of constipation or pain on defecation, and (4) that if in fact the child had a small scar on his anus the child's pediatric records and history as given by the parents provided a number of alternative explanations for a small scar.

The defendant's expert strongly disagreed with the State's expert that a small scar on the child's anus is "consistent with" the child's story that a stick had been forced into the child's rectum. The defendant's expert explained that due to the size of a young child's anus and rectum, a stick forced into the child's rectum in the manner alleged by the child could have caused

severe injuries to the child and there would have been pain and blood associated with the injury.

I. Do not be afraid to challenge the qualification of the "expert" who claims to have diagnosed findings consistent with sexual abuse. When I first became involved in child sexual abuse cases, the police, DFS workers and prosecutors extolled the qualification of their "expert." However, when I investigated this expert's qualifications, he came up short in several areas. Two of those areas that should be brought out on cross-examination are:

(a) Impartiality: The "expert" used most often by the State testified in the trial referred to above that he had never testified on behalf of the defense.

(b) Publications: The "expert" used most often in St. Louis has never published, in a journal or textbook, an article on sexual abuse. Yet if you do not tie him down on this point he will testify as follows:

Q. Have you published any articles in this field - sexual abuse of children.
A. Yes, I have.

Q. Okay. And I served you with a subpoena. Did you bring those articles that the subpoena required you to bring today.

A. They weren't published at the time.

Q. I served you with the subpoena last week. Are they still not published.

A. They're in, they're in, yeah, they're published now. They're

in the book that I presented, not in this, not in sexual abuse, not, the article I published pertains to urethral dilation in girls. And it's in the proceedings of the international meeting that was held in Rio do Janeiro.

Q. The only article you've published is published in Brazil?

A. No, it's published here. It's published in Denver, out of Denver.

Q. Okay. And I served you with a subpoena and asked you to bring every article, every paper you've ever written. Did you bring that with you today?

A. No, sir, I didn't.

Q. What is this one article you say you've published? What does it have to do with?

A. Vaginal findings in girls.

Q. And what this is is they typed up a transcript of your speech in Rio Do Janeiro; is that correct?

- -

Q. And these are speeches you gave and someone tape- recorded it and typed it up; isn't that correct?

A. No. They weren't speeches. They were submitted papers and then I talked on the submitted paper.

Q. Have they ever been published in any authoritative journal such as in "Pediatrics?"

A. No.
Q. Any published in an authoritative textbook?

A. No, sir, they have not.

Q. Will you have time after you leave here today before this case is over to bring your article back to us?

A. Not back. I can probably find a way to get it to you, sure.

Q. Okay. You'll do that for us, won't you.

A. Certainly.

This trial lasted another two days and this article was never produced.

There is no doubt that many "experts" are experts because of their experience. The fact that an expert has not published does not make that person any less of an expert. However, "experience" does not necessarily make the person an expert. In assessing what weight to give an expert's testimony because of his experience, consider the following comments:

"Finally, a note on "experience." Experience, like consensus, is not enough to move from conjecture to science. Feedback, i.e., controlled testing of ideas through research, is necessary to be sure that one's experience is not filled with incorrect notions that go unrecognized. Thousands of women, for example, underwent radical mastectomy because highly experienced surgeons, and doctors in general, believed it was the best way to save lives. Only subsequent research demonstrated that simple mastectomy saved as many lives.

The situation is even worse when the doctor's opinion will itself influence the ultimate findings of the justice system. If Doctor X opines that a child has been molested, based on findings which in truth do not prove molest, a court will frequently rubber stamp such an opinion. This judicial finding then becomes the confirmation which makes the doctor feel he can rely on his "experience." Such "confirmation" is of course scientifically meaningless."

IV. Behavioral Indicators of Sexual Abuse

In Missouri a prosecutor may elicit testimony (assuming a witness has otherwise been properly qualified) that an alleged victim displays psychological changes that are consistent with those resulting from a traumatic or stressful sexual experience. (See Briefs and Motions in Appendix E for citations). However, an expert cannot testify that the victim suffers from "rape trauma syndrome" or "child molestation or abuse syndrome." State v. Taylor, 663 S.W.2d 235 (Mo. banc 1984).

In my experience, false allegations of sexual abuse are often the result of leading and suggestive questioning of children by parents who are led to believe their children have been sexually abused because their children have "behavior indicators consistent with sexual abuse." If a doctor, nurse, social worker or other professional advises a parent that they believe the child has been sexually abused because the child has "behavioral indicators consistent with sexual abuse," the parent interprets this as proof

of sexual abuse. Interviewers are more likely to ask leading and suggestive questions that elicit false allegations of sexual abuse if they believe the child has been sexually abused. They often believe the child has been sexually abused because of an overinterpretation of a medical finding or "behavioral indicator" by a professional.

Take for example the case of a four-year old boy taken to a hospital in St. Louis for evaluation by a sexual abuse team. Another child had indicated that this boy may know something about alleged sexual abuse taking place at the child's day care center. The police questioned the child on videotape and the child denied that he was sexually abused. Even when the police suggested to the child that he or other children had been sexually abused by a named suspect, the child denied the allegations.

When the child was taken to this hospital, a nurse interviewed this child in a very leading and suggestive manner. Despite the interviewing techniques used by the nurse, the child continued to deny that he had been sexually abused. The nurse could not get the child to admit that the suspect had engaged in any improper behavior. When the child refused to give the nurse the affirmations of abuse she was requesting, the nurse held a group interview. In that interview, two other boys stated, in the presence of this boy, that the suspect had hit them. Still this boy continued to deny that the suspect engaged in any improper behavior.

Despite the boy's consistent denials and despite a normal physical examination the doctor and nurse concluded this child had been sexually abused. Here is what the doctor wrote in his report:

"Though physical findings are not remarkable, this does not negate sexual abuse. I believe strongly this child has been sexually abused -- has strong behavior indicators, night terrors, sleep disorders, fears falling asleep, handling and touch."

The parents and police took this doctor's report to be medical proof the child had been sexually abused. The child was then taken to a therapist (referred to the parents by the same hospital). That therapist testified that she assumed the child had been sexually abused because the "experts" had made that diagnosis. She testified that even though the child continued to deny the allegations for several weeks of therapy sessions, she assumed his denials were due to his fear of the suspect.

After numerous interviews with different interviewers (police, nurse, parents, therapist) and after weeks of therapy the child finally admitted that the defendant had abused him by tying

him up in a chair and sticking needles into the child's legs. According to the child, this all occurred in the presence of numerous other children. When those other children were questioned about the defendant abusing this child by sticking needles in his leg, they had no knowledge of this.

What was the "expert's" explanation for his statement that he strongly believed this boy had been sexually abused even though the boy denied abuse and he had a normal physical examination? In a deposition, the "expert" testified as follows:

Q. And what were your conclusions regarding any sexual abuse of the child?

A. I felt that he was -- I can read my SAM evaluation. No physical findings are not remarkable. This does not negate sexual abuse. I believe strongly this child has been sexually abused, has strong behavioral indicators, night terrors, sleep disorders, fears of falling asleep, handling, and touching.

Q. So based upon those indicators alone, that's why you believe strongly he had been sexually abused?

A. Yes.

Q. And is that consistent --

A. Well, no, no, that's behavioral, and what other history, too, I think is important.

Q. Well, in his history he denied any sexual abuse?

A. That's not unusual.

Q. I'm asking you how you made a statement such as the following: I believe strongly this child has been sexually abused, has strong behavioral indicators, night terrors, slight disorders, fears falling asleep, handling and touch.

A. I want to know everything you base that finding on.

Numerous objections made. Witness refuses to answer question without reviewing videotape of nurse's interview.

Q. So when you testified at the preliminary hearing that the sole basis for your finding that you believed the child was sexually abused, was because of the strong behavioral indicators, night terrors, sleep disorders, fears falling asleep, handling and touch; are you now telling us that there may have been something else?

A. There may have been. There may not have been either.

The expert then testified that his statement that he believed strongly that the child had been sexually abused was also based upon the fact that the child's parents had said the child admitted that he had been in the suspect's office and that he described being paddled (the parents in their testimony denied that their child had reported this to them prior to the hospital examination). He then testified his statement regarding this child was also based upon the fact that three other boys were allegedly involved. He testified as follows:

A. . . . So it is not unusual for children who have been sexually abused, and chronically sexually abused to deny it happened.

Q. Is it unusual for children who have not been sexually abused to deny that it's happened?

A. Yeah. That's true too.

Q. You assume when a child comes in that he's been sexually abused?

A. Not at all.

Q. I'll go back to my question. Assume that the police interview of this child was consistent denials, that the hospital interview of this child was consistent denials, that your physical exam of this child was, I think you have not remarkable, but you still conclude that the child has been sexually abused, based upon the behavioral indicators.

A. And what the parents said and the whole scenario of cases.

Q. And what did the parents tell you?

A. That he was having problems, and that he was -- he described being in the suspect's office, and that he described being paddled.

Q. Parents told you those things?

A. Yes.

Q. And based upon that, you made the statement that you strongly believe he had been sexually abused?

A. Yes.

Q. Let me ask you about these behavioral indicators. Is it unusual for a child to have night terrors, sleep disorders, fears falling asleep?

A. Not at all.

Q. In fact, a large percentage of children have those; isn't that correct?

A. Yes, they do.

Q. And a large percentage of children who have not been abused have that?

A. Yes.

Q. Let me ask you if you agree with a statement by a Dr. Anthony Rostain, a medical doctor, obtained in a book in the hospital library entitled, Principles and Practice of Clinical Pediatrics. "Sleep disorders are common during childhood and vary according to the age of the child."

Do you agree with that?

A. Yes, I do.

Q. "Toddlers and preschoolers have difficulties with falling and staying asleep, night terrors, nightmares, and enuresis."

Do you agree with that?

A. They can, yes.

Q. "Although estimates vary widely, a majority of children will have some type of sleep disorder during childhood, most of which resolve with minimal or no treatment."

Do you agree with that statement?

A. Yes.

Q. From the same article, I ask you if you agree with these treatments.

"Special consideration should be given to details in the bedtime routine that may aid in diagnosis, e.g., scary bedtime stories or television programs, too much physical activity before bedtime, irregular habits or no fixed schedule."

Do you agree with that?

A. Yes.

Q. And did you take any history from these parents as to the child's bedtime routine?

A. No.

Q. Let me ask you if you agree with this: "The presence of family stresses should be explored, since sleep problems often begin in response to other family problems."

Do you agree with that?

A. Yes.

Q. And let me ask you if you agree with this statement: "Finally, a family history of sleep disorders, neurological diseases, or psychiatric illness must be ruled out."

Do you agree with that?

A. Yeah.

Q. And when you took these behavioral indicators as a basis for sexual abuse, did you rule out the other causes of sleep disorders?

A. Again, you're isolating each one of these, and if you can, and I'm sure you can take each one of these and not look at the whole picture, and make a case for all of it.

Q. Let me ask you about that, Doctor. Did the police give you a background on the whole situation?

A. No. Not that I recall, no.

Q. And I'm asking you to explain if you went through the normal medical diagnosis in this case, to rule out various things such as bedtime routine, family stresses, or history of sleep disorders, did you do any of those things in diagnosing this sleep disorder as being connected with sexual abuse?

A. No. I felt it was strongly due to sexual abuse.

Q. And is it common for you, Doctor, not to, or is it common for you to make a diagnosis without ruling out other causes for that diagnosis?

A. When you, you know, there is, you know, there is a policy in medicine that you put down your differential diagnosis, and people often will put down 50 different things that can cause a situation. Everyone knows in a situation in medicine you can list 50 things that cause just about anything.

But still, a good physician has his first impression and he stands by that. This is how I feel it is, and you put all your thoughts together and you come up with an answer.

Q. And a good physician doesn't even question the family about medical history of other problems.

A. Not when he has -- If it walks like a duck and quacks like a duck, it's a duck.

- -

Q. The question again is, can you tell me any medical journal, any article whatsoever, based upon reasonable medical procedure, that says the correct way to diagnose a problem is to disregard other conditions that can cause that same problem, and not even question those other conditions?

A. No.

Q. Did you or anyone at the hospital question the parents to rule out all the possible causes of these sleep disorders?

A. No, we didn't.

Q. Let me refer you again to the article, "Principles of Practice of Clinical Pediatrics," edited by Dr. William Schwartz, and ask you if you agree or disagree with this statement: "Nightmares are normal occurrences."

A. I disagree.

Q. Let me ask you in the same article if you agree or disagree with this statement: "Night terrors are most frightening for parents and other family members, they need to be reassured that these are not serious or pathological episodes."

A. Did I agree with that in context, in the context that's used there, they're probably correct.

Q. What do you mean by your statement in the child's reports about handling and touch.
A. That they don't want anyone to touch them, they don't want to

be -- That's basically it, they are resistive to being touched.

Q. And who advised you that the child was resistant to being touched?

A. The parents.

Q. And did they advise you when that first began?

A. Not that I recall.

Q. Wouldn't it be important to determine when that first began?

A. May or may not be.

Q. But you didn't obtain that information; is that right?

A. No. Not that I recall, no.

According to the parent's testimony, their child was never resistant to being touched while he attended the day care center where the abuse allegedly occurred. According to the parent's testimony, the child first indicated a resistance to touch the day after he was interviewed by the police and questioned about being touched in his private areas. Prior to the police interview, the child had never been resistant to touch. As to the sleep disturbances, etc., through discovery the defense was able to show that these "behavioral indicators" began shortly after the child's father was arrested for a felony assault.

One of the leading legal scholars in the area of child witness law has these comments on basing an opinion of sexual abuse on such behavioral indicators as those mentioned by the above expert:

"The most casual examination of these symptoms (behaviors attributed to sexual abuse) reveals, however, that many of them are associated with other developmental and psychological problems of childhood and adolescence. For example, the fact that a child suffers from nightmares, loss of appetite, regression, and depression says very little, if anything, about sexual abuse. A myriad of other factors can cause such symptoms, and it would be improper for an expert to base an opinion relating to sexual abuse on such ambiguous symptoms alone." Myers at 157."

In State v. Maule, 35 Wash. App. 287, 667 P.2d 96 (1983) an expert identified the typical characteristics of sexually abused children to include:

". . . sleep disruption of some kind, appetite disruption,

nightmares fairly common sort of reaction; sometimes other behavior changes might be noted, particularly the child being withdrawn or perhaps having regressed in their behavior, acting like a younger child, being rather clingy to the mother, being afraid of being alone with a particular person, something like that."

The Court in Maule rejected the expert opinion based on such symptoms, finding that the testimony was not supported by adequate medical or scientific research, and was not based on the

type of evidence reasonably relied upon by experts in the field.

Id. at 100; Myers at 159-60.

Likewise, if the prosecution proposes to introduce testimony such as that given by the "expert" in deposition, counsel should move to exclude such evidence for the same reasons set forth in State v. Maule and for the reasons set forth in Appendix E. (See also Note, The Unreliability of Expert Testimony on the Typical Characteristics of Sexual Abuse Victims, 74 Geo. L.J. 429 (1985); McCord, Expert Psychological Testimony About Child Complainants in Sexual Abuse Prosecutions: A Foray Into the Admissibility of Novel Psychological Evidence, 77 J. Crim. L. & Criminology 1 (1986)).

For similar comments from psychologists regarding the unreliability of expert testimony based on such behavior indicators, consider the following:

"The relationship between these behaviors and any sexual abuse is the weakest and most tenuously supported of the claims that have been made. The most that can be said is that these behaviors may be related to any stress experience . . .

The base rates of the presence of many such behaviors in fully normal children, in troubled children, in non-abused children, and as part of the normal developmental process for all children is so high that any attempt to use them as indicating abuse will result in a high rate of error.

These alleged behavioral indicators of sexual abuse are found in many different situations, including divorce, conflict between parents, economic stress . . . and almost any stressful situation children experience. Possible consequences arising from an allegation of sexual abuse -- a frightening and perhaps painful physical examination by a stranger, separation from one or both parents, possible removal to a foster home, multiple interrogations by a number of interviewers -- are themselves the source of significant stress."

Because the consequences arising from an allegation of sexual abuse can be the source of these behavior indicators, it is important that you document, through discovery, when the indicators first began. Often the "indicators" first begin after the child has been interviewed by the police or after "therapy" sessions begin.

V. Admissibility of Child's Hearsay Statements Under 491.075 RSMo.

If you have been successful in convincing the trial judge that the child's statements disclosing abuse are the result of contamination by leading and suggestive questioning of the child, you may be able to prevent the prosecutor or juvenile office from introducing the hearsay statements of the child. See Appendix F for a memorandum of law that discusses what factors courts have considered in deciding on the admissibility of hearsay statements under 491.075 RSMo. and similar statutes.

VI. References

1. Wakefield, Hollida and Underwager, Ralph, Accusations of Child Sexual Abuse, Charles C. Thomas Publisher (1988). (This is a 500-page book that is an excellent source for lawyers. The book is written by two psychologists who have extensive experience in assessing accusations of sexual abuse by children.)

2. Nurcombe, Barry, "The Child as Witness: Competency and Credibility." Journal of the American Academy of Child Psychiatry 25, 473 - 480 (1986).

3. Benedek, Elissa and Schetky, Diane, "Clinical Experience, Problems in Validating Allegations of Sexual Abuse," Journal of the American Academy of Child and Adolescent Psychiatry 26, 6:912 - 921 (1987).

4. Ceci, Ross, and Toglia, "Suggestibility of Children's Memory: Psycholegal Implications," Journal of Experimental Psychology: General 116, No. 1, 38 - 49 (1987).

5. Humphrey, H. (1985) Report of Scott County Investigations, St. Paul, MN: Attorney General's Office.

6. Van DeKamp, J.K. (1986), Report on the Kern County Child Abuse Investigation, Sacramento, CA. Office of the Attorney General, Division of Law Enforcement, Bureau of Investigation.

7. Dale, Loftus and Rothburn. The influence of the Form of the

Question on the Eyewitness Testimony of Preschool Children." Journal of Psycholinguistics Research, 7, 269 - 277 (1978).

8. Coleman, Lee, Has a Child Been Molested? California Lawyer, July 1986.

9. Coleman, Lee, "Medical Examination for Sexual Abuse: Are We Being Told the Truth. In press Family Alternatives, Minneapolis, MN (1989).

1

Presented to the Secretary of State for Social Services by the Right Honourable Lord Justice Butler - Sloss DBE, Her Majesty's Stationery Office, London, July 1988.

Emans, S.J., Woods E.R., Flagg, N. T., Freeman, A., "Genital Findings in Sexually Abused, Symptomatic and Asymptomatic Girls." 79 Pediatrics #5, p. 778, May 1987.

McCann, Anatomical Standardization of NormalPrepubertal Children (Study in press but McCann's lecture presented at a meeting sponsored by the Center for Child Protection of a meeting sponsored by the Center for Child Protection of the San Diego Children's Hospital is on audiotape and is available through Convention Recorders, P. O. Box 87042, San Diego, California.

Coleman, Lee, Medical Examination for Sexual Abuse: Are We Being Told the Truth in Press: Family Alternatives, Minneapolis, MN (1989).

C. Psychological Changes or Behavioral Indicators of Sexual Abuse:

Wakefield and Underwager, supra.

Note, The Unreliability of Expert Testimony on the Typical Characteristics of Sexual Abuse Victims, 74 Geo. L. J. 429 (1985).

D. Legal Resource:

Myers, J., Child Witness Law and Practice (John Wiley & Sons Publisher (1987).

APPENDIX "A"

INTERVIEWER VARIABLES THAT CAN CONTAMINATE
THE RELIABILITY OF THE CHILD'S STATEMENT

Source: Wakefield and Underwager, Accusations of Child Sexual Abuse

1a) Open-objective questions or statements to which the child can respond spontaneously, based upon his or her own personal experience. No information is provided by the interviewer, and no attempt is made to lead or influence the child's response.

Examples:

Where were you when that happened?
What happened next?
How did you feel?
What were you wearing that day?

Here the child is providing the information free of suggestions or potentially false information.

1b) Open-suggestive questions. These questions are open in nature, but are suggestive or leading in that they may provide or imply information which may in fact be incorrect, and may pertain to information or events to which the child has not previously referred.

Examples:

Who else was there? (There may not have been others present).
Whose house were you at when the big person touched you? (The child may not have been at a house).
What did the other big person do to you? (The other person may not have done anything).
How big was the bed that was in the room? (When there was no previous mention of a bed).

2a) Closed-objective questions or statements in which some information may be supplied to the child by the interviewer. Minimal response (such as "yes" or "no") is required.

Examples:

Does your daddy ever spank you?
Was there anyone else there?
Was there a bed in the room?
Did the other person do anything?

2b) Closed-suggestive questions or statements which supply information to the child that may be incorrect, or pertain to information to which the child has not previously referred. Minimal response is required. Questions in this category are leading or suggestive questions.

Examples:

Does he hurt you?
Does this always happen in your room?
Has it ever happened in daddy's room?
Was it you that she caught him doing it to?
Here, the interviewer, not the child, provides most of the information.

3a) Combination-objective questions. Questions which contain elements of both closed and open-ended questions. They may begin as open questions, and end as closed questions, or vice versa. In addition, combination questions may ask for more than one type of response, and may give conflicting or confusing messages.

Examples:

What else? (open) Did he touch you again? (closed)
Where? (open) Down there? (closed)
And then they took you away, right? (closed) How did you feel about that? (open)
What kind of games did you play, good or bad ones?
Were there other children there too? (closed) Who were they? (open)
Tell me about your school. (open) Did you ever go on trips? (closed)
Do you remember when you told me about what happened to John? (closed) Tell me some more about that. (open)

3b) As above, but leading or suggestive in nature.

4) Questions or statements which put the child on the spot, and coerce or pressure him or her to respond as expected. Questions in this category demand a response, and may contain stated or implied threats. Commands given by the interviewer should be included in this category. Non-verbal messages can also be used for this purpose.

Examples:

All of the other children talked to us, and they felt better.
Last time, you told me that they hurt you. Is that true, or not?

If you don't tell, you will feel yucky inside.
If you don't talk to us, your mommy will be very disappointed in you.
Tell us what you told your mommy.
Answer my question right now!
We can't play with the game until we finish.
It's important.
We need you to tell us so other children won't get hurt.
You can't go outside until you finish telling me!

Non-verbal behaviors in this category can include using a cold or neutral tone of voice, moving away from the child, avoiding the child's eyes, and ignoring the child's responses or questions.

5) Various rewards -- verbal, non-verbal, and material -- which the child receives for responding as expected.

Examples:

You're a good talker!
Good -- That's just right.
You're so brave to tell us all of this!
Mommy will be so proud if you tell us.
After you talk to us, then you can have an ice cream cone.
If you can tell us what happened to you, that icky feeling inside will go away!

Non-verbal rewards can include smiling, touching or moving closer to the child, head nods, and changing from a cold or neutral voice to a warm voice.

6) Modeling or teaching by the interviewer. (Often used in conjunction with dolls, puppets, drawings, or books).

6a) Discussing case with parents or guardians while the child is present.

7)

9) Minimize cues given to a child about what he is supposed to say. A child should not be told that "Johnny told us that the teacher touched his pee pee," and then asked, "Did anything like this happen to you?" This tells the child what you want to hear.
10) A frequent subtle cue to a child as to what the interviewer wants is the repetition of a question when the child has already answered but not in the desired direction. When an interviewer ignores a child's denial but keeps asking the question until an affirmation is obtained, the affirmation is not reliable.

11) Drilling, coercion, repeated questioning when a child gives a negative response or says, "I don't know" tells the child that he is not producing what the adult in authority wants.

12) Interview the child alone. The presence of another person may induce bias, distortions or omissions in the child's account. Two or more interrogatories can produce a significant pressure to comply with the messages about what is the expected answer.

13) Child's gives answer that makes no sense or answer that interviewer does not believe. Interviewer ignores and does not inquire further.

14) Child is told to pretend or make believe.

15) Interviewer tells the child that his response is incorrect.

16) Interviewer tells the child what to say or what happened to child.

APPENDIX "B"

At a preliminary hearing, a therapist of a four-year old boy testified that the boy had reported to her that the defendant had taken "icky" and "naughty" pictures of him. The therapist testified that she had not suggested or led the child into making this statement. The parents also testified that the child had told them that the defendant took "icky" and "naughty" pictures of him. Through discovery, I found out that the therapist had tape recorded some of her sessions with the child. I obtained the tape recordings and made transcripts of all the tapes. The following is part of the transcript when the child allegedly first reported that the defendant took "icky" and "naughty" pictures of him. Note that what the child is doing is mimicking the therapist's suggestion that the pictures were icky and naughty when in fact the child doesn't even know the meaning of the words "icky" and "naughty." Also note that the child also indicated that he had his clothes on when the pictures were taken and he was unable to report why he thought the pictures were icky or naughty. If these tape recordings had not existed, a judge or jury would have only heard the testimony of the therapist that the child said the pictures were icky and naughty and they would not have known that it was the therapist that said the pictures were icky and naughty and the child just repeated these phrases not knowing what the words meant.

Therapist (T): So you had your picture taken with other boys at the same time? Did you have your clothes on when they took your pictures?

Child (C): Yes.

T: Yes? Do you know why they took your picture?

C: No.

T: Was it a fun picture or did it feel icky?

C: Icky.

T: Icky? What was icky about it?

C: (Inaudible)

T: I don't understand.

C: They said they were going to give the picture to us icky.

T: I don't know what that means. Do you know what I mean when I say icky?

C: No.

T: No? I think I used a goofy word. I wondered if when they took your picture, it was a nice picture or a naughty picture.

C: Naughty.

T: Naughty? Do you know what that means?
C: No.

T: No? Did it feel good to have your picture taken?

C: Nope.

T: What didn't feel good?

C: They said they were going to give it icky and naughty.

T: Ummm. . . What were you doing when you had your picture taken?

C: I was good and they were bad.

T: How were they bad to you? (Long pause)

C: I don't know.

T: You don't . . . this is real hard for you to talk about isn't it?

B. Medical Examination and Findings

1. In nearly every metropolitan area "law enforcement and child protection workers quickly learn which examiners are more likely to make findings supportive of an allegation of molest. Most often those examiners are attached to a `sex abuse team'" (9). In the St. Louis metropolitan area, the police and Division of Family Services workers have learned which sex abuse team is more likely to make findings supportive of an allegation of molest. Since I have been involved in numerous cases where a well-known doctor (head of a sexual abuse team) has found evidence (consistent with sexual abuse), I will use that doctor's previous testimony in those cases to demonstrate how to attack medical findings of sexual abuse.

2. The most important motion an attorney can file when faced with medical findings consistent with sexual abuse is to attempt to have the child examined by another doctor. It is not unusual for one expert to examine a child and report physical findings of molestation and another expert to examine the same child and find

none ( ).

In a criminal case, no Missouri statute or rule authorizes a trial court to order a physical or mental examination of a prosecution witness and appellate courts have upheld trial courts' refusals to order mental examinations. State v. Clark, 711 S.W.2d 885 (Mo. App. E.D. 1986); State v. Wallace, 745 S.W.2d 233 (Mo. App. E.D. 1987). However, in State v. Johnson, 714 S.W.2d 752 (Mo. App. W.D. 1986), the Western District disagrees with the .pn2 Eastern District's ruling in State v. Clark that a trial court never has authority to order a mental examination of a prosecution witness. The Johnson case suggests that Missouri trial courts have authority to order such an examination ("We note only that the thoughtfully wrought decisions of virtually all jurisdictions which have considered the essential question recognize just such a discretion in a trial court to protect the integrity of the fact-finding in a criminal case -- the want of a rule or statute notwithstanding.") State v. Johnson, supra at 758 fn. 6. (See State v. Johnson at 757-8 for a discussion of cases from other states).

Missouri Supreme Court Rule 60.01(a) allows a court in a civil case to order a party, or a person in the custody or under the legal control of a party, to submit to physical or mental examinations. Consequently if a juvenile court proceeding or domestic relations case is pending that involves the child a physical examination can be ordered.

3. To date, there are only two studies where doctors have attempted to establish what findings occur in normal children. Both of these studies are considered authoritative studies and are very useful in cross examining experts who claim they have found evidence of sexual abuse. If lawyers become familiar with these two studies, they can demonstrate to judges and juries that "experts" are reporting as "findings of sexual abuse" findings which commonly occur in children who have not been sexually abused. The two studies that report what findings occur in the genital and anal area of young children who have not been sexually abused are: (1) Emans, Woods, Flag, Freeman, "Genital Findings in Sexually Abused, Symptomatic and Asymptomatic Girls." Pediatrics, V. 79, No. 5, May 1987 and (2) A study done by Dr. McCann, Dr. Voris and Dr. Simon which is not in print yet but which was presented at a meeting in St. Diego in January, 1988 sponsored by the Center for Child Protection of a San Diego children's hospital. Dr. McCann's findings as presented at that meeting are contained on audio cassette tapes and will soon be published (13).

Dr. Lee Coleman has recently written an article entitled "Medical Examination for Sexual Abuse: Are We Being Told the

Truth?" In that article he summarizes some of the findings of the Emans and McCann studies:

"Emans, et al.attempted to compare three groups of girls: abused (Group 1), asymptomatic and non-abused (Group 2) and symptomatic and non-abused (Group 3). This study has serious flaws. The examiners were not blind to which category each girl belonged; no information is given on how certain it was that alleged molest victims were true victims; and examiners were not randomly assigned. Instead, the lead author was the exclusive examiner of girls assumed to be molested.

Nonetheless, the authors deserve credit for at least addressing what has been ignored by so many others. They concluded from their literature search, just as I have from my own, that `no previous study has reported the incidence of various genital findings in girls . . .'

Presence or absence of 20 genital findings were recorded on each child. These included hymenal clefts, hymenal bumps, synechiae (tissue bands), labial adhesions, increased vascularity and erythema (redness), scarring, friability (easy bleeding), rounding of hymenal border, abrasions, anal tags, anal fissures, condyloma accuminata (venereal warts). These are the kinds of findings which are being attributed to sexual abuse in courts across the land, despite their having been `no previous study.'

Their findings: `the genital findings in Groups I and III were remarkably similar . . . there was no difference between Groups I and III in the occurrence of friability, scars, attenuation of the hymen, rounding of the hymen, bumps, clefts, or synechiae to the vagina.' These findings, in other words, are not specific to molest.

Emans, et al. do claim that only the abused group showed hymenal tears and intravaginal synechiae. Doubts about this, however, are raised by the results of the only other research effort done so far. It is not yet in print, but Dr. John McCann has recently discussed the findings. McCann, Voris and Simon have taken a different approach from Emans group. They have taken on the very necessary task of trying to establish the range of anogenital anatomy in normal children. Without such data, the `findings' so regularly attributed to molest are essentially meaningless. That there are as yet no published data on this is itself highly significant.

At a meeting in San Diego in January, 1988, sponsored by the Center for Child Protection of the St. Diego Children's Hospital, McCann reported on this research. Three hundred pre-pubertal children were examined, and it was found that many of the things currently

being attributed to molest are present in normal children. Here are some conclusions:

- - vaginal opening size varies widely in the same child, depending on how much traction is applied and the position of the child. Knee-high chest position leads to different results from frog position.

- - 50% of the girls had what McCann calls bands around the urethra. He has heard these described as scars indicative of molest. So have I.

- - 50% of the girls had small (less than 2 mm) labial adhesions when examined with magnification (colposcope). Twenty-five percent had larger adhesions visible with the naked eye.

- - Only 25% of hymens are smooth and contour. Half are redundant, and a high percentage are irregular.

- - What are often called clefts in the hymen, and attributed to molest, were present in 50% of the girls.

- - `We were struck with the fact that we couldn't find a normal (hymen). It took us three years before we found a normal of what we had in our own minds as a preconceived normal . . . You see a lot of variation in this area just like any other part of the body . . . We need a lot more information about kids . . . We found a wide variety . . .'

- - ` . . . in the literature, they talk about . . . intravaginal synechiae and it turns out that . . . we saw them everywhere . . we couldn't find one that we couldn't find those ridges.'

- - When does normal asymmetry become a cleft? I don't know.'

Anal examination were equally revealing of a good more variation among normal children than the `experts' have so far been recognizing.

- - 35% of children had perianal pigmentation.

- - 40% had perianal redness. The younger the age group, the more likely this finding.

- - One-third of the children showed anal dilatation less than 30 seconds after being positioned for the examination.

- - Intermittent dilatation, said by Hobbs and Wynne to be clear evidence of molest, was found in two-thirds of the children.

Recall that Emans found that while abused (by `history' at least) girls were remarkably similar to non-abused but symptomatic (infections, rashes, etc.) girls, hymenal tears and intravaginal synechiae were said to be found only in the abused group. We now see the McCann's group finds that it cannot be sure what is a tear and what is a normal asymmetry, and that they `saw intravaginal synechiae everywhere.'

What little research exists, then, shows that a small group of self-appointed `experts,' given credibility by an all- two-eager law enforcement and child protection bureaucracy, has misled the courts, falsely `diagnosed' sexual abuse, and damaged the lives of countless non-abused children and falsely accused adults." (9)

4. Have the "experts" in our metropolitan area reported as proof that a child has been sexually abused findings which occur in a large percentage of non-abused normal children? The answer is a definite yes. To illustrate, I will take testimony from the "expert" in our metropolitan area and compare it to the recent studies referred to above. The medical finding that I will use as an illustration is an anal tag. An anal tag is defined "as a mound of skin on the anal verge which may be associated with or have resulted from a fissure."

The following testimony was given by the prosecution's "expert" at a preliminary hearing:

Q: What physical findings must be present before you can specifically conclude based solely upon the physical findings that the child has been sexually abused as regards the anus?

A. Tags and tears. Dilation. And these children, the history becomes very pertinent and your behavioral indicators. You need to show dilation, and I think -- you should ideally if at all possible, dilation and tears and tags and funneling. They are all physical findings.

Q. What I'm asking you is, is based solely on physical findings what do you have to observe before you can conclude positively that that child has been sexually abused through anal intercourse?

A. Any of the things I mentioned.

(Objection made and overruled.)

Q. What physical evidence must you have, or must any pediatrician or expert in this field have before they can conclude based solely upon the physical finding that the child has definitely been anally penetrated?

A. Nothing else.

Q. With nothing else --

A. After a kid's physical exam?
Q. Yes.

A. And I had no other input but that physical exam, if I saw a tear or a tag I would say this child would be very likely to have been sexually abused, getting some history, getting some --

Q. But you're still not answering my question --

A. But I have answered your question.

Q. My question is what physical findings must you see before you can conclude positively that this child has been anally penetrated not knowing any other behavioral indicators or background?

A. Dilation.
Q. Let me stop you there.

(At this point the expert testifies on the significance of dilation of the anus. According to McCann's study, dilation can be a normal finding in children who have not been abused. Since I am only discussing anal tags, I will not discuss this any further).

Q. Other than dilation what other physical findings must you see for you to determine that without a doubt this child has been anally penetrated if you have no history or no background on the child or any behavioral indicators?

(Objection made and overruled).

Q. Other than dilation is there anything else as far as physical findings where you can look at the anus of a child and determine based solely upon the physical findings that that child has been anally penetrated?

A. Yes. Tags.

Q. And how many tags do you have to find before --

A. One is sufficient.

Q. So when you find one tag you can conclude that that child without a doubt has been anally penetrated.

A. Yes.

This expert who the prosecutors in the metropolitan area claim is the leading expert on diagnosing child abuse and child sexual abuse can make a positive diagnosis of sexual abuse without obtaining any history on that child if he observes one anal tag. According to the two studies of "normals," this is not possible because anal tags are found in "normal" non-abused children (12, 13).

In the Emans study, the percentage of anal tags found in sexually abused girls did not differ significantly from the percentage of anal skin tags seen in girls with other genital complaints. The Emans article notes that some children are born with anal skin tags. (Yet the "expert" above can see a tag and without a history conclude the child has been sexually abused). According to Emans, "anal tags were seen in all groups; when known congenital tags were specifically excluded, group 1 (sexually abused girls) was slightly more likely than group 2 (normal girls with no genital complaints) to have tags." The percentage of anal tags seen in sexually abused girls and asymptomatic but non-abused girls was similar. Similarly, the McCann study found that normal children have anal skin tags (13).

In a comprehensive study of the significance of medical findings in young children in England that study had the following to say about the significance of finding anal tags: "They (anal skin tags) would not appear in themselves to be grounds for suspicion" (14).

Unfortunately, according to the testimony of the expert in St. Louis, not only are they grounds for suspicion but they are diagnostic of sexual abuse. I have been unable to find any source that agrees with the St. Louis expert.

I never got the opportunity to impeach this expert at trial with the above materials because the charges against my client were dismissed just before trial. However, in depositions, this "expert" retreated from his original claim that observing an anal tag is proof of sexual abuse. In my experience with the expert, I have seen him attribute numerous other "normal" anal and vaginal findings as being consistent with sexual abuse.

5. Differential Diagnosis: Those experts who find evidence of sexual abuse more often than other experts, often do not consider alternative causes of a particular finding. It is important for a defense attorney to show that the finding that the expert is relying on to conclude that this child has been sexually abused could have been the result of causes other than sexual abuse. If the defense attorney can show that the particular finding could be the result of causes other than sexual abuse, you may be able to establish reasonable doubt. If the expert is one

used by the prosecution, that expert may not admit that the finding has many causes.

How do you get the State's expert to admit that the finding has many causes? Again, I will illustrate this through testimony in a case I handled. This is the same expert that prosecutors and DFS workers consider to be the leading expert on child abuse. This testimony occurred at a preliminary hearing where I cross-examined the State's expert:

Finding: Small scars and dimples on child's anus.

Testimony: Isn't is true that passing large stool can cause small scarring?

A. Yes.

Q. What else can cause small scars other than passing large stool and sexual abuse.

A. I don't think of anything else.

Q. You don't know of anything in the literature that would cause small cars?

A. I'm sure there must be something. Turns to judge: He must have found something.

After the preliminary hearing but prior to trial, I had to disclose what authoritative sources I intended to use at trial.

The State's expert apparently read those sources because when he testified at trial on direct examination he testified as follows:

Q. By prosecutor: Now, what other things can cause scars in a child's anus like this?

A. Very few things. But you can get anal trauma and anal problems with chronic constipation. You can get it with severe diarrhea, explosive diarrhea in which people have. And you can also get it with chronic colonic disease.

To prepare for my cross-examination I spent several hours at the St. Louis University Medical Library to obtain authoritative sources which discuss the various causes of scars on a child's anus. After spending only a few hours at the medical library, I had obtained authoritative sources that indicated any of the following could cause scars on a child's anus:

1. Constipation.

2. Any trauma to area: ranging from the child acidentally sitting on a sharp object to intentional injuries.

3. Scratching induced by eczema or other perianal condition; i.e., child does not wipe himself thoroughly.

4. Crohn's disease.

5. Anal stenosis.

6. Crypt abscess.

7. Juvenile polyps.

8. Perianal inflammation.

9. Inflammatory bowel disease.

10. Improper insertion of anal thermometer.

11. Insertion of finger, either child's or adults while wiping child.

12. Diarrhea.

13. Giving a child an enema - if not done properly can cause a small scar.

At the trial this "expert" was then asked, on cross-examination, questions such as the following:

Q. And you have previously testified that Nelson's Textbook on Pediatrics is an authoritative source, isn't that correct?

A. On pediatrics, yes, sir.

Q. Let me ask you if you agree with this statement in Nelson's Textbook on Pediatrics: "The causes of most anal fissures and scars are often not evident but may be secondary to constipation with passage of large stools, scratching induced by irritation from enterobius vermicularis or eczema or other perianal conditions."

A. This child did not have eczema. And eczema doesn't usually attack that area. But if Nelson said it, I guess it's feasible.

Using this same approach with each of these causes the State's expert admitted that every one of the items in the above list can cause small scars on a child's anus similar to the one he

"allegedly" observed on this child's anus.

I then finished this part of my cross-examination with the following questions:

Q. Doctor, there's other things besides which I have listed here that can cause scars in a child's anus, aren't there?

A. That looks pretty thorough to me. There might be other small --

Q. Have you previously testified that everyone knows in any situation in medicine you can list at least 50 things that can cause the same thing?

A. Sure. You can get --

Q. I don't quite have 50 though, do I?

A. No, but you give a differential. And you've got to take, as I said at that time too, if a child comes to you as to why that scar is there, then you can list 50 things that can cause it. But when a child comes and gives you a history, then that list is diminished in size.

Q. Let me ask you about correct procedure on examining a child. Are you familiar with procedures used and recommended in other states where the doctor does not hear the history before examining the child because of the biasing effect, that the studies have shown that if you are told a child is sexually abused, you are more likely to find evidence of that and ignore other possible causes?

A. I imagine that could be feasible in a place that doesn't see a lot of kids.

Q. When you attended the summit conference in California, wasn't that a recommendation and isn't that what they use in San Diego, that a doctor does not get to hear the history before he examines the child because if you hear a history that has a biasing effect on any normal individual?

A. I guess that's feasible, but I think that the history is important too.

Q. Before you examine the child?

A. Yes, sir, I believe that is. I'd like to believe I wouldn't be biased by that.

6. In the above example, we saw that the expert initially

claimed a particular finding could only be caused by two things -- constipation and sexual abuse (in this case forcing a stick into the child's rectum). The expert claimed he asked the parents if the boy had ever been constipated and when they denied constipation he concluded the small scar on the anus was "consistent with sexual abuse as related by the child." He then advised the police and parents of his opinion.

This expert did not tell the police or the parents that this small scar could have fifty other causes. Nor did he inquire into the child's medical history to determine the likelihood of these other causes. The parents and police interpreted this expert's conclusion that the small scar was consistent with sexual abuse as medical proof that the child was sexually abused. From that point on, any hope for a neutral investigation was lost forever (Coleman, p. 3). Everyone who then interviewed the child, including his psychologist, admitted they assumed the child was a victim of sexual abuse because of this expert's findings -- the investigation into the truth or source of the allegation stopped.

This expert's phrase that the physical examination of the child showed evidence "consistent with" sexual abuse means very little. Dr. Coleman describes the term "consistent with" as a pseudofinding:

"Likewise, it might seem obvious that a normal ano/genital examination is no help in establishing molest. Such normal examinations are, nonetheless, frequently termed "consistent with" sexual abuse. Rarely have I seen this followed by a statement indicating that a normal examination is equally consistent with no abuse . . .

Given that many victims of molestation show no physical results, it follows that <u>every child's</u> anatomy is `consistent with' molest because normal anatomy is also consistent with non-traumatic molest."

Not only does this "pseudofinding" often stop the truth-seeking process, at times it starts a false allegation. If a parent, police officer or DFS worker is told that the expert found medical findings consistent with sexual abuse it often is only a matter of time before the interviewer's bias (in this case a belief that there is medical proof of molest) results in the child affirming the interviewer's belief.

7. I began this section with a recommendation that you always attempt to obtain a second medical examination of the alleged victim. The case I have been discussing in this section is a good example of why a second examination is important.

In his medical report and at the preliminary hearing, the State's expert did not indicate the size or shape of the small scar he claims to have observed on the child's anus. In depositions he testified as follows:

Q. Was this small well-healed scar at six o'clock as large as a millimeter?

A. I don't recall.

Q. Was it smaller than a millimeter?

A. I don't recall.

At trial in this case this "expert" gave the following testimony on direct examination regarding the size of this alleged scar:

Q. Well, first, about how big was this scar?

A. . . . I din't measure it. It's hard to say, but I <u>know</u> it would be <u>at least</u> a centimeter. Maybe longer. (Note: A centimeter is 10 times longer than a millimeter).

On cross-examination this expert admitted that he did not document the size of the scar by either photographing it, drawing it in the medical report or indicating the size in his medical records. He also testified that he had no records that would refresh his recollection as to the size of the scar. He was then confronted with the testimony he had given approximately 10 months earlier:

Q. Have you ever given different testimony as to the size of that scar in this case?

A. Not that I recollect. Again, I didn't measure it. It's hard to say. I might have given different sizes. I might have said something other, but my recollection at this point is that that would be about it.

Q. Well, you wouldn't be mistaken and be off as much as 10 times the length, would you?

A. I don't think so.

When this expert was confronted with his previous testimony that he did not recall if the scar was smaller or larger than a millimeter but he now remembered it was at least a centimeter, he testified as follows:

Q. Well was your memory better a year ago or is it better today?

A. I don't recall it. I didn't recall then and again I said I would think. I didn't say it was one centimeter. I said I would think it would be at least that length.

I had requested that this child be examined by another expert but this request was denied. In the hearing on the motion for a second examination, I introduced evidence that the State's expert had on previous occasions observed evidence of sexual abuse that other experts failed to observe when the child was seen by a second expert. If a second opinion had been ordered at least the size of the scar would have been determined and the size of the scar would not have grown from the depositions to the trial.

8. Even when you cannot obtain a second examination of the alleged victim, you may still be able to contest the existence of a particular finding. This can be accomplished by obtaining a complete history of any medical complaints made by the child (through a deposition of the child's parents and through the pediatric records of the child) and demonstrating how the medical history is inconsistent with the allegations being made by the child. For continuity, I will again use the child with an alleged small scar on his anus as an example. In this case the State charged the defendant with forcing a stick into the child's rectum. According to the father of the child, the child said the Defendant held onto the stick with both hands and made three quick thrusts with his hands when he forced the stick into the child's rectum.

In depositions of the child, the child at first said there was no pain when the stick was forced into his rectum and then he said it hurt just a little. However, at trial when the State asked the child if this was one of the child's most painful experiences, the child answered in the affirmative.

The State's expert testified that this small scar on the child's anus (size disputed) was consistent with the child's allegation that a stick had been forced into his rectum. The nurse who worked with this expert had not told him that while she was interviewing the child he took her scissors and told her the defendant had also stuck those scissors into his rectum. However, when I pointed that out to this expert, he said the small scar was also consistent with pointed scissors being forced into the child's rectum. His testimony on this is as follows:

A. . . . I examine the child and I see a scar. And I say that scar is consistent with what the child says.

Q. And if you didn't see anything, no findings at all, that also

is consistent with what the child said, isn't it?

A. It can be, yes, sir.

Q. And in fact, no findings at all are consistent with what the child said?

A. That's feasible. Besides, 50 percent of children who are sexually abused show no findings.

Q. So there is nothing that is inconsistent with what the child says according to you, is there?

A. According to everyone who works in the field.

- -

Q. Let me ask you if you agree with this statement in the Medicine, Science and the Law by Dr. Paul. "Fissures, scars, and anal verge, hematoma can both result from the passage of constipated stools so great care must be taken in the interpretation of such a solitary finding. History of any sudden change in an infant's bowel habit is of great importance. A child previously potty-trained and regular in his bowel habits who suddenly resents being pottied or refuses to have his bowels helped is frequently found to have some injury to his anal verge. Such a history is associated with a history of an alleged sexual assult and with clinical findings of anal verge injury is good corroboration. Any child who has been the victim of anal penetration will experience pain on defecation for sometime afterwards and this discomfort will persist even in the absence of an anal fissure or scar. If a fissure or scar is present, the discomfort may persist for as long as two weeks. So specific is that the doctor should view with great suspicion any history where there is no complaint of pain on defecation. Such a history is inconsistent with penetration."

A. I don't know if I agree with that entirely.

- -

Q. Let me ask you if you agree with this statement in Nelson's Textbook on Pediatrics regarding fissures and scars. "Pain on defecation and frequently refusal to defecate are the principle manifestations of an anal fissure." Do you agree or disagree with that?

A. Fissure, oh, yeah, anal fissures are common. They don't often, they usually don't scar.

Q. Because they're less severe than what causes a scar?

A. Breaks in skin. You get little fissures on the lip the same way. A break in the skin. Tender, heals, doesn't leave a scar.

Q. So it's not severe?

A. Has to be deeper to leave a scar, yes, sir.

Q. So a principle manifestation of what the child would have shown because of this scar would be pain on defecation and refusal to defecate?

A. Does Nelson list in there sex abuse as a cause of scars?

Q. No, he doesn't.

A. Then he's not complete either, is he?

Q. I'll get to the American Medical Association Diagnostic list in a minute. Now, Nelson, that's a national publication, textbook?

A. Yes, sir, it is.

Q. You've also told me that another book which is in pediatrics is Current Pediatric Diagnosis and Treatment, ninth edition, edited by Kempsey and Silver; is that correct?

A. Yes, sir.

Q. And that's an authoritative source, isn't it?

A. It's considered, yes, sir.

Q. Let me ask you if you agree with this statement as to what findings the child will have if they've had a small scar or fissure on their anus. And it's in Current Pediatrics Diagnosis and Treatment. "The infant or child cries with defecation and will try to hold back stools. Sparse bright red bleeding is seen on the outside of the stool or the toilet tissue following defecation. Fissure can often be seen if the patient is held in the knee-chest position." Do you agree with that?

A. Yes, sir.

Q. So again we have --

A. That's why it's a vicious circle. Children who are sexually abused can have, get a history of chronic constipation.

Q. And did you ask his parents if the child ever had a history of pain on defecation?

A. I don't recall if I did. I don't think I did.

Q. Doctor, are you familiar with the medicine, American Medical Association's journal where the council on scientific affairs has listed a diagnostic list of factors you look for to determine if there's been child abuse or child sexual abuse?

A. If that's it.

Q. Yes. Are you familiar with the AMA diagnostic and treatment guidelines concerning child abuse and neglect?

A. Yes, I think I have seen that.

Q. Okay. Let me ask you a specific question about that.

A. Sure.

Q. There is a list of approximately 16 items, signs of sexual abuse, physical signs. Let me ask if you agree with these, any of the following physical signs may indicate sexual abuse: Difficulty in walking or sitting.

A. Sure.

Q. Did you have any history of that --

A. No, sir.

Q. - - from the child?

Q. Did you have any history of torn, stained or bloody underwear?

A. No, I did not sir.

Q. Bruises or bleeding of the perianal area, did you find that?

A. No, sir.

Q. Recurrent urinary track infections, gonococcal, syphilis, herpes, sperm or acid toxilate, lax rectal tone. Did you find any of that?

A. No, sir.

Q. Is there anywhere on this list put out by the American Medical Association scientific affairs published in 1985 that says that

small scars on the anus are physical findings of sexual abuse?

A. Well, I don't think it's a complete list. They listed, the most uncommon thing is not there. It just doesn't, that's not the complete list either. I think that's incomplete.

Q. So they left out --

A. If they left out scars, I think that's an oversight on their part. They also left out normal findings as a finding too. So I think that's an incomplete list.

Q. This is the Journal of American Medical Association, isn't it?

A. Yes, sir, it is.

In cross-examination of the parents, it was brought out that this child had never been constipated, had never had complaints of pain on defecation and had never made complaints of pain to his anal area (except once approximately two weeks <u>after</u> his removal from the school where the abuse allegedly occurred). Further, his parents had never observed any blood on his underwear or blood in his stool. The child's pediatric records were introduced to show that this child was never taken to his pediatrician for any complaints of pain or injury to his anus or rectum.

The defendant's expert testified among other things (1) that a small scar on the anus could not properly be identified as a scar by simply looking at the scar as was done by the State's expert, (2) that the State's expert's failure to "document" the scar by photographing the scar or at least describing the size and shape in his medical report was not consistent with standard medical procedure, (3) that if in fact the child had a small scar on his anus there should have been a history of constipation or pain on defecation, and (4) that if in fact the child had a small scar on his anus the child's pediatric records and history as given by the parents provided a number of alternative explanations for a small scar.

The defendant's expert strongly disagreed with the State's expert that a small scar on the child's anus is "consistent with" the child's story that a stick had been forced into the child's rectum. The defendant's expert explained that due to the size of a young child's anus and rectum, a stick forced into the child's rectum in the manner alleged by the child could have caused severe injuries to the child and there would have been pain and blood associated with the injury.

9. Do not be afraid to challenge the qualification of the "expert" who claims to have diagnosed findings consistent with

sexual abuse. When I first became involved in child sexual abuse cases, the police, DFS workers and prosecutors extolled the qualification of their "expert." However, when I investigated this expert's qualifications, he came up short in several areas. Two of those areas that should be brought out on cross-examination are:

a) Impartiality: The "expert" used most often by the State testified in the trial referred to above that he had never testified on behalf of the defense.

(b) Publications: The "expert" used most often in St. Louis has never published, in a journal or textbook, an article on sexual abuse. Yet if you do not tie him down on this point he will testify as follows:

Q. Have you published any articles in this field - sexual abuse of children.

A. Yes, I have.

Q. Okay. And I served you with a subpoena. Did you bring those articles that the subpoena required you to bring today.

A. They weren't published at the time.

Q. I served you with the subpoena last week. Are they still not published.

A. They're in, they're in, yeah, they're published now. They're in the book that I presented, not in this, not in sexual abuse, not, the article I published pertains to urethral dilation in girls. And it's in the proceedings of the international meeting that was held in Rio do Janeiro.

Q. The only article you've published is published in Brazil?

A. No, it's published here. It's published in Denver, out of Denver.

Q. Okay. And I served you with a subpoena and asked you to bring every article, every paper you've ever written. Did you bring that with you today?

A. No, sir, I didn't.

Q. What is this one article you say you've published? What does it have to do with?

A. Vaginal findings in girls.

Q. And what this is is they typed up a transcript of your speech in Rio Do Janeiro; is that correct?

- -

Q. And these are speeches you gave and someone tape- recorded it and typed it up; isn't that correct?

A. No. They weren't speeches. They were submitted papers and then I talked on the submitted paper.

Q. Have they ever been published in any authoritative table such as in pediatrics?

A. No.

Q. Any published in an authoritative textbook?

A. No, sir, they have not.

Q. Will you have time after you leave here today before this case is over to bring your article back to us?

A. Not back. I can probably find a way to get it to you, sure.

Q. Okay. You'll do that for us, won't you.

A. Certainly.

This trial lasted another two days and this article was never brought in to the court.

There is no doubt that many "experts" are experts because of their experience. The fact that an expert has not published does not make that person any less of an expert. However, "experience" does not necessarily make the person an expert. In assessing what weight to give an expert's testimony because of his experience, consider the following comments:

"Finally, a note on "experience." Experience, like consensus, is not enough to move from conjecture to science. Feedback, i.e., controlled testing of ideas through research, is necessary to be sure that one's experience is not filled with incorrect notions that go unrecognized. Thousands of women, for example, underwent radical mastectomy because highly experienced surgeons, and doctors in general, believed it was the best way to save lives. Only subsequent research demonstrated that simple mastectomy saved as many lives.

The situation is even worse when the doctor's opinion will itself influence the ultimate findings of the justice system. If Doctor X opines that a child has been molested, based on findings which in truth do not prove molest, a court will frequently rubber stamp such an opinion. This judicial finding then becomes the confirmation which makes the doctor feel he can rely on his "experience." Such "confirmation" is of course scientifically meaningless."

APPENDIX "C"

TRANSCRIPT OF POLICE VIDEO INTERVIEW
OF
FOUR-YEAR OLD BOY

The following contains portions from a transcript of a police videotape of an alleged sexual abuse victim. I want to use this transcript to demonstrate several important points. First, if the interview of the child is not tape recorded or videotaped, you will never know what suggestions were made to the child nor will you know the extent of the denials made by the child. The two police officers who conducted the following interview and the mother of the child that sat in on the interview all testified under oath that no one in the interview asked any leading questions and no one in the interview made any suggestions to the four year old child.

At the preliminary hearing and pre-trial motions, the police officers and the mother testified that the four year old boy on videotape told them the name of the suspect, that he was a white man and that he took the child upstairs into his office. They also testified that the boy told them that when he took the child in his office he pulled the child's pants down and put food in and on the child's penis and in the child's rectum. They all three denied that the child made any statements inconsistent with that version of the offense. Not one of the three remembered that the child first described the suspect as a black man; not one of the three remembered that the child said the bad man only took him to McDonald's and that the child never said that the man

took him upstairs to his office; not one of the three remembered that the child told the police officers that his mother told him to say that someone put food in his private parts; not one of the three remembered that even after 40 minutes of suggestion, coercion and leading questions, the child could not name the suspect and did not name the suspect until the sound went off on the videotape machine for a period of 40 seconds and when the sound came back on, the police officer stated the name of the suspect and continued the interview as if the child had named the suspect when the sound was off.

Remember that an interviewer's distorted perception of what occurred in an interview is not an unusual occurrence in the interviews of young children. The experts that have studied false allegations of sexual abuse have indicated that it is very common for interviewers to "perceive" that a child said one thing when in fact the child said the opposite or to "perceive" that a child

said one thing when in fact it was the interviewer who made the statement. In this case, I have known the two police officers for some time. I do not believe that either of those police officers lied under oath when they stated that they did not lead or suggest any of the answers to the young child or when they stated that the child made certain statements that the child never made. They went into the interview assuming that the suspect was a particular person and assuming that that suspect was guilty. When the child made statements that did not confirm this assumption, they either ignored those statements or they "perceived" that the child was too afraid to tell them the truth or that the child was confused. Certainly they would not have lied about this knowing that there was a videotape of the interview. However, if there was not a videotape of this interview, I am certain, based upon the two police officers' memory of the interview, that my client would have been convicted of this offense. When there is no videotape or tape recording, there is reason to suspect that the interviewer's memory is even more distorted.

The second point that I would like to make through the use of this transcript is the importance of making a typewritten transcript of all videotapes or tape recordings and reviewing those very closely to determine what suggestions have been made and how those suggestions distorted the child's memory. An example of this can be seen in the following transcript. In that transcript, the child at one point is sitting in front of the videotape and he has french fries, a hamburger and a Coca- Cola that the police have bought him from McDonald's. As you will see in the transcript, the police officer gives him a french fry and asks him to pretend that is other food and to show them what the suspect did with the food. Several months after this interview, the child reported to his therapist and to his parents that the suspect put french fries, hamburgers and Coca-Cola up his rectum. The State had taken the position that no one had suggested this to the child and that the child could not have made up this allegation. However, a careful review of the videotape and the transcript showed the source of this false allegation. As you will see in the transcript, the police directly suggested to him that french fries were put in his rectum and the police directly suggested to the boy that he was taken upstairs to the suspect's office. During the interview, the boy kept reporting that the suspect only took him to McDonald's (the police had just brought the boy from McDonald's to the police station). However, in later interviews, not only did the boy incorporate the french fries into the false allegation, but he included the Coca-Cola and hamburger and he claimed this occurred in the suspect's office.

VIDEO POLICE INTERVIEW

Codes: (Det. 1) Detective 1 Det. 2) Detective 2
(M) Mother (C) Child

Background

Detective 2 testified that prior to the videotape interview, Detective 2 interviewed the child at his home. Detective 2 testified the child's mother told him that she believed the boy has been sexually abused by the suspect because her son told her the suspect had good food upstairs and they played games upstairs. According to Detective 2, because of these statements and certain behavioral changes noticed in her son, the mother concluded he had been sexually abused by this suspect. However, the mother testified that she did not tell Detective 2 that she believed the suspect had sexually abused her son prior to Detective 2 interviewing her son. She testified that the first time she knew her son was accusing the suspect was after the detective interviewed her son and told her what her son said in the interview.

Detective 2 testified that in his interview of the child approximately one-half hour prior to the videotape interview, the child told him that the suspect took him to his office, pulled the child's pants down and put green beans, corn and donuts in the child's rectum and penis. On cross-examination, the detective said when he asked the child if the suspect took him up to his office and put green beans and corn in his private areas, the child first denied this "because he didn't trust me at first." He testified that after about thirty minutes of talking with the child, the child trusted him and agreed that the suspect put green beans and corn in his rectum and penis. (The detective never could explain why he would ask a four-year old boy if a man pulled his pants down and put green beans and corn in his rectum).

With this background here are some portions of the transcript of the videotape interview:

Questions and Answers Comments

Det. 2: Who are we going to take care of?

C: Oh, the bad guys . . .

Det. 2: What was that bad guy's name? What did we call him?

- - - - - - - - - - - - - - - - - - -

Det. 1: Did you have a special class room you were supposed to be in at the old school, or a special room you were in all the time? Did you ever leave that room?

C: No.

Det. 2: (Very quickly jumps on child to say) Remember what I told you? That we always have to tell the truth because we're all friends and you want to be a policeman.

Det. 2: Are we going to take care of Mommy, Daddy and your friends for you?

Det. 1: That's what we're here for and we're here to help. Will you tell me what you were talking about with the officer here?

C: About bad guys (mumbles). Wait a second. (Child leans over and whispers to his Mother). What was his name?

M: . . . You'll have to tell them . . .

- - - - - - - - - - - - - - - - - -

Det. 1: Did he used to come down and eat lunch with you? (Child the shakes his head no).

(The child's day care center was in the basement. The suspect was the only person who had an office upstairs and the only person who came down and ate lunch with the day care workers.)

Det. 1: Do you remember what color his hair is?

C: Gray.

Det. 1: What color is his skin? Do you know what a white man or a black man looks like?

C: He's a black man.

(The suspect is a white man.)

Det. 1: He's a black man? You know what black is don't you? See Mama's purse over there? That's black. Does he look like that? (Child shakes his head no). Then what color is he?

C: He's a boy, black.

Det. 2: Remember what we were talking about? Do you remember what you told me he looked like? What's the bad man look like? Does he

have my color of skin?

M: Does he look like Mommy and Daddy?

Det. 1: He does? Color like your Mama's skin?

C: Yeah.

Det. 1: O.K. So he's what we would call a white man, right? (Child nods yes)

Det. 2: Does he wear anything on his face?

(The suspect wears his glasses.)

C: No.

- - - - - - - - - - - - - - - - - -

Det. 1: What kind of bad things does the bad man do?

C: He hits people all the time.

C: He hits a . . . he does this on your cheek. (Hits his own right cheek)

Det. 2: On your cheek? Does he ever hit any of your friends?

Det. 1: Would he hit you anywhere else?

C: No.

Det. 2: Remember I'm here to protect you and nothing is going to happen to you.

C: (Shouts disgustingly) I KNOW!!!

Det. 2: Oh, you're tired of me telling you that aren't you? (Child nods yes) (But you know that we're friends, right?

C: YES!!!

- - - - - - - - - - - - - - - - - -

Det. 1: Do you remember what this bad man's name is?

C: No.

Det. 1: Have you ever seen him before?

C: Let me see here (twists and thinks; no answer) . . .

- - - - - - - - - - - - - - - - - -

Det. 1: These dolls of mine (Referring to anatomically correct dolls. They help me find out when a bad man and a little boy get together. Now let's pretend that this will be the bad man that you know (one in his rt. hand) and let's pretend this is you (one in lt. hand) I want you to take the bad man and show me what the bad man did to you, O.K.? Can you do that? Can you show me what happened between you and the bad man using these little dollies, can you? (Child takes a doll in each hand, dances them up and down, bangs heads together and lets both dolls drop to floor falling on each other) O.K., what else happened?

C: O.K. (grabs dolls, dances them up and down and then takes good doll and crosses it over head of bad doll) it jumped over his head.

Det. 1: O.K., but show me what the bad man would do to you though, O.K.? (Child takes bad doll and smacks it into good doll) He would hit you?

Det. 2: Weren't you taking a nap sometimes when the bad man would come?

Det. 1: Did the bad man ever spank you? The child later reported the suspect spanked him. (Child takes bad doll and spanks good doll).

Det. 2: Is that how the bad man spanked you? Show me again, I didn't see it, just one more time. There you go, buddy.

- - - - - - - - - - - - - - - - - -

Det. 2: Show us what the bad man did to little boys, O.K.? (Child continues to bounce doll) Do it. O.K.?

C: I'm doing it.

Det. 2: Well, he didn't . . .

Det. 1: Did he do more than that, did he do more than just bounce you up and down like that?

C: He did this, boing, boing, voom (bounces doll and flips it completely over).

Det. 2: Did he hit you?

C: Yeah, he hit me.

(C) Boing, boing, boing, voom.

Det. 1: And what else would he do?

Det. 2: (Sternly calls child's name!) Remember what we - what you told me . . .

- - - - - - - - - - - - - - - - - -

Det. 2: You're showing us what the bad man did to you. (Child mumbles and laughs as he flips doll over and over).

Det. 1: O.K., did the bad man do anything else to you besides spin you around and hit you in the face?

Det. 1: Did he ever hit you anywhere besides in your face? Did he hit you on your (pats self on bottom) back here? (Child shakes his head no) Where would he hit you?

C: He has jeans on and I have jeans on.

Det. 2: Didn't the bad man ever make you take anything off? Show me with the doll.

Det. 1: Yeah, show us what the bad man did with you, O.K.?

C: He takes his pants off.

Det. 1: Well, go ahead.

M: Go ahead and do it, it's O.K.

C: What?

C: O.K., O.K. (Starts taking doll's pants down) Now, almost.

Det. 2: Is that what the bad man did to you? What else did the bad man do?

Det. 1: Oh, he's got his pants pulled down.

Det. 1: Did the bad man do that to you?

C: Yeah.

- - - - - - - - - - - - - - - - - -

Det. 1: O.K. Did the bad man ever touch your willie? (Child shakes his head no). (The child in later inter views reported the suspect touched his penis) (name child uses for "willie.")

Did the bad man have you pull your pants down or did he pull them down for you?

C: He pulled the pants down for me.

- - - - - - - - - - - - - - - - - -

C: Huh? What's this? (points to doll's pubic hair) I don't know, what is that?

Det. 1: Did you ever see that on the bad man? (Child shakes head no) (The child in later interviews reported that he did see suspect's "privates.") You never saw that on the bad man?

C: (Shakes head no) What is it?

Det. 1: What is this? (points to doll's hair on head)

C: Hair.

Det. 1: Well, what is that? (points to pubic hair)

C: Hair.

Det. 1: Did you ever see any hair down there on the bad man? (Child spinning good doll over and over).

C: Nooo.

Det. 1: Put yourself (meaning good doll) down here and show me what the bad man did to you when he had his pants down too.

Det. 2: You can use this stuff over here too, O.K.?

Det. 2: Can you show me what happened to your private parts? Just show me what happened to it, O.K.? Remember these things over here? (points to food)

C: Uh, huh.

Det. 2: Well, let's pretend they are something else. What do you want to say this stuff is? (Det. 2 hands child a french fry).

Det. 2: Well, let's pretend they are something else.

Det. 2: Yeah, show me what happened to your private part, using that (French Fry).

Det. 2: But you show me what happened to your private part. (Child goes to good doll). That's good, show me what happened. It's O.K.

C: (Shouts) I KNOW!!

C: I got two big ones (shows 2 french fries).

Det. 2: O.K. You got two big ones. (Child flips dolls over on back). O.K., there's the private part.

C: Turn it over. (Starts sticking FF in penis)

Det. 2: Yeah, what is that? What are we pretending that stuff is? Is that . . . what is it?

C: I'm calling these FF's.

Det. 1: Yeah, but what are we pretending they are?

C: I pretend that these are (?) food! (Starts inserting FF into doll's bottom).

Det. 2: These are food. Oh, is that what happened to the food?

C: Yeah.

Det. 1: What are you doing now?

C: Putting it back here.

Det. 2: Yeah, how come you are doing that? Did somebody show you to put that there? Who showed you to put that there? Did somebody show you to put that there?

C: Yes.

Det. 1 and Det. 2: Who? (in unison)

C: (Growls loudly) MOMMY!!

Det. 2: Who?

C: Mommy. (When the detective receives an answer that he doesn't believe he tells the child that he gave the wrong answer.

Det. 2: No. Mommy didn't show you. I think somebody else showed you.

C: Uh huh.

Det. 1: Did somebody else show you to put food back there? Was that supposed to be food or supposed to be something else?

(The detectives never questioned the mother regarding the child's accusation.)

C: It supposed to be food.

Det. 1: O. K.

Det. 2: Who put that food back there? Who put that food in there? Who's this guy? (shows child bad doll)

C: Bad guy.

- - - - - - - - - - - - - - - - - -

Det. 2: Show us what the bad man did.

C: Ummm, boom! (drops FF aiming at good doll on floor).

Det. 2: You're going to help me with the bad man.

C: I missed it (FF doesn't hit doll) missed, missed, missed.

When the child claimed food was put in his rectum they never asked him if that was really true. It is only when he claims french fries were thrown at him that they doubt his story.

M: Is this really true?

C: (Yells loudly at mother) YES!!!

Det. 2: After you show us what the bad man did, I'll let you put my handcuffs on the bad man and we'll take him away.

Det. 1: What would he do?

Det. 2: Show us what the bad man would do. (Child throws FF on floor at doll). No?

C: He did so.

C: I know I'm talking . . . he would do this (throws another FF at doll).

Det. 1: He would throw things at you?

C: Uh huh.

Det. 1: Well, what were the things he would throw?

(The child is already incorporating the french fries (FF) into his story.

C: FF or Danish . . .

- - - - - - - - - - - - - - - - -

Det. 1: I know, but who was the one that put the (picks up FF and puts on good doll's penis).

C: Just bad guys.

Det. 1: Well, without a name, we can't put handcuffs on somebody that's for sure. We have to have their name.

M: It's OK.

C: Let me see, what's his name?

Det. 1: What would I call this guy if he was the bad guy. I gotta name this doll.

C: Mom, what's his name?

(Several times throughout the interview the child would ask his mother to tell him the name of the suspect.)

M: I can't think of a good name.

Det. 1: What's the bad guy's name that I'm going to keep away from your friends and protect your mommy and daddy from?

Det. 2: What's that bad man's name? The guy at the gas station's name?

(Prior to the interview the mother had told the police that she and the child had seen the suspect at a gas station.)

Det. 2: Yeah, but you gotta tell me so I can go get him and protect your mommy and daddy and your friends.

C: It was . . .

C: I don't know his name.

Det. 2: Yeah, you do.

C: I don't know his name.

Det. 2: He used to come down and eat lunch with you. Who was the guy, remember? When you were taking the child by Det. 2 is a nap and this guy that would come the suspect. and get you from your nap? (Child sighs). You almost said it.

C: What?

- - - - - - - - - - - - - - - - - - -

Det. 2: Where did he take you?

Det. 2: Where did he take you?

C: McDonald's.

Det. 2: He took you to McDonald's? No, he didn't. He took you someplace in the building. Didn't he used to take you someplace in the old school?

The police testified that in this interview the child said the suspect took him to his office and they did not remember saying the suspect took him to McDonald's.

- - - - - - - - - - - - - - - - - - -

THE SOUND ON THE TAPE IS BLANK FOR 45-50 SECONDS

(The police testified that they must have accidentally disconnected the microphone. They testified that during the 45- 50 seconds that the sound was off the child named the suspect. This was more than forty (40) minutes into the interview after the child had been

asked more than 20 times to name the suspect and he had been unable to.)

DETECTIVE 2 IS SHOWN SHAKING CHILD'S HAND JUST PRIOR TO SOUND RETURNING.

Det. 1: So the suspect (names suspect was at the church?

Det. 2: Here I tell you what. Let's take care of (the suspect). Yea, we gotta put our handcuffs on (the suspect), don't we? Cause he's bad. Put these old handcuffs on (the suspect) and lay him down here. O.K.? Is that better?

Det. 1: So (the suspect) is the one that used to take these things (picks up FF) and put on your privates. Is that what he would do?
Det. 2: He can't get you anymore because I'm protecting you.

- - - - - - - - - - - - - - - - - -

Det. 2: Did (the suspect) touch your willie?

Det. 1: Did (the suspect) touch your willie? (Child ignores the detective) Huh?

Det. 1: Would the suspect take his hand and touch your willie like that? (Reaches over and flattens willie) Would he do that sometimes? (Child acts and looks puzzled).

Det. 2: That's O.K.

Det. 1: You can tell me if he did.

Det. 2: It's O.K. because we're friends.

C: He didn't.

Det. 1: He done it? (Child shakes head no). He didn't? (Child keeps shaking head no). He didn't (Still shakes head no). He never touched your willie? (Child continues to shake head no). How did he get the Danish by your willie then? How did he do that if he didn't touch it? Would he tell you to do it?

(The police will not accept the child's answer even though he has consistently denied this throughout the interview.)

C: No (Picks up FF)

Det. 1: Then how did he do it?

C: Put this right here (puts FF on doll's eye) this right here (on other eye) and this right here (on nose).

C: O.K. (Puts both hands up to doll's mouth as if putting something in mouth). Put (inaudible) on him and they do this (takes doll) move my coke and hamburger. I'm going to do something and move my food and glass . . .

Det. 2: O.K. Show me where (the suspect) put the green beans.

C: You green bean? (Looking at FF Det. 2 is holding).

Det. 2: I got the green bean (Child taps doll's penis). (The suspect) would put the green bean here? (No response)

Det. 1: Would he touch you when he put the green bean there?

C: No.

Det. 2: Would he just lay it down like this? (Lay FF beside doll and child nods yes).

C: (Takes his FF and puts in doll's hand) and I'll put mine right here.

Det. 2: And you'd put your green bean there?

Det. 1: O.K.

Det. 2: I guess we need some corn now too don't we?

Det. 1: Yeah, see if we can find some corn. (Leans over looking at food)

C: How about . . .

Det. 2: Here's some corn (leans over and picks up more FF). We need this as corn, where would the corn go? Show me.

C: (Points to doll's mouth) In the mouth.

Det. 2: But didn't the corn go . . . you told me once someplace else too . . . let me remember . . it was . . . where?

C: (Grabs doll's penis) Squish this.

Det. 1 and Det. 2: (Unison) Squish that?

Det. 2: Who held onto that?

C: (Takes FF off doll and hands to Det. 1 (Points to doll's penis and looks at Det. 2 and says) You hold onto that. (Det. 2 holds doll's penis)

Det. 2: Who would hold onto that? (meaning penis)

C: (Hands Det. 1 FF) Hold that.
Det. 2: Who would hold onto this? (penis)

Det. 1: Who would hold onto that while you would roll over?

C: You (rolls doll over on stomach and Det. 2 hangs onto penis)

Det. 2: Who am I? Who am I pretending to be? Am I . . . who? Am I that bad man?

C: Nooo.

Det. 2: Show me what the bad man would do with the corn (hands child a FF and child inserts into rectum) Why would he put it there?

C: Because.

Det. 2: Because why?

Det. 1: And then what would he do?

C: Give me this FF.

Det. 2: What's that now?

C: (Puts in doll's right hand) This was in this hand.

Det. 2: Well, who held your willie?

C: Where's that other FF?

Det. 1: (Picks one up off floor) Must be here.

Det. 2: Who held your willie? When this was happening who would hold onto your willie?

C: You can let go.

Det. 2: (Let's go off penis) I can let go because nobody held onto your penis? Then you would lay like this? (Det. 2 pats doll on back)

- - - - - - - - - - - - - - - - - -

Det. 2: But this is the suspect. The suspect has to go to . . . away.

C: Huh?

Det. 2: (The suspect) has to go away so we can't play with this one.

C: Why?

Det. 1: Because (the suspect) . . . you know . . . Did anybody say something about hurting you?

C: Then put these handcuffs on him.

Det. 2: O.K.

Det. 1: So he won't hurt you, right?

Det. 2: And he's not going to hurt your friend is he?

C: And pretend this is the police doll.

Det. 2: Where did (the suspect) take you? (Child ignores question).

C: Pretend this is the police guy.

Det. 2: Where did (the suspect) take you. (Child ignores question).

C: Pretend this is the policeman, O.K.?

Det. 2: O.K. But where did (the suspect) take you? He took you someplace in the building didn't he?

Det. 2: Remember when (the suspect) would take you places? (Child ignores the detective)

Det. 2: Tell me where he took you, buddy?

C: I don't know.

Det. 2: Well . . . you told me before now, remember at the school?

C: (mumbles) McDonald's.
Det. 2: Well, no, we didn't go to McDonald's.

C: So I can order food.

Det. 2: (The suspect) took you someplace in the school didn't he? By yourself didn't he?

C: I don't know.

Det. 2: Yes he did. Tell the truth, remember?

Det. 2: (Turning to child) Where did he take you? Where did he take you? Huh? Where? Hurry up and tell me. Yell it out like you did before.

(In this interview the child never claimed (the suspect) took him anywhere in the building; yet the police testifiedthey were sure he said the suspect took him to his office in the building.

C: He took me to McDonald's (whispered)

Det. 2: Where did he take you in school, buddy? Where did he take you in school?

- - - - - - - - - - - - - - - - - -

Det. 2: O.K. Why don't we all go home now and then I'll come over to your house at 7:00 o'clock, O.K.?

B. Medical Examination and Findings

1. In nearly every metropolitan area "law enforcement and child protection workers quickly learn which examiners are more likely to make findings supportive of an allegation of molest. Most often those examiners are attached to a `sex abuse team'" (9). In the St. Louis metropolitan area, the police and Division of Family Services workers have learned which sex abuse team is more likely to make findings supportive of an allegation of molest. Since I have been involved in numerous cases where a well-known doctor (head of a sexual abuse team) has found evidence (consistent with sexual abuse), I will use that doctor's previous testimony in those cases to demonstrate how to attack medical findings of sexual abuse.

2. The most important motion an attorney can file when faced with medical findings consistent with sexual abuse is to attempt to have the child examined by another doctor. It is not unusual

for one expert to examine a child and report physical findings of molestation and another expert to examine the same child and find none ( ).

In a criminal case, no Missouri statute or rule authorizes a trial court to order a physical or mental examination of a prosecution witness and appellate courts have upheld trial courts' refusals to order mental examinations. State v. Clark, 711 S.W.2d 885 (Mo. App. E.D. 1986); State v. Wallace, 745 S.W.2d 233 (Mo. App. E.D. 1987). However, in State v. Johnson, 714 S.W.2d 752 (Mo. App. W.D. 1986), the Western District disagrees with the .pn2

Eastern District's ruling in State v. Clark that a trial court never has authority to order a mental examination of a prosecution witness. The Johnson case suggests that Missouri trial courts have authority to order such an examination ("We note only that the thoughtfully wrought decisions of virtually all jurisdictions which have considered the essential question recognize just such a discretion in a trial court to protect the integrity of the fact-finding in a criminal case -- the want of a rule or statute notwithstanding.") State v. Johnson, supra at 758 fn. 6. (See State v. Johnson at 757-8 for a discussion of cases from other states).

Missouri Supreme Court Rule 60.01(a) allows a court in a civil case to order a party, or a person in the custody or under the legal control of a party, to submit to physical or mental examinations. Consequently if a juvenile court proceeding or domestic relations case is pending that involves the child a physical examination can be ordered.

3. To date, there are only two studies where doctors have attempted to establish what findings occur in normal children. Both of these studies are considered authoritative studies and are very useful in cross examining experts who claim they have found evidence of sexual abuse. If lawyers become familiar with these two studies, they can demonstrate to judges and juries that "experts" are reporting as "findings of sexual abuse" findings which commonly occur in children who have not been sexually abused. The two studies that report what findings occur in the genital and anal area of young children who have not been sexually abused are: (1) Emans, Woods, Flag, Freeman, "Genital Findings in Sexually Abused, Symptomatic and Asymptomatic Girls." Pediatrics, V. 79, No. 5, May 1987 and (2) A study done by Dr. McCann, Dr. Voris and Dr. Simon which is not in print yet but which was presented at a meeting in St. Diego in January, 1988 sponsored by the Center for Child Protection of a San Diego children's hospital. Dr. McCann's findings as presented at that meeting are contained on audio cassette tapes and will soon be published (13).

Dr. Lee Coleman has recently written an article entitled "Medical Examination for Sexual Abuse: Are We Being Told the Truth?" In that article he summarizes some of the findings of the Emans and McCann studies:

"Emans, et al.attempted to compare three groups of girls: abused (Group 1), asymptomatic and non-abused (Group 2) and symptomatic and non-abused (Group 3). This study has serious flaws. The examiners were not blind to which category each girl belonged; no information is given on how certain it was that alleged molest victims were true victims; and examiners were not randomly assigned. Instead, the lead author was the exclusive examiner of girls assumed to be molested.

Nonetheless, the authors deserve credit for at least addressing what has been ignored by so many others. They concluded from their literature search, just as I have from my own, that `no previous study has reported the incidence of various genital findings in girls . . .'

Presence or absence of 20 genital findings were recorded on each child. These included hymenal clefts, hymenal bumps, synechiae (tissue bands), labial adhesions, increased vascularity and erythema (redness), scarring, friability (easy bleeding), rounding of hymenal border, abrasions, anal tags, anal fissures, condyloma accuminata (venereal warts). These are the kinds of findings which are being attributed to sexual abuse in courts across the land, despite their having been `no previous study.'

Their findings: `the genital findings in Groups I and III were remarkably similar . . . there was no difference between Groups I and III in the occurrence of friability, scars, attenuation of the hymen, rounding of the hymen, bumps, clefts, or synechiae to the vagina.' These findings, in other words, are not specific to molest.

Emans, et al. do claim that only the abused group showed hymenal tears and intravaginal synechiae. Doubts about this, however, are raised by the results of the only other research effort done so far. It is not yet in print, but Dr. John McCann has recently discussed the findings. McCann, Voris and Simon have taken a different approach from Emans group. They have taken on the very necessary task of trying to establish the range of anogenital anatomy in normal children. Without such data, the `findings' so regularly attributed to molest are essentially meaningless. That there are as yet no published data on this is itself highly significant.

At a meeting in San Diego in January, 1988, sponsored by the Center

for Child Protection of the St. Diego Children's Hospital, McCann reported on this research. Three hundred pre-pubertal children were examined, and it was found that many of the things currently being attributed to molest are present in normal children. Her

- - Intermittent dilatation, said by Hobbs and Wynne to be clear evidence of molest, was found in two-thirds of the children.

Recall that Emans found that while abused (by `history' at least) girls were remarkably similar to non-abused but symptomatic (infections, rashes, etc.) girls, hymenal tears and intravaginal synechiae were said to be found only in the abused group. We now see the McCann's group finds that it cannot be sure what is a tear and what is a normal asymmetry, and that they `saw intravaginal synechiae everywhere.'

What little research exists, then, shows that a small group of self-appointed `experts,' given credibility by an all- two-eager law enforcement and child protection bureaucracy, has misled the courts, falsely `diagnosed' sexual abuse, and damaged the lives of countless non-abused children and falsely accused adults." (9)

4. Have the "experts" in our metropolitan area reported as proof that a child has been sexually abused findings which occur in a large percentage of non-abused normal children? The answer is a definite yes. To illustrate, I will take testimony from the "expert" in our metropolitan area and compare it to the recent studies referred to above. The medical finding that I will use as an illustration is an anal tag. An anal tag is defined "as a mound of skin on the anal verge which may be associated with or have resulted from a fissure."

The following testimony was given by the prosecution's "expert" at a preliminary hearing:

Q: What physical findings must be present before you can specifically conclude based solely upon the physical findings that the child has been sexually abused as regards the anus?

A. Tags and tears. Dilation. And these children, the history becomes very pertinent and your behavioral indicators. You need to show dilation, and I think -- you should ideally if at all possible, dilation and tears and tags and funneling. They are all physical findings.

Q. What I'm asking you is, is based solely on physical findings what do you have to observe before you can conclude positively that that child has been sexually abused through anal intercourse?

A. Any of the things I mentioned.

(Objection made and overruled.)

Q. What physical evidence must you have, or must any pediatrician or expert in this field have before they can conclude based solely

upon the physical finding that the child has definitely been anally penetrated?

A. Nothing else.

Q. With nothing else --

A. After a kid's physical exam?

Q. Yes.

A. And I had no other input but that physical exam, if I saw a tear or a tag I would say this child would be very likely to have been sexually abused, getting some history, getting some --

Q. But you're still not answering my question --

A. But I have answered your question.
Q. My question is what physical findings must you see before you can conclude positively that this child has been anally penetrated not knowing any other behavioral indicators or background?

A. Dilation.

Q. Let me stop you there.

(At this point the expert testifies on the significance of dilation of the anus. According to McCann's study, dilation can be a normal finding in children who have not been abused. Since I am only discussing anal tags, I will not discuss this any further).

Q. Other than dilation what other physical findings must you see for you to determine that without a doubt this child has been anally penetrated if you have no history or no background on the child or any behavioral indicators?

(Objection made and overruled).

Q. Other than dilation is there anything else as far as physical findings where you can look at the anus of a child and determine based solely upon the physical findings that that child has been anally penetrated?

A. Yes. Tags.

Q. And how many tags do you have to find before --

A. One is sufficient.

Q. So when you find one tag you can conclude that that child

without a doubt has been anally penetrated.

A. Yes.

This expert who the prosecutors in the metropolitan area claim is the leading expert on diagnosing child abuse and child sexual abuse can make a positive diagnosis of sexual abuse without obtaining any history on that child if he observes one anal tag. According to the two studies of "normals," this is not possible because anal tags are found in "normal" non-abused children (12, 13).

In the Emans study, the percentage of anal tags found in sexually abused girls did not differ significantly from the percentage of anal skin tags seen in girls with other genital complaints. The Emans article notes that some children are born

abused could have been the result of causes other than sexual abuse. If the defense attorney can show that the particular finding could be the result of causes other than sexual abuse, you may be able to establish reasonable doubt. If the expert is one used by the prosecution, that expert may not admit that the finding has many causes.

How do you get the State's expert to admit that the finding has many causes? Again, I will illustrate this through testimony in a case I handled. This is the same expert that prosecutors and DFS workers consider to be the leading expert on child abuse. This testimony occurred at a preliminary hearing where I cross-examined the State's expert:

Finding: Small scars and dimples on child's anus.

Testimony: Isn't is true that passing large stool can cause small scarring?

A. Yes.

Q. What else can cause small scars other than passing large stool and sexual abuse.

A. I don't think of anything else.

Q. You don't know of anything in the literature that would cause small cars?

A. I'm sure there must be something. Turns to judge: He must have found something.

After the preliminary hearing but prior to trial, I had to disclose what authoritative sources I intended to use at trial.

The State's expert apparently read those sources because when he testified at trial on direct examination he testified as follows:

Q. By prosecutor: Now, what other things can cause scars in a child's anus like this?

A. Very few things. But you can get anal trauma and anal problems with chronic constipation. You can get it with severe diarrhea, explosive diarrhea in which people have. And you can also get it with chronic colonic disease.

To prepare for my cross-examination I spent several hours at the St. Louis University Medical Library to obtain authoritative sources which discuss the various causes of scars on a child's

anus. After spending only a few hours at the medical library, I had obtained authoritative sources that indicated any of the following could cause scars on a child's anus:

1. Constipation.

2. Any trauma to area: ranging from the child acidentally sitting on a sharp object to intentional injuries.

3. Scratching induced by eczema or other perianal condition; i.e., child does not wipe himself thoroughly.

4. Crohn's disease.

5. Anal stenosis.

6. Crypt abscess.

7. Juvenile polyps.

8. Perianal inflammation.
9. Inflammatory bowel disease.

10. Improper insertion of anal thermometer.

11. Insertion of finger, either child's or adults while wiping child.

12. Diarrhea.

13. Giving a child an enema - if not done properly can cause a small scar.

At the trial this "expert" was then asked, on cross-examination, questions such as the following:

Q. And you have previously testified that Nelson's Textbook on Pediatrics is an authoritative source, isn't that correct?

A. On pediatrics, yes, sir.

Q. Let me ask you if you agree with this statement in Nelson's Textbook on Pediatrics: "The causes of most anal fissures and scars are often not evident but may be secondary to constipation with passage of large stools, scratching induced by irritation from enterobius vermicularis or eczema or other perianal conditions."

A. This child did not have eczema. And eczema doesn't usually attack that area. But if Nelson said it, I guess it's feasible.

Using this same approach with each of these causes the State's expert admitted that every one of the items in the above list can cause small scars on a child's anus similar to the one he "allegedly" observed on this child's anus.

I then finished this part of my cross-examination with the following questions:

Q. Doctor, there's other things besides which I have listed here that can cause scars in a child's anus, aren't there?

A. That looks pretty thorough to me. There might be other small --

Q. Have you previously testified that everyone knows in any situation in medicine you can list at least 50 things that can cause the same thing?

A. Sure. You can get --

Q. I don't quite have 50 though, do I?

A. No, but you give a differential. And you've got to take, as I said at that time too, if a child comes to you as to why that scar is there, then you can list 50 things that can cause it. But when a child comes and gives you a history, then that list is diminished in size.

Q. Let me ask you about correct procedure on examining a child. Are you familiar with procedures used and recommended in other states where the doctor does not hear the history before examining the child because of the biasing effect, that the studies have shown that if you are told a child is sexually abused, you are more likely to find evidence of that and ignore other possible causes?

A. I imagine that could be feasible in a place that doesn't see a lot of kids.

Q. When you attended the summit conference in California, wasn't that a recommendation and isn't that what they use in San Diego, that a doctor does not get to hear the history before he examines the child because if you hear a history that has a biasing effect on any normal individual?

A. I guess that's feasible, but I think that the history is important too.

Q. Before you examine the child?

A. Yes, sir, I believe that is. I'd like to believe I wouldn't be

biased by that.

6. In the above example, we saw that the expert initially claimed a particular finding could only be caused by two things -- constipation and sexual abuse (in this case forcing a stick into the child's rectum). The expert claimed he asked the parents if the boy had ever been constipated and when they denied constipation he concluded the small scar on the anus was "consistent with sexual abuse as related by the child." He then advised the police and parents of his opinion.

This expert did not tell the police or the parents that this small scar could have fifty other causes. Nor did he inquire into the child's medical history to determine the likelihood of these other causes. The parents and police interpreted this expert's conclusion that the small scar was consistent with sexual abuse as medical proof that the child was sexually abused. From that point on, any hope for a neutral investigation was lost forever (Coleman, p. 3). Everyone who then interviewed the child, including his psychologist, admitted they assumed the child was a victim of sexual abuse because of this expert's findings -- the investigation into the truth or source of the allegation stopped.

This expert's phrase that the physical examination of the child showed evidence "consistent with" sexual abuse means very little. Dr. Coleman describes the term "consistent with" as a pseudofinding:

"Likewise, it might seem obvious that a normal ano/genital examination is no help in establishing molest. Such normal examinations are, nonetheless, frequently termed "consistent with" sexual abuse. Rarely have I seen this followed by a statement indicating that a normal examination is equally consistent with no abuse . . .

Given that many victims of molestation show no physical results, it follows that <u>every child's</u> anatomy is `consistent with' molest because normal anatomy is also consistent with non-traumatic molest."

Not only does this "pseudofinding" often stop the truth-seeking process, at times it starts a false allegation. If a parent, police officer or DFS worker is told that the expert found medical findings consistent with sexual abuse it often is only a matter of time before the interviewer's bias (in this case a belief that there is medical proof of molest) results in the child affirming the interviewer's belief.

7. I began this section with a recommendation that you always attempt to obtain a second medical examination of the alleged victim. The case I have been discussing in this section

is a good example of why a second examination is important.

In his medical report and at the preliminary hearing, the State's expert did not indicate the size or shape of the small scar he claims to have observed on the child's anus. In depositions he testified as follows:

Q. Was this small well-healed scar at six o'clock as large as a millimeter?

A. I don't recall.

Q. Was it smaller than a millimeter?

A. I don't recall.

At trial in this case this "expert" gave the following testimony on direct examination regarding the size of this alleged scar:

Q. Well, first, about how big was this scar?

A. . . . I din't measure it. It's hard to say, but I <u>know</u> it would be <u>at least</u> a centimeter. Maybe longer. (Note: A centimeter is 10 times longer than a millimeter).

On cross-examination this expert admitted that he did not document the size of the scar by either photographing it, drawing it in the medical report or indicating the size in his medical records. He also testified that he had no records that would refresh his recollection as to the size of the scar. He was then confronted with the testimony he had given approximately 10 months earlier:

Q. Have you ever given different testimony as to the size of that scar in this case?

A. Not that I recollect. Again, I didn't measure it. It's hard to say. I might have given different sizes. I might have said something other, but my recollection at this point is that that would be about it.

Q. Well, you wouldn't be mistaken and be off as much as 10 times the length, would you?

A. I don't think so.

When this expert was confronted with his previous testimony that he did not recall if the scar was smaller or larger than a

millimeter but he now remembered it was at least a centimeter, he testified as follows:

Q. Well was your memory better a year ago or is it better today?

A. I don't recall it. I didn't recall then and again I said I would think. I didn't say it was one centimeter. I said I would think it would be at least that length.

I had requested that this child be examined by another expert but this request was denied. In the hearing on the motion for a second examination, I introduced evidence that the State's expert had on previous occasions observed evidence of sexual abuse that other experts failed to observe when the child was seen by a second expert. If a second opinion had been ordered at least the size of the scar would have been determined and the size of the scar would not have grown from the depositions to the trial.

8. Even when you cannot obtain a second examination of the alleged victim, you may still be able to contest the existence of a particular finding. This can be accomplished by obtaining a complete history of any medical complaints made by the child (through a deposition of the child's parents and through the pediatric records of the child) and demonstrating how the medical history is inconsistent with the allegations being made by the child. For continuity, I will again use the child with an alleged small scar on his anus as an example. In this case the State charged the defendant with forcing a stick into the child's rectum. According to the father of the child, the child said the Defendant held onto the stick with both hands and made three quick thrusts with his hands when he forced the stick into the child's rectum.

In depositions of the child, the child at first said there was no pain when the stick was forced into his rectum and then he said it hurt just a little. However, at trial when the State asked the child if this was one of the child's most painful experiences, the child answered in the affirmative.

The State's expert testified that this small scar on the child's anus (size disputed) was consistent with the child's allegation that a stick had been forced into his rectum. The nurse who worked with this expert had not told him that while she was interviewing the child he took her scissors and told her the defendant had also stuck those scissors into his rectum. However, when I pointed that out to this expert, he said the small scar was also consistent with pointed scissors being forced into the child's rectum. His testimony on this is as follows:

A. . . . I examine the child and I see a scar. And I say that scar is consistent with what the child says.

Q. And if you didn't see anything, no findings at all, that also is consistent with what the child said, isn't it?

A. It can be, yes, sir.

Q. And in fact, no findings at all are consistent with what the child said?

A. That's feasible. Besides, 50 percent of children who are sexually abused show no findings.

Q. So there is nothing that is inconsistent with what the child says according to you, is there?

A. According to everyone who works in the field.

- -

Q. Let me ask you if you agree with this statement in the Medicine, Science and the Law by Dr. Paul. "Fissures, scars, and anal verge, hematoma can both result from the passage of constipated stools so great care must be taken in the interpretation of such a solitary finding. History of any sudden change in an infant's bowel habit is of great importance. A child previously potty-trained and regular in his bowel habits who suddenly resents being pottied or refuses to have his bowels helped is frequently found to have some injury to his anal verge. Such a history is associated with a history of an alleged sexual assult and with clinical findings of anal verge injury is good corroboration. Any child who has been the victim of anal penetration will experience pain on defecation for sometime afterwards and this discomfort will persist even in the absence of an anal fissure or scar. If a fissure or scar is present, the discomfort may persist for as long as two weeks. So specific is that the doctor should view with great suspicion any history where there is no complaint of pain on defecation. Such a history is inconsistent with penetration."

A. I don't know if I agree with that entirely.

- -

Q. Let me ask you if you agree with this statement in Nelson's Textbook on Pediatrics regarding fissures and scars. "Pain on defecation and frequently refusal to defecate are the principle manifestations of an anal fissure." Do you agree or disagree with that?

A. Fissure, oh, yeah, anal fissures are common. They don't often, they usually don't scar.

Q. Because they're less severe than what causes a scar?

A. Breaks in skin. You get little fissures on the lip the same way. A break in the skin. Tender, heals, doesn't leave a scar.

Q. So it's not severe?

A. Has to be deeper to leave a scar, yes, sir.

Q. So a principle manifestation of what the child would have shown because of this scar would be pain on defecation and refusal to defecate?

A. Does Nelson list in there sex abuse as a cause of scars?

Q. No, he doesn't.

A. Then he's not complete either, is he?

Q. I'll get to the American Medical Association Diagnostic list in a minute. Now, Nelson, that's a national publication, textbook?

A. Yes, sir, it is.

Q. You've also told me that another book which is in pediatrics is Current Pediatric Diagnosis and Treatment, ninth edition, edited by Kempsey and Silver; is that correct?

A. Yes, sir.

Q. And that's an authoritative source, isn't it?

A. It's considered, yes, sir.

Q. Let me ask you if you agree with this statement as to what findings the child will have if they've had a small scar or fissure on their anus. And it's in Current Pediatrics Diagnosis and Treatment. "The infant or child cries with defecation and will try to hold back stools. Sparse bright red bleeding is seen on the outside of the stool or the toilet tissue following defecation. Fissure can often be seen if the patient is held in the knee-chest position." Do you agree with that?

A. Yes, sir.

Q. So again we have --

A. That's why it's a vicious circle. Children who are sexually abused can have, get a history of chronic constipation.

Q. And did you ask his parents if the child ever had a history of pain on defecation?

A. I don't recall if I did. I don't think I did.

Q. Doctor, are you familiar with the medicine, American Medical Association's journal where the council on scientific affairs has listed a diagnostic list of factors you look for to determine if there's been child abuse or child sexual abuse?

A. If that's it.

Q. Yes. Are you familiar with the AMA diagnostic and treatment guidelines concerning child abuse and neglect?

A. Yes, I think I have seen that.

Q. Okay. Let me ask you a specific question about that.

A. Sure.

Q. There is a list of approximately 16 items, signs of sexual abuse, physical signs. Let me ask if you agree with these, any of the following physical signs may indicate sexual abuse: Difficulty in walking or sitting.

A. Sure.

Q. Did you have any history of that --

A. No, sir.

Q. - - from the child?

Q. Did you have any history of torn, stained or bloody underwear?

A. No, I did not sir.
Q. Bruises or bleeding of the perianal area, did you find that?

A. No, sir.

Q. Recurrent urinary track infections, gonococcal, syphilis, herpes, sperm or acid toxilate, lax rectal tone. Did you find any of that?

A. No, sir.

Q. Is there anywhere on this list put out by the American Medical Association scientific affairs published in 1985 that says that small scars on the anus are physical findings of sexual abuse?

A. Well, I don't think it's a complete list. They listed, the most uncommon thing is not there. It just doesn't, that's not the complete list either. I think that's incomplete.

Q. So they left out --

A. If they left out scars, I think that's an oversight on their part. They also left out normal findings as a finding too. So I think that's an incomplete list.

Q. This is the Journal of American Medical Association, isn't it?

A. Yes, sir, it is.

In cross-examination of the parents, it was brought out that this child had never been constipated, had never had complaints of pain on defecation and had never made complaints of pain to his anal area (except once approximately two weeks <u>after</u> his removal from the school where the abuse allegedly occurred). Further, his parents had never observed any blood on his underwear or blood in his stool. The child's pediatric records were introduced to show that this child was never taken to his pediatrician for any complaints of pain or injury to his anus or rectum.

The defendant's expert testified among other things (1) that a small scar on the anus could not properly be identified as a scar by simply looking at the scar as was done by the State's expert, (2) that the State's expert's failure to "document" the scar by photographing the scar or at least describing the size and shape in his medical report was not consistent with standard medical procedure, (3) that if in fact the child had a small scar on his anus there should have been a history of constipation or pain on defecation, and (4) that if in fact the child had a small scar on his anus the child's pediatric records and history as given by the parents provided a number of alternative explanations for a small scar.

The defendant's expert strongly disagreed with the State's expert that a small scar on the child's anus is "consistent with" the child's story that a stick had been forced into the child's rectum. The defendant's expert explained that due to the size of a young child's anus and rectum, a stick forced into the child's rectum in the manner alleged by the child could have caused severe injuries to the child and there would have been pain and blood associated with the injury.

9. Do not be afraid to challenge the qualification of the "expert" who claims to have diagnosed findings consistent with sexual abuse. When I first became involved in child sexual abuse cases, the police, DFS workers and prosecutors extolled the

qualification of their "expert." However, when I investigated this expert's qualifications, he came up short in several areas. Two of those areas that should be brought out on cross-examination are:

(a) Impartiality: The "expert" used most often by the State testified in the trial referred to above that he had never testified on behalf of the defense.

(b) Publications: The "expert" used most often in St. Louis has never published, in a journal or textbook, an article on sexual abuse. Yet if you do not tie him down on this point he will testify as follows:

Q. Have you published any articles in this field - sexual abuse of children.

A. Yes, I have.

Q. Okay. And I served you with a subpoena. Did you bring those articles that the subpoena required you to bring today.

A. They weren't published at the time.

Q. I served you with the subpoena last week. Are they still not published.

A. They're in, they're in, yeah, they're published now. They're in the book that I presented, not in this, not in sexual abuse, not, the article I published pertains to urethral dilation in girls. And it's in the proceedings of the international meeting that was held in Rio do Janeiro.

Q. The only article you've published is published in Brazil?

A. No, it's published here. It's published in Denver, out of Denver.

Q. Okay. And I served you with a subpoena and asked you to bring every article, every paper you've ever written. Did you bring that with you today?

A. No, sir, I didn't.

Q. What is this one article you say you've published? What does it have to do with?

A. Vaginal findings in girls.

Q. And what this is is they typed up a transcript of your speech in Rio Do Janeiro; is that correct?

- -

Q. And these are speeches you gave and someone tape- recorded it and typed it up; isn't that correct?

A. No. They weren't speeches. They were submitted papers and then I talked on the submitted paper.

Q. Have they ever been published in any authoritative table such as in pediatrics?

A. No.
Q. Any published in an authoritative textbook?

A. No, sir, they have not.

Q. Will you have time after you leave here today before this case is over to bring your article back to us?

A. Not back. I can probably find a way to get it to you, sure.

Q. Okay. You'll do that for us, won't you.

A. Certainly.

This trial lasted another two days and this article was never brought in to the court.

There is no doubt that many "experts" are experts because of their experience. The fact that an expert has not published does not make that person any less of an expert. However, "experience" does not necessarily make the person an expert. In assessing what weight to give an expert's testimony because of his experience, consider the following comments:

"Finally, a note on "experience." Experience, like consensus, is not enough to move from conjecture to science. Feedback, i.e., controlled testing of ideas through research, is necessary to be sure that one's experience is not filled with incorrect notions that go unrecognized. Thousands of women, for example, underwent radical mastectomy because highly experienced surgeons, and doctors in general, believed it was the best way to save lives. Only subsequent research demonstrated that simple mastectomy saved as many lives.

The situation is even worse when the doctor's opinion will itself influence the ultimate findings of the justice system. If

Doctor X opines that a child has been molested, based on findings which in truth do not prove molest, a court will frequently rubber stamp such an opinion. This judicial finding then becomes the

APPENDIX "D"

(SUSPECT CHARGED WITH TAKING FOUR-YEAR OLD BOY FOR WALK AND WHILE ON THAT WALK PUTTING STICK IN CHILD'S RECTUM)

Charge, and the Suggestions Leading Up to the Charge

Questions and Answers (as testified to in preliminary hearing	Suggestions: (Defense attorney's opinions)
1. Prior to December 15, l986 child had never told his parents anything suspicious about his Day Care or the suspect.	1. No suggestions made to child by his parents
2. 12/12/86 - Right after the first telecast on the news, mother started questioning child. She asked the following questions:	2(a). In these questions mother suggested that someone touched the child where they should not.
(a) Q. Has anyone touched you where they should not?	(b) She suggests that someone took his clothes off.
A. No. (PH 72, 94)	
(b) Q. Has anyone taken your clothes off:	
A. No. (PH 94)	
3. 12/12/86 - 12/16/86 - Prior to any disclosures by child, the mother brought up the name of the suspect.	3. The suggestions made by each of these questions are as follows:
(a) Q. Did the suspect ever take you for walks?	(a) She suggests that The suspect took the child for a walk.
A. No. (PH 92, 93)	
(b) Q. Did anyone touch you where they should not?	(b) She suggests that someone touched the child where they should not.
A. No. (PH 94)	

(c) Q. Did anyone take your clothes off?

A. No. (PH 94)

(c) She suggests that someone took off the child's clothes.

Therefore, prior to the child making any disclosures, his Mother has suggested to him in her questioning that the suspect took him for walks and that someone took the child's clothes off and touched him where he should not.

4. 12/15/89 - Police Video

(a) The child is taken to the police station by his Mother and father to be questioned by a police officer

(a) Being taken to a police station and being questioned by a police officer in and of itself suggests that someone did something bad and the police are trying to find out what that is.

(b) The detective begins his interview by stating the following: I want to talk to you for a little bit about where you used to go to school. The detective asked the following question:

(b) Detective suggests that someone gives spankings at the school and he suggests that when the teachers make the child stand in the corner and that's bad.

Q. Do they spank you or anything at school? (p. 2)

A. No. But sometimes when I don't eat, they make me stand in the corner. (p. 3)

The detective then says they sometimes make you stand in the corner? By gosh, that's bad.

(c) Q. What else did they do to you when you were a bad boy in school?

A. Only that.

Q. Only that? They don't spank you?

(c) Detective suggests that something else happens at the school when a boy is bad and he again suggests that they spank you at school. He further suggests that they put you in a special room that you don't like

A. (Shakes head no). (p 3)

Q. Do they put you in any special room?

A. No.

Q. They don't put you in any special room for being bad? Did they have any room at all that you don't like to go to?

A. Yes.

Q. Tell me what room you don't like to go into?

A. Miss _____ and Miss _____?

Q. How come you don't like to go in their room?

A. I like to go in their room. (p. 3.)

(d) The detective shows child the anatomically correct dolls. He shows him the adult male anatomically correct doll and tells child the following: Now this one is not a very good doll . . . This one is not a very good one. Now this one here sometimes is not too nice. Do you know anybody that used to be at your school that's a boy that I can name this after, it's not very nice? Actually he's not a boy, he's a man doll, okay? He's got to be a man that you know though that's not nice. We need to have a man that's not very nice . . . Do you know any men that are not very nice? Do you know any of that that are like that? Answer: No. (p. 4)

(d) In his questioning detective makes it very clear to child there is a man at his school who is not very nice. (The only man at the school is the suspect)

(e) Q. Has any man or any

(e) The detective again

to go in.

woman ever touched you that you didn't like? Tell me is there anybody that has ever touched you that you don't like to have touch you?

suggests that someone touches child that he doesn't like.

A. Yes. (names another child (p. 4)

(f) The child explains to the detective that (names another child) sometimes pees in the room and when he pees, he gets a spanking from teacher. The child then explains to detective that the teacher other child's shirt off. The detective asks the following:

Q. She took his shirt off?

A. (child laughs).

Q. Did she really? Remember, policemen have to tell the truth.

A. No.

Q. She didn't take his shirt off did she? (p. 5)

(g) Child discovers the penis and buttocks on the anatomical doll. Detective asks child what part of the doll gets spanked.

Q. Oh, but what part would get spanked? What is that? What do you call that? Has anybody ever touched you . . you didn't like? Touched you in a special way you didn't like?

A. No.

(h) Q. Show the part of you that your Daddy would have ... if you were a . . . ever a bad boy . . . which is not very often, probably.

A. (Child turns around and hits himself on bottom, stands to pull on pants). (p. 6)

(f) The child has already learned through the interview that detective wants him to say that someone at the school took some clothes off of someone else and gave them a spanking. The child then tells the detective that teacher did this to another child. However, through further suggestive questioning the detective gets the child to admit that this did not really happen. Note that at no time in any of the interviews did the detective or any of the other interviewers ever suggest that nothing happened with the

suspect.

(g) Detective is suggesting to child that what he is interested in is whether anyone touched him on the part of him where he gets spanked.

(h) Again, Detective emphasizes that he's interested in the private areas of the doll and of the child.

detective states as follows:

Right there . . . that's where your Daddy . . . okay you don't have to pull your pants down. But you can pull the pants down on these dolls if you want to.

(i) Q. Has anybody ever touched your pee at school? Son, has anybody ever touched your pee at school? Has anybody ever touched your pee at school?

A. I don't go pee (shakes head no).

Q. Has anybody ever spanked your bottom at school?

A. Yes.

Q. Who has spanked your bottom at school?

A. This one (points to doll).

Q. That one has spanked your bottom at school?

A. (Points to doll on Mother's lap and doll on his lap). This one and this one.

Q. Okay, but has a teacher ever spanked you at school?

A. (Hold doll up) Oh, this is the . . . this one . . the teacher. (p. 7)

(j) Q. Do you have any grown ups that come down and visit you at school that may work there but aren't teachers?

A. Yeah.

Q. Is it a man or a woman?

(i) Detective again suggests that someone at the school touched child's penis. He also suggests that someone at the school spanked the ch

(j) Detective suggests that someone comes down (obviously from upstairs) and visits the children. The only person upstairs in the school is the defendant.

A. It's a woman, a big woman., (p. 8)

(k) Q. Does that big woman ever bother the kids?

A. (Child shakes head no.)

Q. Have you ever been bothered at nap time?

A. No.

Q. Does anybody ever bother anybody at school?

A. No.

Q. Tell me all about what you do at school?

A. Pray. (p. 8)

(l) Child gets out of his Dad's lap and walks over and puts doll around detective's shoulders. Detective then says:

Q. Does anybody do this to you at school?

A. Yes.

Q. Do you do this at school with all your friends?

A. No.

Q. Does anybody do this to you?
A. No. (p. 9)

(m) Q. Is there anybody at school that you don't like to come by you? Any grown-ups?

Q. When you lay down at school at nap time, does any grown-up come by and get you up?

(k) Detective suggests that someone bothers the child and the other kids at school.

(l) Because of detective's suggestion, child first tells him someone at school does put their legs around his shoulders like

child did with the doll. Child then changes his mind and says no one at school does do that.

(m) Detective suggests that a grown-up comes by and bothers him at nap time and he further suggests that a grown-up takes him away at nap time.

A. No.
Q. Do any grown-ups take you away from nap time? (p. 10)

A. Just sit them in the corner.

(n) Q. Have you ever seen any of your little friends get taken away from nap time and go anywhere besides the corner?

A. No, just in the corner. (p. 10)

(o) Q. Is there anybody at school that you don't . . . any grown-ups that you don't like?

A. (Gives name of another child).

Q. Are there any grown-ups at your school that you don't like?

A. No.

(n) Detective suggests that someone takes the little kids away from school at nap time.

(o) Detective again suggests that there is a grown-up at the school he doesn't like.

Through leading and suggestive questioning, the detective has suggested to the child that there is someone at the school who comes down from upstairs and that person does bad things to the children which might include taking them away from school. He also suggests through his questioning that that person may also spank the kids at school. Even though the child denies these questions, these suggestive questions will be reported as the truth at a later time by the child.

5. After the interview by the detective, mother asked child the following:

(a) Q. Did anything bad happen at school?

A. No.

(b) Q. Has anyone touched you?

A. No. 5. By her questioning, the mother suggests (a) that something bad happened at school, (b) that someone touched him, and (c) that he is afraid of someone.

(c) Q. Are you afraid of anyone?

A. No. (PH p. 73)

6. Each time child was questioned he was urged to continue his story by his father telling him that they thought he probably had more he wanted to tell them. He was told sometimes grown-ups did bad things and lied to kids and if he thought he knew about anything like that he could help us to protect him from grown-ups doing that by telling us about it. Did something that you think is wrong or bad happen at school? The child was reinforced by telling him he had done nothing wrong and was in no trouble.

6(a)
After the police interview, father asks child if he told the police everything and the child answered no. He would tell more later. (notes p. 2)

7. Later that same day (12/15/86) child said he did not want to go back to school because there were bad things that happened there. The father asked child what the bad things were and child said people use bad words and another child is bad to me. (Father repeats comments in No. 6 above). The father asked if there was more and the child said yes, he would tell more later. (Notes p. 2-3)

6(a)
The father is suggesting that something more happened at school.

7. Clearly, the suggestions of his parents and the police have convinced child that, for the first time since he's been attending the school, he does not want to go back to school and that for the first time he has said that something bad happened at school. However, the only thing bad he knows now is that another child at school is bad and uses bad words. The child has not learned what the interviewers expect him to disclose.

8. 12/17/86 - Child mentions suspect's name to father for the first time.

9. 12/17/86 - The child tells the father that one of the bad things at school was walks that the suspect took some of the boys on. The child then tells father that he did not go on one of the walks but that other children had told him about what happened. He said when they went on the walks they went downstairs, upstairs and

outside. He said they got to walk on the long chairs upstairs. Father asked him if any other bad things happened on the walk and child tells him yes, he would tell him more later. (Notes p. 3)

10. 12/22/86 - The father asks the son further questions about the bad things that happened at school. Child tells the father that he had gone on one walk with the suspect and another boy went along. They walked outside and then went upstairs in the school building., The suspect took the child's pants down and spanked him. He did the same to another child. That is all that happened.

11. 12/22/86 - The father asked child if the suspect did anything else to him when he pulled his pants down.

8. The Mother has suggested suspect's name and now the child is repeating that name.

9. Through the interviews child is learning what his parents are expecting him to say. The child tries to give them the answer they are looking for but when father continuously asks him what else happened or what other bad things happened child knows that father expects him to say something more occurred. When he can't think of anything more, the child tells his father that he will tell him more later. This gives him additional time to think of something else that happened.

10. Child has now completely changed his story and he is repeating the very things that have been suggested to him in other questions. Child's mother suggested that he went for a walk with the suspect. Child's mother and detective suggested suspect took the child's pants down. The detective suggested that the suspect spanked child. These are exactly the things that the child is now reporting.

11. By asking this question it is suggested to child that something else happened when suspect pulled his pants down.

12. The mother has testified that child said that the suspect spanked him with a stick. (Depo. 11)

13. 12/29/86 - The father notices feces in child's pants. the father asked child why he did not wipe himself. Child responds that he didn't wipe himself because the paper hurt him when he wiped himself. Father asked the following:

Q. Did anything happen to make your bottom hurt?

A. Yes.
Q. What happened?

A. I will tell later.

The father then examines the child's anus and rectum.

14. 1/6/87 - Question by the father. What made your bottom sore?

A. The child thought for several minutes and then described the following: He was in his classroom with a teacher, and three other children. The suspect came in and said come on, let's go for a walk. After walking outside they went upstairs. Child could not describe where.

12. Child has reported that the suspect spanked him with a stick.

His Mother and Father continue to question him if suspect did anything else to him when his pants were pulled down. With the passage of time the child will report that suspect did in fact do something more with the stick.

13. By his questions to child, the father has suggested that something happened to child's anus and rectum to make it hurt. When child does not have a response to father's question did something bad happen to make it hurt, child says he would tell later and this gives him time to think of what happened.

14. After the father heard from child that his bottom was sore on 12/19/86 there obviously was questioning by the father and the mother regarding what made his bottom hurt. There may have been questions by either or both that the suspect did something to make his bottom hurt. It had already been suggested that the suspect slapped him on the face, took his pants down, spanked him and then took a stick and put it in his coo coo. Child said that the suspect grabbed the stick like a baseball bat and made a thrusting motion three times. He was then taken back to class.

The suspect said if he told what happened he would be slapped and his Mom and Dad would be run over by a car. Child was never clear when the threats were made. Child said the suspect should go to jail walks, that the suspect took his clothes off, that the suspect spanked him and that the suspect did something bad in addition to the stick. It has also been suggested by mother that the suspect was someone that child should be afraid of. The child obviously knows policemen put bad people in jail and over a three-week period was able to determine that suspect was the bad person that everyone was talking about. Also during this time child had been removed from the school and several TV newspeople and police officers had been around the school during this period. Through these and other suggestions child comes up with a story that is based upon the suggestions made to him. After he made this disclosure, the typical question that comes to the parents' mind is "why didn't you tell me this before? Did the suspect threaten you or say we would be hurt if you told?"

Summary

According to psychological literature, if a preschool child is given misleading information in the form of a suggestive question after an event occurred, that misleading information in the question will distort the child's memory and the child will report that misleading information in his answer at a later time. The misleading information given to the child is the following: By taking the child to the police station and having the detective

interview him about his school, it is suggested to the child that something bad is happening at his school. By then removing him from the school, which he lives next door to, this also suggests that there is some reason for his removal. Prior to the police interview, the child's mother suggested that the suspect has done something bad to him and she suggests that this might include taking him for walks, touching him where he should not have and taking his clothes off. The detective has suggested similar things in his interview when he suggests that someone comes down from upstairs at the school and that that someone is a man who is not very nice. The detective suggested that that someone spanks him and that that someone is interested in his bottom or his penis. Over the next three weeks, the child learns from his father what his parents expect him to say. When the child gives an explanation of what happened at the school, his father keeps asking him if something else bad at the school happened. The child keeps adding on to his story and the information he adds on is supplied by his mother and father. Underwager and Wakefield in their book have the following to say that is applicable to the situation:

> "When the progression of the story, across weeks or months, is from innocuous, relatively innocent behaviors to ever more intrusive and abusive behaviors alleged by the child, there is a strong possibility that the growth and embellishment of the story represents the learning experience and adult reenforcement." (p. 314)

At page 79 they state the following:

> "If erroneous information is introduced in an interview of a preschool child through the use of leading or suggestive questions, it may resurface in the form of the child's reconstruction of the events. Preschoolers are more likely to incorporate erroneous post-event information into their subsequent recollections than older children."

At page 30 of that book, the authors state the following:

> "In every interview the child learns more about what the interrogator expects. The child learns about explicit sexual behavior. The child learns what adults, including parents, want and expect from the child. the child learns what gets a reenforcing response from the interrogator. The child learns the tale, and by repetition, may come to experience the subjective reality that it happened, even when it never did happen."

In the next few months, the child is subjected to more interviews by a nurse, his parents, and his therapist. During this period, a number of things are occurring. The first reported interview after the child made these disclosures to his father on January 6, l987 is the interview by the nurse. However, the mother has testified that her husband always told her what the child told him and then she would go back and question the child. However, she did not keep notes of any of her questioning. The following comments from Underwager and Wakefield apply to the interview by the nurse:

> "If teaching aids such as anatomically correct dolls or coloring books are used, detail can be supplied to a child by the interview. The use of leading questions, coercion, and pressure by an interviewer plus minimal response by a child often results in a claim that a child has supplied details when, in fact, it has been

15. 1/15/87 - Hospital video-videotape with nurse.

(a) Q. did anybody ever touch you on your pee pee or coo?

A. No.

Q. Do you remember who did that?

A. No.

Q. Who did that:

A. The doctor.

Q. Who else did that? Anybody else?

A. No.

The nurse then immediately says she wants to ask child questions about his old school.

(b) Q. The nurse tells child that his father told her some-thing that child has told his father. She then says to child "your dad told me that

15.

(a) The nurse suggest to the child that someone touched him on his penis or his anus. When he tells her that no one did she ignores that response and asks him who did it. When he tells her that the doctor did it, she ignores that response and says who else and when he tells her no one else she immediately directs his attention to

his old school. This form of questioning suggests to the child that she believes someone did it even though he is telling her otherwise and she suggests to the child that it has something to do with his old school.

(b) The nurse has now suggested to child that she is interested in hearing about what child has told his father, you told him something about taking walks at your school. Who did you take walks with?

A. (Names the suspect)

(c) Q. So when you went for walks with the suspect you would go outside. Did anyone go with you or did you go by yourself with the suspect?

A. With (names boy).

Q. Did you ever go anywhere inside on walks or just outside?

A. Outside and inside.

Q. Where would you go when you went inside?

A. Up in the church and downstairs and then outside.

Q. And sometimes another child would go with you?

A. Yeah.

Q. And sometimes you would go by yourself or would all the time another child go with you?

A. All the time with the other child.

The nurse then leaves the room and when she comes back in she says the following:

Q. Okay. Sometimes the other child would be with you and sometimes

ignores this response and when she comes back into the room she makes the statement to the child that sometimes another child would be with him. By making this statement she completely ignored his previous answers because she did not believe the other child had gone along.

(d) Q. Did the suspect want you to tell anybody about what he did or did he want you to keep it a secret?

A. Keep it . . . tell.

Q. Um?

A. Tell.

Q. Did he want you to tell somebody or not to tell?

A. Tell.

Q. Did he do that to you one time or lots of times?

A. Lots of times.

(e) Q. Do you remember what we were talking about, what the rules were about your body?

A. Yeah.

Q. Do you remember what we talked about what parts of your body were private?

A. Yeah.

Q. And that your pee pee and your coo was private, right?

Q. And you said that he put a stick in your coo, right?

A. Um.

Q. Did he ever see your pee pee or your coo when he did that?

A. No (loudly).

Q. Um?

(d) When child gives her the answer that the suspect wanted him to tell people, she questions that response and he again repeats "tell." She then repeats the question a third time and he again repeats "tell." The nurse in her deposition has admitted that this is a subtle way of suggesting to the child that the interviewer

wants a different response.

(e) This series of questions demonstrates that child does not have any recollection of the event or any picture in his mind of what occurred. All he is doing is responding to questions or cues given to him by the interviewer.

This series of questions demonstrates a number of improper questioning techniques that induce error into a child's account. First, when nurse asks child if the suspect saw his pee pee or coo when he stuck the stick into his rectum child answers no. If the nurse had received an affirmative response to this question she would have repeated the child's answer like she did on other

A. No.

Q. Look at me for a minute.

A. No.

Q. Did he break the rules and did he see . . . did he pull your pants down or were they up.

A. No response.

Q. Look at me. I don't understand. Can you show me where he put that stick? Show me on this doll.

A. (Takes doll and turns it on its stomach, pulls pants down a little ways).

Q. And were your pants up or down when he did that?

A. Up.

Q. Were . . . look at me. Look here. If your pants were up, how could he put a stick in your coo? (Shows child the doll with the pants up).

A. (pulls pants down)

Q. Oh, he pulled them down.

A. Pulled down and put in her . . . stick it.

Q. Ah.

A. And scissors, too.

Q. Scissors, too.

A. Yeah . . . these (shows her scissors).

Questions where she got an affirmative response. Since she got a negative response she gives him a cue which is acting like she didn't understand his answer and makes him repeat the answer again. When he repeats it twice more she then gives him the following cue: "Did he break the rules?" Note that earlier in her interview she told child that the rules are that no one can see your pee pee or coo and that no one should take your clothes off and look at your pee pee and coo. By asking child did he break the rules she is suggesting to him that he did break the rules and that he did in fact pull his pants down. After that question, she then specifically asked him did he pull your pants down or were they up and she tells him that she doesn't understand his previous answers that the suspect did not pull his pants down. She then hands him the anatomically correct doll and tells him can you show me where he put the stick - show me on the doll. She knows that he will not be able to show the bottom of the doll and the anal opening unless he pulls the pants down on the doll. She then for the third time repeats a similar question which is, "Were your pants up or down? Answer: "Up." When he gives his answer she immediately suggests to him the following: "If your pants were up, how could he put a stick in your coo?" This suggestion could not be made anymore direct, and in response to this

Q. Goodness. Did he do that to the other boys or just you?

A. Just me.

Q. Did anybody else ever do that kind of thing to you?

A. Unintelligible.

Q. No.

suggestion child looks at the doll, pulls the pants down and says he put in here a stick. Now instead of giving him the cue of disbelief she repeats his answer and says, " oh, he pulled them down." This series of questions demonstrate the bias of the nurse and demonstrates how the nurse is able to teach the child the details of the abuse and make him a more credible witness by providing him with details that he must know if the event actually occurred. An unbiased interviewer would have let him answer the questions without suggesting answers and when he gave the answers that the suspect did not pull his pants down and did not see his bottom but put the stick in his bottom when his pants were up, the interviewer would have concluded that possibly the child was never abused in this manner.

This demonstrates another opportunity where an unbiased interviewer

would have determined that the child is not telling the truth.

(f) The nurse had earlier asked the child several questions about whether or not the suspect told him to tell what happened or not to tell. Now she begins asking similar questions as follows: "Did the suspect want you to keep this a secret?" Answer: "No." She then says to the child, "That is a bad thing for him to do. Sounds like he broke the rules. Did you tell anyone what the suspect did? Who did you tell? Who did you tell? Answer: My teacher."

When the child tells the nurse that the suspect put the very scissors in the interview room in his coo, the nurse totally ignores that answer. She ignores it because she doesn't want him saying that those scissors were put in his rectum. She knows if she brings this evidence out on videotape that his account of the suspect putting the stick in his bottom would be subject to question. The natural question that an unbiased interviewer would have asked would have been when did he do that or how did he do that or did he do that at the same time that he put the stick in and those questions could have made it clear that the child was not abused and that he is making up his answers as he goes along. Instead, the nurse ignores his answers, takes the scissors from him and directs the interview in a different direction.

(f) When the nurse was unable to get the child to state earlier in the interview that the suspect told him not to tell, she now rewards the question to get him to say the same thing. However, the child denies that the suspect told him to keep it a secret and when he makes this denial, the nurse then tries to influence that answer by asking him if in fact he told

(g) The nurse continues with this line of questioning:

Q. Which teacher?

A. (Names a teacher)

Q. What did she say?

A. She said don't do that (to the suspect). Child then gets up and demonstrates that his teacher started hitting and kicking the suspect. The nurse immediately changes the subject.

(h) Q. What happened when you were bad at your old school? Who would punish you?

A. My teacher

Q. What would they do when they punished you?

A. They said get in here and if you don't I'll pull down your underwear. anyone. If the child would have said he did not tell anyone she would have suggested to him that he didn't tell anyone because the suspect told him not to tell anyone. However, the nurse gets an unexpected answer from the child and he says that he told his teacher.

(g) Here is another opportunity where an unbiased interviewer would have questioned the child about the fact that after the suspect stuck a stick in his rectum that he told his teacher and the teacher started beating up on the suspect. This evidence could corroborate or not corroborate the child's story and is a perfect opportunity for the interviewer to determine if in fact the child is telling the truth. However, the nurse is not an unbiased interviewer and she knows that this evidence is not helpful to the credibility of the child so she ignores his response and leads him in a different direction.

in the pursuit of truth. There is a wide range of good research evidence pointing to the possibility and the mechanism by which error may be mistaken for truths." (p. 30)

16. 1/29/87. On this date the father indicates that he took the child over to his old school with a member of the church (names member). While at the school, the child walks through the school showing him where different things occurred. They go upstairs and the child identifies a room as a room where this occurred. (Note: this is not the suspect's office).

16. By taking the child back over to the school and walking him through the school and the upstairs, the child is able to learn where these things might have occurred. By viewing the different offices he is able to learn some details and descriptions of those offices. However, even with this, the child fails to identify the suspect's office.

At the child's deposition in May of l988, he testified that his Mother and Dad help him remember things about the suspect. He says that he goes in his room and practices it. However, even with the "practice" the child's story has changed significantly. The child claimed at the deposition in May that the suspect took him and another boy on walks outside and that they walked by the other boy's house and then they stopped in front of the church outside and threw some rocks. When they were throwing rocks, the suspect stuck a stick in the child's rectum and he also stuck one in the other boy's rectum. The two boys then ran inside and told their teacher what happened. The child said that on that same day when he got home from school, he told his Mother and Dad what the suspect did. The child also stated that when he stuck the stick in his butt, it did not hurt. When I questioned that he then said again that it didn't hurt and then he changed it and said it hurt a little bit but he did not cry.

Even after year and a half of practice, therapy, questioning by the prosecutor and his parents, taking the child into the courtroom and showing him what will take place, the child is not able to give any details of what occurred. All he is able to say is that he stuck the stick in his butt and that's about it. He has changed the location from inside the church to outside the church and he now states that the suspect did this to another boy also. He earlier said that the suspect didn't do this to anyone else. He now also believes that he immediately told the teachers and on the same day he told his Mother.

Wakefield and Underwager state the following:

"Significant contradiction and variation in the story

across time, especially when the account shows that the child has no visual image but is responding to verbal cues, supports the possibility of the child learning the story from adults."

APPENDIX "E"

STATE OF MISSOURI)
) ss.
COUNTY OF ST. CHARLES)

IN THE CIRCUIT COURT OF ST. CHARLES COUNTY, MISSOURI
CIRCUIT JUDGE DIVISION

STATE OF MISSOURI,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	CAUSE NO.
	)	
	)	
	)	
	)	
Defendant.	)	

DEFENDANT'S MOTION IN LIMINE RE: RAPE TRAUMA OR CHILD MOLESTATION OR CHILD ABUSE TRAUMA SYNDROME EVIDENCE

COMES NOW William N. Seibel, Jr., Attorney for Defendant, and in support of this Motion in Limine states as follows:

1. That the above-styled cause has been set down for a trial by a jury on the merits.

2. According to the Information, such trial will involve a determination on the issue of whether or not the Defendant sexually molested or abused the children listed as "victims" in the above cause.

3. Based on the testimony in the preliminary hearing in the above cause which included repeated questions on the part of the assistant prosecuting attorney concerning opinions as to rape trauma or child molestation or abuse syndromes and personal opinions as to whether or not these children were sexually molested or victims of child abuse, the Defendant believes and hence alleges that the State intends to repeatedly elicit such testimony as well as testimony of observations of symptoms of said syndromes from several witnesses at any trial in the above cause.

4. Defendant's Objections to the above-referred evidence both as to syndromes and/or observations of symptoms of said syndromes have been simultaneously filed with the Court in a separate pleading and said pleading referred hereto as "Defendant's Specific Objections to the State's Offering Expert or Lay Testimony in the Nature of Rape Trauma Syndrome or Child Molestation-Abuse Trauma Syndrome Evidence," is expressly incorporated herein by reference.

5. The law in Missouri strictly forbids the Prosecuting Attorney from eliciting an expert opinion (or a lay opinion) concerning whether or not an alleged victim or victims in the above cause displays "rape trauma syndrome" or "child molestation or child abuse syndromes" or any such testimony as to whether or not a particular act of child molestation or child abuse occurred as alleged by the State's Information on the basis of a conclusion on the part of a State's witness drawn from the opinion that said alleged victim or victims suffer from the aforesaid syndromes. State v. Taylor, 663 S.W.2d 235 (Mo. banc 1984); State v. Burke, 719 S.W.2d 887, 889 (Mo. App. 1986); and State v. Shackelford, 719 S.W.2d 943, 945 (Mo. App. 1986). At most the prosecutor may elicit testimony (assuming a witness has otherwise been properly qualified) that an alleged victim displays psychological changes that are consistent with those resulting from a traumatic or stressful sexual experience. State v. Taylor, supra at 239-242; State v. Burke, supra at 889; State v. Shackelford, supra at 945.

6. In spite of the case law cited above, Defendant contends that even evidence of the observations associated with these syndromes should be excluded by the Court from evidence for the reasons stated in Defendant's Objections incorporated herein by reference.

WHEREFORE, Defendant prays this Honorable Court to exercise its power over the conduct of trials and order and instruct the State not to elicit any of the aforementioned evidence or testimony concerning, respecting, mentioning or referring, either directly or indirectly to the evidence and matters mentioned above and for such further orders as the Court deems wise and just under the circumstances.

Respectfully submitted,

BRIDGES, NICHOLS & SEIBEL

By _____

WILLIAM N. SEIBEL, JR. #24052
Attorney for Defendant
200 North Second Street
St. Charles, Missouri 63301
723-7020 or 946-4996

STATE OF MISSOURI)
) ss.
COUNTY OF ST. CHARLES)

IN THE CIRCUIT COURT OF ST. CHARLES COUNTY, MISSOURI
CIRCUIT JUDGE DIVISION

STATE OF MISSOURI,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	CAUSE NO.
	)	
	)	
	)	
	)	
Defendant.	)	

DEFENDANT'S SPECIFIC OBJECTIONS TO THE STATE'S OFFERING EXPERT OR LAY TESTIMONY IN THE NATURE OF RAPE TRAUMA SYNDROME OR CHILD MOLESTATION-ABUSE TRAUMA SYNDROME EVIDENCE

COMES NOW William N. Seibel, Jr., Attorney for Defendant, and raises the following specific objections to any testimony offered on the behalf of the State to show expert opinions or evidence of any manifestations of rape trauma syndrome or child molestation-abuse trauma syndrome:

1. The State has failed to lay a proper foundation for such testimony.

2. Such tests commonly referred to as syndromes are not the type of scientific tests that accurately and reliably determine whether or not a child has been raped, abused or molested.

3. The scientific evaluation of such tests or syndromes has not reached a level of reliability that surpasses the quality of common sense evalauation present in jury deliberations.

4. Such evidence constitutes a wrongful incursion into the province of the jury and robs the jury of their decision making function as the ultimate fact finders in the above cause.

5. The probative value of any such evidence is substantially outweighed by the danger that it could prejudice, confuse or

mislead the jury.

6. Such testimony is based upon inadmissible hearsay statements related to the witness by an alleged victim in the above cause. Such evidence would, if introduced, violate the Fifth, Sixth and Fourteenth Amendments to the United States Constitution and Article 1, Section 10 and Article 1, Section 18(a) of the Missouri Constitution in that introduction of said testimony would deprive Defendant of his rights to confront and cross-examine witnesses against him and to due process of law.

7. The witness' personal opinion as to whether or not an alleged victim was or was not molested or abused is irrelevant and immaterial to the issues and facts to be determined by the jury in the above cause.

8. The characteristic symptoms of the so-called rape trauma syndrome or child molestation-abuse syndrome are the same symptoms that may follow any psychologically traumatic event and not just rape or child molestation or child abuse.

9. Such syndromes are not meant to be fact finding tools but are merely therapeutic tools of possible use in counseling and are of no benefit to the jury in its deliberations.

10. Such testimony is unfairly prejudicial to Defendant in that it gives a stamp of scientific legitimacy to the truth of the complaining witness' factual testimony impermissibly bolstering or vouching for said testimony.

11. Such testimony violates the rule that expert opinion testimony should never been admitted unless it is clear that the jurors themselves are not capable, for want of experience or knowledge of a subject, to draw correct conclusions from the facts proved.

12. The State has not presented conclusive evidence that such testimony and opinions have been widely accepted as reliable in the general scientific community.

13. Such evidence should be excluded as it unnecessarily diverts the attention of the jury from the questions to be decided in the above cause and cause confusion with numerous collateral issues.

14. Such expert opinion testimony is not admissible as it relates to credibility of witnesses.

15. Such testimony unfairly and prejudicially presupposes the existence of a rape or child molestation or child abuse, facts

which must be proven to the satisfaction of the jury and which are not to be assumed as true for purposes of any testimony in this case, expert or otherwise.

16. The State has not properly qualified the witness as an expert who can relate the specific incident or incidents that caused the alleged victims symptoms in the above cause and is merely offering such testimony to bolster said alleged victims' statements by unrelated scientific evidence.

WHEREFORE, Defendant moves the Court to exclude any evidence as to expert opinions or manifestations or observations of symptoms of rape trauma syndrome or child molestation or child abuse syndrome based on Defendant's aforegoing Objections and Defendant requests that the Court allow Defendant to make said Objections "standing objections" on the record so that they may be raised and applied to any and all such testimony offered by the State in the above cause without requiring Defendant to make repeated objections to said evidence as it may be offered at various times by the State in the above cause.

Respectfully submitted,

BRIDGES, NICHOLS & SEIBEL

By _____

WILLIAM N. SEIBEL, JR. #24052
Attorney for Defendant
200 North Second Street
St. Charles, Missouri 63301
723-7020 or 946-4996

STATE OF MISSOURI)
) ss.
COUNTY OF ST. CHARLES)

IN THE CIRCUIT COURT OF ST. CHARLES COUNTY, MISSOURI
CIRCUIT JUDGE DIVISION

STATE OF MISSOURI,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	CAUSE NO.
	)	
	)	
	)	
	)	
Defendant.	)	

BRIEF IN OPPOSITION TO STATE'S MOTION TO ALLOW STATE TO PRESENT EXPERT TESTIMONY IN EVIDENCE

In the State's Motion to Allow State to Present Expert Testimony in Evidence, the State requests this Court to allow the State to present expert testimony in evidence on a number of topics. In this brief, the Defendant wishes to address each of those topics.

The first topic that the State wishes to present expert testimony on is the "child sexual abuser profiling." There is no authority in Missouri to allow the State to introduce evidence that a particular defendant fits a profile referred to as a child sexual abuser profile. Such testimony is objectionable to on a number of grounds. First, such testimony is not the type of scientific tests that accurately and reliably determine whether or not a defendant has or has not committed a sexual offense. Second, the scientific evaluation of such tests or testimony has not reached a level of reliability that surpasses the quality of common sense evaluation present in jury deliberations. Third, such evidence constitutes a wrongful incursion into the province of the jury and robs the jury of their decision making function as the ultimate fact finder. Fourth, the probative value of any such evidence is substantially outweighed by the danger that it would unduly prejudice the defendant. Fifth, the State has not presented any evidence that such testimony and opinions have been widely or generally accepted as reliable in the general scientific community. For these and other reasons, the State should be precluded from introducing such evidence or from mentioning such evidence at any stage of the trial.

The State next proposes to introduce what it refers to as "age appropriate behavior in children." In that the Defendant does not understand what type of evidence the State proposes to introduce in this regard, the Defendant at this time cannot make an appropriate objection.

The remaining three areas which the State wishes to introduce expert testimony in evidence on can all be discussed under the same category. Those three items are "recantation by

child victims," "late or nonreporting by child victims," and "child sexual abuse syndrome." In Missouri, an expert may not characterize the psychological changes in an alleged victim as "rape trauma syndrome" because the limited scientific acceptability of this concept is outweighed by its potentially prejudicial effect. State v. Taylor, 663 S.W.2d 235, 241 (Mo. banc 1984). Similarly, the State should not be allowed to present expert testimony into evidence that these children suffer from "child sexual abuse syndrome." There is no authority in Missouri for an expert to testify that recantation by child victims is a symptom of sexual abuse or that late or nonreporting by child victims is a symptom of sexual abuse. A leading author in this area states as follows:

"The fact that a child suffers from nightmares, loss of appetite, regression, and depression says very little, if anything, about sexual abuse. A myriad of other factors can cause such symptoms, and it would be improper for an expert to base an opinion relating to sexual abuse on such ambiguous symptoms alone.

Some of the symptoms attributed to sexual abuse are flatly inconsistent. For example, some sexually abused children regress to less mature levels of functioning, while others exhibit pseudo-mature behavior. Furthermore, one important symptom, recantation, is expressly inconsistent with the finding of abuse. While it is true that a recantation may be false, it is also possible that it is true. Yet the expert is permitted to say, in effect, that since the child withdrew the allegation of abuse, he must be abused. As one commentator remarks, `There is something fundamentally strange about saying that since the child denies that the event occurred, it must have occurred.' Certainly, if the only evidence of sexual abuse is a combination of highly ambiguous symptoms coupled with a recantation, a finding of sexually abused child syndrome should be regarded as of de minimis evidentiary value but of great potential prejudice."

Myers, Child Witness Law and Practice (1987) at pp. 157-58.

The State should be precluded from introducing any evidence

at any stage of the trial that because these victims recanted or delayed reporting the abuse, this is evidence that they in fact were abused. Furthermore, as to recantation and late or nonreporting by child victims, the State should be precluded from presenting any evidence at any stage of the proceedings that these two characteristics are consistent with a sexually abused child.

Attached to Defendant's brief are specific objections that the Defendant makes to the State's offering of expert testimony in the nature of child molestation trauma syndrome and the Defendant's Motion in Limine regarding the same subject.

Respectfully submitted,

BRIDGES, NICHOLS & SEIBEL

By _____

CHARLES E. BRIDGES #25305
Attorney for Defendant
200 North Second Street
St. Charles, Missouri 63301
723-7020 or 946-4996

STATE OF MISSOURI)
) ss.
COUNTY OF ST. CHARLES)

IN THE CIRCUIT COURT OF ST. CHARLES COUNTY, MISSOURI
CIRCUIT JUDGE DIVISION

STATE OF MISSOURI,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	CAUSE NO.
	)	
	)	
	)	
	)	
Defendant.	)	

DEFENDANT'S BRIEF IN SUPPORT OF DEFENDANT'S MOTION IN LIMINE REGARDING THE CREDIBILITY OF THE ALLEGED VICTIMS

Expert opinion testimony is not admissible as it relates to credibility of witnesses. Beishir v. State, 522 S.W.2d 761, 765 (Mo. banc 1975). At the preliminary hearing, (Nurse) and (Doctor) were allowed to testify that based upon their interviews with the children, they concluded that these children were sexually abused. This is the type of testimony which is specifically prohibited under Missouri law. In State v. Taylor, 663 S.W.2d 235 (Mo. banc 1984), the State used a psychiatrist to testify that his diagnosis that a victim was sexually abused was based upon his belief of what the victim had told him. In State v. Taylor, the Court held that clearly the psychiatrist's specific statement that the victim did not fantasize the rape was an express opinion about her credibility, and his entire testimony that the victim suffered from rape trauma syndrome carried with it an implied opinion that the victim had told the truth in describing the rape. The Missouri Supreme Court further stated that "the jury was competent to determine the victim's credibility; therefore, the doctor's testimony designed to invest scientific cachet on the critical issue was erroneously admitted. Otherwise, trials could degenerate to a battle of experts expressing opinion on the substance of witness veracity." State v. Taylor, supra at 241.

(Doctor) testified at the preliminary hearing that his determination of whether or not a victim is sexually abused is

based upon three categories. He says the most important category is what the victim tells him or his nurse. The second most important category is the behavioral indicators of the victim, and the least important category is the physical findings of sexual abuse that he observes in the children. He testified that his conclusion that a child is sexually abused is based upon all three categories with the order of importance as stated.

(Doctor) and (Nurse) repeatedly volunteered testimony that these children were sexually abused. This testimony is specifically prohibited because it is a comment on the credibility of the witnesses. The Defendant believes that based upon (Doctor) and (Nurse's) testimony at the preliminary hearing, the State intends to introduce the same testimony and unless the Defendant's Motion in Limine is granted, the State will introduce such inadmissible testimony.

The Defendant attaches hereto his Motion in Limine on this subject matter.

Respectfully submitted,

BRIDGES, NICHOLS & SEIBEL

By _____

CHARLES E. BRIDGES #25305
Attorney for Defendant
200 North Second Street
St. Charles, Missouri 63301
723-7020 or 946-4996

APPENDIX "F"

STATE OF MISSOURI)
) ss.
COUNTY OF ST. CHARLES)

IN THE CIRCUIT COURT OF ST. CHARLES COUNTY, MISSOURI
CIRCUIT JUDGE DIVISION

STATE OF MISSOURI,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	CAUSE NO.
	)	
	)	
	)	
	)	
Defendant.	)	

MEMORANDUM OF LAW

Section 491.075 RSMo. provides as follows:

A statement made by a child under the age of twelve relating to an offense under chapter 565, 566 or 568, RSMo., performed with or on a child by another, not otherwise admissible by statute or court rule, is admissible in evidence in criminal proceedings in the courts of this state as substantive evidence to prove the truth of the matter asserted if:

(1) The court finds, in a hearing conducted outside the presence of the jury that the time, content and circumstances of the statement provide sufficient indicia of reliability; and

(2) The child either:

(a) Testifies at the proceedings; or

(b) Is unavailable as a witness.

In 1982 the Washington legislature enacted a child victim hearsay exception which has served as the model for statutes in other states. Myers, Child Witness Law and Practice (1987) at p. 373. The Washington statute is nearly identical to Missouri's statute and reads as follows:

A statement made by a child when under the age of ten describing any act of sexual contact performed with or on the child by another, not otherwise admissible by statute or court rule, is admissible in evidence in dependency proceedings . . . and criminal proceedings in courts of the state of Washington if:

(1) The court finds, in a hearing conducted outside the presence of the jury, that the time, content, and circumstances of the statement provide sufficient indicia of reliability; and

(2) The child either:

(a) Testifies at the proceedings; or

(b) Is unavailable as a witness: Provided, That when the child is unavailable as a witness, such statement may be admitted only if there is corroborative evidence of the act.

As in the Missouri statute the heart of the Washington child victim exception "is the requirement that hearsay be reliable. The statute states that the evidence must bear `sufficient indicia of reliability.' But what is the meaning of sufficient? Guidance on the probable meaning of this key term comes from two sources, the United States Supreme Court's decision in Ohio v. Roberts and the catchall exception of Rule 803(24)" (Federal Rules of Evidence). Myers at 375.

In Ohio v. Roberts, 448 U.S. 56 (1980) the U. S. Supreme Court stated that if hearsay does not fall within a firmly rooted exception, then there must be a "showing of particularized guarantees of trustworthiness." Ohio v. Roberts, supra at 66. In Lee v. Illinois, 106 S.Ct. 2056 (1986) the Court remarked in dicta that hearsay that is not within a firmly rooted exception is presumptively unreliable. Id. at 2064.

Hearsay exceptions like the Washington and Missouri statutes are not firmly rooted hearsay exceptions. State v. Slider, 688 P.2d 538 (1984); Myers at 375. "Therefore, before evidence can be admitted under such exceptions there must be a `showing of particularized guarantees of trustworthiness' sufficient to overcome the presumption of unreliability." Myers at 375.

According to Myers,* in those states that have enacted statutes similar to the Missouri and Washington statute the courts have considered the following factors, among others, in determining whether or not there is sufficient indicia of reliability to admit the child's hearsay statements:

1. Prior Testimony. If the out-of-court statement was given

under oath at a prior hearing or trial at which the adversary cross-examined the declarant regarding the statement, the hearsay assumes added reliability. Myers at 363; State v. Bellotti, 383 N.W.2d 308 (Minn. Ct. App. 1986). The children in our case have not testified at a prior hearing or trial.

2. Substance of Statement Corroborated. If the content of an out-of-court statement is supported or corroborated by other evidence, the reliability of the hearsay is strengthened. State v. Taylor, 704 P.2d 443 (N.M. Ct. App. 1985). In our case there is little or no corroboration of the hearsay statements. In

*The Myers book has been cited by a recent Missouri Court of Appeals decision, State v. Bohanon, 747 S.W.2d 294 (Mo. App. 1988).

those limited instances of corroboration that corroboration is the result of suggestions made to the child by the interviewer. However, there is substantial evidence that the things referred to in the hearsay statements could not have occurred as alleged by the children. (See infra where this lack of corroboration of each statement is discussed).

3. Spontaneity. Spontaneity is an important indicator of reliability. The more spontaneous a statement, the less likely the statement is to be a product of fabrication,memory loss, or distortion. Myers at 365; State v. Smith, 384 N.W.2d 546 (Minn. Ct. App. 1986); State v. Billotti, 383 N.W.2d 308 (Minn. Ct. App. 1986). None of the hearsay statements made by the children in our case were spontaneous.

4. Statement Elicited by Questioning. The reliability of an out-of-court statement is related to its spontaneity. When a statement is made in response to questioning, particularly leading questioning, the possibility arises that the questioner influenced the statement, thus potentially decreasing reliability. Myers at 366; State v. Billotti, supra; State v. Carver, 380 N.W.2d 821 (Minn. Ct. App. 1986) (in applying a child victim hearsay exception, court held that hearsay statements by young children were not sufficiently reliable when statements were elicited by questions from a physician). The hearsay statements in our case are the product of leading, suggestive and in some instances coercive questioning. (See infra which describes the leading and suggestive questioning).

5. Level of Certainty Regarding Facts Described. If a child's answers to questions indicate that the child lacks understanding of factual matters contained within the hearsay statement, the reliability of the statement is called into question. Myers at 366; State v. Smith, 384 N.W.2d 546 (Minn. Ct. App. 1986). Reliability is enhanced when a child does not agree with everything a questioner asks, or when a child corrects a

questioner. Disagreement indicates that the child was not simply responding unthinkingly, or answering questions to please the questioner. Myers at 366; State v. Billotti, supra.

6. More Than One Victim With the Same Story. Two or more children may be exposed to the same event. If the children are interviewed separately, and each tells the same story, their statements are mutually corroborative, enhancing the reliability of each. If, on the other hand, the children are interviewed together, the fact that they tell the same story does little to bolster the reliability of their individual statements, since one child may be influenced by the other. State v. Carver, 380 N.W.2d 821, 826 (Minn. Ct. App. 1986) (in interpreting a child victim hearsay exception, court held that hearsay statements by young children were not sufficiently reliable in part because children were interviewed together). Myers, supra at 366.

7. Corroboration by an Eyewitness. The testimony at trial of an eyewitness to an event may strengthen the reliability of a child's hearsay statement describing the event. Myers, supra at 367. Other than the children, the State has produced no eyewitnesses.

8. Consistent Statements. Reliability is significantly enhanced when a child repeats an out-of-court statement more than once, and when each version is consistent. If the details of a child's statement vary each time an event is described, reliability is questionable. This is not to say, of course, that complete consistency is required to find a hearsay statement reliable, but the fact that a child repeats the same story to several people, especially to adults such as police officers, tends to "mitigate the risks of insincerity and faulty memory." Myers, supra at 367. (See infra where the inconsistencies and denials are discussed).

9. "Kids Don't Make Such Things Up." "Numerous courts and commentators state that children of tender years lack the experience to fabricate detailed accounts of abuse. It is difficult to conceive, for example, of a four-year old capable of inventing a detailed and anatomically accurate account of anal intercourse or fellatio unless the child has either experienced such acts or been exposed to them. When a child's out-of-court statement describes an event which a similarly situated child could not reasonably be expected to fabricate, the statement gains in reliability.

Courts and counsel should not accept at face value the argument that "kids don't make these things up." It may be true that a particular child is incapable of inventing the scenario described in a statement, but it is important to look behind the

statement to determine whether an adult with an axe to grind has implanted the event in the child's mind. A psychiatrist, Dr. Lee Coleman, writes:

When it comes to a child's statements about sexual victimization, there are not two possibilities -- lying or telling the truth -- but three. A child may be neither lying nor telling the truth. A child, particularly a very young one, may say what he or she believes is true, even though it is not the truth.

At first blush, this seems a rather unlikely possibility, to say the least. A child believes in sexual abuse which has not taken place. I would certainly be skeptical of such an idea if I hadn't had a chance to see how children are being manipulated by adult interviewers -- sometimes by a police officer or protective service worker, sometimes by a mental health professional -- who have been trained to believe that those who really care and are sufficiently skilled at their work will help the child talk about sexual abuse.

Consider what such methodology does to a case in which the child has been manipulated before the police or child protection worker arrives. Especially when divorce and child custody disputes are taking place, it is a tragic fact that certain parents either deliberately create false accusations, or interpret a child's problems as "subtle clues" to child sexual abuse. Everything from nightmares to temper tantrums is being listed by the experts as signs that should alert parents to the possibility of sexual abuse."

Myers, supra at 367-69.

Not a single child has given an accurate account of anal intercourse or other sexual abuse. The children have only affirmed or denied the interviewer's account.

10. Admission by Defendant. An admission or confession by the defendant corroborates the child's statement. D.A.H. v. G.A.H., 371 N.W.2d 1 (Minn. Ct. App. 1985). In our case, the Defendant has consistently denied the allegations.

Under the above factors discussed in Myers, it is clear that the State has failed to overcome the presumption that these hearsay statements are unreliable.

In an article entitled "Indicia of Reliability and Face to Face Confrontation: Emerging Issues in Child Sexual Abuse Prosecutions," 40 Univ. Miami L.R. 19 (1985) Professor Graham writes that the following factors are relevant and bear upon the determination of truthworthiness of a child's statement that describes an act of sexual contact:

(1) the child's partiality, that is, interest, bias, corruption, or coercion;

(2) the presence or absence of time to fabricate (A court is more likely to admit statements made soon after the event than statements made after a substantial lapse of time. Similarly, initial statements are more easily admitted than subsequent statements. Nevertheless, although time and sequence are important, they are not preclusive because delay in reporting and vacillation are commonly associated with complaints of child sexual abuse);

(3) the physical and mental condition of the child when the statement was made (It is appropriate to consider the child's chronological age, mental age, and maturity in order to determine the child's physical and mental condition at the time he or she made the statement);

(4) suggestiveness, brought on by the use of leading questions coupled with an evaluation of the child's relationship to the questioner, considered in light of surrounding circumstances;

(5) the age of the child;

(6) the nature and duration of the sexual contact;

(7) the relationship of the child and the accused; and

(8) whether the child has reaffirmed or recanted the statement.

An analysis of the facts in our case under the indicia of reliability referred to in Professor Graham's article results in the same conclusion as before. The hearsay statements of these children do not possess sufficient indicia of reliability to allow their introduction into evidence. The following excerpt from Graham's article is particularly applicable:

Applying the relevant factors, proponents will often succeed in introducing the child's initial statement that describes the act of sexual contact performed with or on the child by another, as well as additional statements made immediately after the initial statement. It is, however, extremely doubtful that a child's statement to a police officer, social worker, or someone specially trained to interview children will be found to possess equivalent circumstantial guarantees of trustworthiness, whether or not the statement was videotaped or otherwise recorded. The normal timing of such an interview, its investigative function, the frequent use of suggestive questions by a person in authority, and the fact that the child will usually have made several earlier statements relating to the alleged sexual contact all militate against admissibility."

Likewise, in our case, the statements made to the police officers, (the hospital) and all statements after the police interviews and (the hospital) interviews do not possess sufficient circumstantial guarantees of trustworthiness.

The third analysis that courts across the country have relied on in determining whether sufficient indicia of reliability exist to admit hearsay is that analysis set forth in the case of State v. Ryan, 691 P.2d 197 (Wash. 1984). Since Missouri's statute is modeled after the Washington statute, this analysis is particularly applicable to this case.

In State v. Ryan, the trial court allowed the statements made to mothers by four and five-year old alleged victims of indecent liberties to be introduced into evidence at the defendant's trial. The trial court stated that it found reliability in the time, content and circumstances of the statement. Thus, the statements were received into evidence under a statute nearly identical to the Missouri statute. On appeal the Supreme Court of Washington reversed the defendant's conviction and found that the statements made to the mothers by the four and five-year old alleged victims of indecent liberties were not sufficiently trustworthy to deprive the defendant of his right of confrontation by admission of the statements through the mothers. According to the Washington Supreme Court the hearsay statements were not admissible under the statute where an indeterminate amount of time elapsed between the alleged act and the victims' reporting of it, statements were made in response to questioning, there was motive to lie, the mothers had been told of the strong likelihood that defendant had committed the acts upon their children before the mothers questioned the children, and there were no observable indications of assault, pain, or distress at the time the statements were made.

The Washington Supreme Court noted that the circumstantial guarantees of trustworthiness on which the various specific exceptions to the hearsay rule are based are those that existed at the time and do not include those that may be added by using hindsight. Ryan at 204. The Supreme Court noted that the statute, which is identical to the Missouri statute in this part, requires separate determinations of reliability and corroboration. Thus, even though the defendant's confession was offered as corroboration absent were the requisite circumstantial guarantees of reliability.

In determining reliability, the Ryan case sets forth a number of factors as to when an out-of-court declaration may be admitted. Those factors are: (1) whether there is an apparent motive to lie; (2) the general character of the declarant; (3) whether more than one person heard the statements; (4) whether the statements were made spontaneously; (5) the timing of the declaration and the relationship between the declarant and the witness; (6) the statement contains no express assertion about past fact; (7) cross-examination cannot show the declarant's lack of knowledge; (8) the possibility of the declarant's faulty recollection is

remote; and (9) the circumstances surrounding the statement are such that there is no reason to suppose the declarant misrepresented defendant's involvement. Ryan at 205.

Applying those nine factors to the circumstances of the Ryan case, the court held that the statements cannot be deemed sufficiently trustworthy to deprive the defendant of his right of confrontation. In applying those factors, the court stated as follows:

"First, there was a motive to lie, and each child initially told a different version of the source of the candy they were not supposed to have. Second, all the record reveals about the character of the children is the parties' stipulation that the children were incompetent witnesses due to their tender years. Third, the initial statements of the children were made to one person, although subsequent repetitions were heard by others. Fourth, the statements were not made spontaneously, but in response to questioning. Fifth, as regards timing, both mothers had been told of the strong likelihood that the defendant had committed indecent liberties upon their children before the mothers questioned their children. They were arguably predisposed to confirm what they had been told. Their relationship to their children is understandably of a character which makes their objectivity questionable."

Ryan at 205. As to the remaining four factors, the court stated as follows: "The statements were undeniably assertions of past facts. While the defendant admitted to misconduct with M, he denied any wrongdoing as to J. Cross-examination was appropriate regarding this dispute. There is no contention that the statements were either spontaneous or against interest."

The court concluded that the time, content, and circumstances of the statements offered against Ryan do not bear adequate indicia of reliability sufficient to make cross- examination and face-to-face confrontation superfluous. The trial court erred in permitting the introduction of the children's statements through hearsay repetition. Ryan at 206.

All the factors that were discussed in Ryan also apply to our case. First, as in Ryan, each child initially told a different version of defendant's involvement. All seven children in our case denied that the defendant had abused them in any manner. It was only after continued questioning by their parents, and in some cases the police, nurses, and therapist, that the children finally made a statement implicating the defendant. Second, as in Ryan, the children are four and five- year olds. Third, as in Ryan, the initial statements of the children were made to one person. Fourth, as in Ryan, the statements were not made spontaneously, but in response to questioning. Unlike the Ryan case where the

children admitted the defendant's involvement after the initial questioning of their mothers, in our case the children in most instances denied defendant's involvement for some period of time. Fifth, as regards timing as in Ryan, the parents in our case had been told of the likelihood that the defendant had committed the offenses before they questioned their children. Again as in Ryan, they were arguably predisposed to confirm what they had been told. And, as in Ryan, "the relationship to the children is understandably of a character which makes their objectivity questionable." In our case, the parents have admitted that they discussed this case with each other and the police prior to the questioning of their children. The parents have admitted that they made up their mind that the defendant was guilty prior to their children stating that the defendant had committed any offense. Sixth, as in Ryan, the statements which the State intends to introduce are assertions of past facts. Seventh, the defendant in Ryan confessed whereas the defendant in our case has denied all allegations against him. Thus, the seventh factor in our case is an even stronger factor that in the Ryan case. That seventh factor being that cross-examination could show the declarant's lack of knowledge. Eighth, as in Ryan, an indeterminate amount of time elapsed between the alleged act and the child's reporting of it. Ninth, as in Ryan, there is no contention that the statements were either spontaneous or against interest.

Thus, as in Ryan, sufficient indicia of reliability do not exist to allow the introduction of hearsay statements.

In determining what factors are important regarding sufficient indicia of reliability under Section 491.075 RSMo.1985, Section 492.304 RSMo. 1985 is relevant. Under Section 492.304 RSMo. Amended 1985 there are eight requirements set forth in the statute before a visual and oral recording of a child may be introduced into evidence. One of those requirements is the following: "The statement was not made in response to questioning calculated to lead the child to make a particular statement or to act in a particular way."

Thus, the Missouri Legislature has recognized that hearsay statements of a child which have been recorded should not be admissible if the statement was made in response to leading questions. If the Legislature intended that hearsay statements which are made in response to leading questions are not admissible if the child's statements were recorded should those same statements be admissible if the statements were not recorded? Certainly the hearsay statement of a child that has been recorded is more accurate and reliable than the same hearsay statement of a child that has not been recorded. Therefore, in determining whether a hearsay statement is admissible under Section 491.075

RSMo. 1985 the Court should not admit that statement if the statement was made in response to leading questions because the Legislature has indicated that such statements are not considered by it to be reliable.

Sections 492.304 and 491.075 have to be read together to determine the intent of the Legislature. Both of these amended statutes were part of House Bill 366 which was passed in 1985. Certainly it was not the intent of the Legislature to prohibit the introduction of hearsay statements of a child made on videotape because those statements were in response to leading questions but to allow hearsay statements of children when they are not on videotape. If this had been the intent the State would then be able to avoid the clear intent of the statute and introduce unreliable hearsay statements made in response to leading questions by simply not videotaping those statements. This is exactly what the State has done in our case. The State videotaped the initial statements made to the police by these child witnesses. In those statements the children were asked questions calculated to lead them to make a particular statement. The children were then sent to (hospital) for more videotaping. In those videotapes the children were again asked questions calculated to lead the children to make particular statements. Under Section 492.304 these statements are not admissible. The State then stopped videotaping the questioning of the children. However, the questioning continued to be calculated to lead the children to make particular statements. Now the State wants to introduce those statements under Section 491.075 RSMo. Amended 1985. Since the Legislature intendedto prohibit hearsay statements made in response to leading questions when that questioning was videotaped they certainly intended to prohibit the same questioning if it occurred after videotapes were made. The Legislature clearly recognized that statements made in response to questioning calculated to lead children to make a particular statement are unreliable. Therefore, those statements should be excluded under both 492.304 RSMo. 1985 and 491.075 RSMo. 1985.

Several recent Missouri decisions provide some guidance on the question of sufficient indicia of reliability. In State v. Wright, 751 S.W.2d 48 (Mo. banc 1988) the Missouri Supreme Court stated as follows:

"Under the statute, evidence of the time, content, and circumstances of the statement must demonstrate the basis for an assessment of reliability. The statements here were made within two hours of the crime, reducing the chance of memory lapse or fabrication as well as contamination from interaction with persons interested in the event and exposure to their suggestions. In this regard it should be noted that defendant was allowed to introduce evidence which he argues indicates possible sources of

`contamination' during the brief period between the crime and the statement. Additional indications of reliability may be found in the circumstances of the interview. The environment was not shown to be threatening; instead, the evidence indicated that the statement took place in a special interview room designed to be comfortable and calming. No one except the victim and Phelan was present, and no direct pressure on the victim from others was possible during that procedure. The record indicates the statements were not the product of coercion or leading questions. Finally, despite some minor inconsistencies and other matters going to the weight to be accorded the declarations, an examination of the contents of the statements does not indicate that they were unreliable. Furthermore, the videotape and transcript of the interview were available to defendant for impeachment purposes and in presenting his argument that the statements lacked the requisite indicia of reliability. In summary `indicia of reliability' must be considered in the context of the particular case and the factors prescribed by the statute."

Thus, the Missouri Supreme Court in Wright identifies the following factors as important:

1) The timing of the hearsay statement. If the statement was made near the time of the alleged abuse, the statement is more likely to be found reliable because "the chance of memory lapse or fabrication as well as contamination from interaction with persons interested in the event and exposure to their suggestions" is reduced.

In the above quote, the Supreme Court recognizes that when a statement is made after a period of time the following may affect the reliability of the statement:

a) Memory lapse;

b) Chance of fabrication;

c) Chance of contamination of that statement from persons interested in the event (i.e., parents, police, social workers) by exposure to their suggestions.

2) Circumstances of interview. If the interview takes place in a non-threatening environment where only the interviewer and the victim are present and "no direct pressure from others" is possible, the statement is considered more reliable.

3) If the statements are "not the product of coercion or leading questions" the statements are considered more reliable.

4) An examination of the content of the statement indicates reliability. If there are only minor inconsistencies in the context of the statements or no inconsistencies, this shows reliability.

The Court notes that a child's out-of-court statement made near the time of the event "may on occasion be more reliable than the child's testimony at trial, which may suffer distortion by

the trauma of the courtroom setting or become contaminated by contact and influences prior to trial."

In Wright, the hearsay statements made by the child were made within an hour or two of the alleged crimes.

In State v. Moesch, 738 S.W.2d 585 (E.D. Mo. App. 1987), the Court of Appeals notes that the videotape statute "precludes leading questions which essentially put words in the child's mouth."

In State v. Potter, 747 S.W.2d 300 (Mo. App. S.D. 1987), the Court of Appeals found the hearsay statements to be reliable and therefore admissible. In that case, the statement to the child's mother was made within minutes of the abuse, the statement to a social worker was made the next day and the statement to a psychologist during a hospital stay were made within a few weeks.

The Court in finding the statements admissible stated the following: "All of the statements were made near the date of the events reported by the child. Considering the child's age, each statement was remarkably consistent with the others insofar as it related the events."

In State v. Bereuter, 755 S.W.2d 351 (E.D. Mo. App. 1988), the Court found the hearsay statements to be reliable. The Court noted "the circumstances surrounding the statements made on both days were neither coercive nor suggestive. The statements on both days were consistent and contained detailed information a child of the victim's age would not be expected to know."

Respectfully submitted,

BRIDGES, NICHOLS & SEIBEL

By _____

CHARLES E. BRIDGES #25305
Attorney for Defendant
200 North Second Street
St. Charles, Missouri 63301
723-7020 or 946-4996