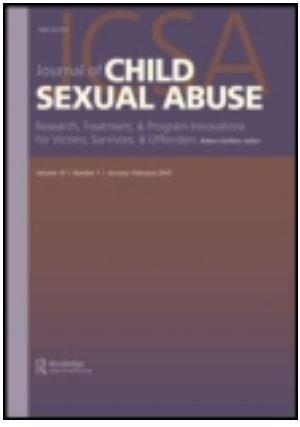

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Abuse of the Child Sexual Abuse Accommodation Syndrome

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CASE CONFERENCE: MENTAL HEALTH/ SOCIAL SERVICE ISSUES AND CASE STUDIES

Abuse of the Child Sexual Abuse Accommodation Syndrome

Roland C. Summit

The Child Sexual Abuse Accommodation Syndrome (CSAAS) (Summit, 1983b) is a clinical observation that has become both elevated as gospel and denounced as dangerous pseudoscience. The polarization which inflames every issue of sexual abuse has been kindled further here by the exploitation of a clinical concept as ammunition for battles in court. The excess heat has been generated by false claims advanced by prosecutors as well as a primary effort by defense interests to strip the paper of any worth or relevance.

The following commentary will address the origins of the child

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sexual abuse accommodation concept and the subsequent distortions that court misuse has imposed. I hope that such a contextual review can serve as a guide toward a more accurate understanding among clinicians, judges, and advocate attorneys.

BACKGROUND

Appeals decisions have groped for a definition of the intent and purpose of the CSAAS, assuming sometimes that it is intended for diagnosis or for substantiation of complaints. It has been presumed at times to be both an instrument and an opinion. I would propose that the answers to such questions can be found not in adversarial debate but in an examination of the origins of the CSAAS itself.

It was only when I began reviewing courtroom opinions during the late 1970's that it became apparent that prevailing clinical experience was at odds with forensic demands. From the viewpoint of a community psychiatrist specializing in sexual abuse consultation, it had become axiomatic that children were reluctant to disclose sexual victimization and that potentially protective adults were often incredulous and threatened by the implications of a child's complaint. I was surprised to discover that lawyers tended to discredit delayed and inconsistent reports, insisting that any legitimate victim would have made an immediate and convincing complaint. I began to understand that legal assumptions equating reliability of testimony with a fresh and consistent complaint merely formalized the standoff that has always existed between victimized children and the adults in authority they must face to gain sympathy and protection. The small victim of a private crime must search against fear of rejection for the adult who will listen to an unwelcome, offensive account and take protective action against a trusted peer.

In the summer of 1979, I put together a list of those factors which were both most characteristic of child sexual abuse and most provocative of rejection in the prevailing adult mythology about legitimate victims. The basis for those typical characteristics was my own broad consulting experience throughout Los Angeles County as well as personal discussions with such national visionaries as Ann Burgess, Sue Sgroi, Nicholas Groth, Lloyd Martin, Louise Armstrong, Lucy Berliner, Hank Giarretto, Kee MacFar-

lane, Karin Meiselman, Judith Herman, Diana Russell and, especially, David Finkelhor.

The first five of the seven factors on the original list formed a logical pattern and sequence of interaction among the victim, the intruder and the potential caretakers. Together, these five points described both the luxury of the adult world not to listen and the accommodating efforts of the child not to complain. The factors as listed were: (1) Secrecy, (2) Helplessness, (3) Entrapment and accommodation, (4) Delayed, conflicted and unconvincing disclosure, and (5) Retraction.

I began to use that pattern as an outline for lectures explaining the dynamics of sexual victimization, calling it the Child Sexual Abuse Accommodation Syndrome. The lectures had the compelling effect of helping professional and public audiences to understand, as if for the first time, how sexual abuse can occur. It became commonplace for adult survivors to seek me out after such a lecture to express gratitude that someone could understand. They typically felt relieved and forgiven, having condemned themselves as uniquely weak or bad for their uncomplaining compliance as a child.

The published record of the CSAAS begins with the transcription of an invited lecture in Victoria, British Columbia on September 29, 1980 (Summit). That publication served as the basis for the text of the CSAAS which was incorporated in each of two book chapters written during the spring of 1981 (Summit, 1982, 1983a). An expanded version was written during the ensuing summer and submitted to a psychiatric journal. The CSAAS article was rejected, not because it was radical or unsubstantiated, but because the reviewers felt it was so basic that it contributed nothing new to the literature!

The unexpected rejection after two years of frustrating delays discouraged any further attempt at publication. Copies of the typescript continued to circulate, however, and the CSAAS took on a life of its own in progressively faded facsimile. Kee MacFarlane recommended the paper for inclusion in the sexual abuse special issue of the International Journal of Child Abuse and Neglect. The typescript was reviewed, unchanged, in the spring of 1983, and finally published (Summit, 1983b).

The significance of the preceding chronology is that the CSAAS, like the labors of disclosure it seeks to describe, was not relevant to established wisdom. Even as it made sense to those with personal and immediate experience, it was unacceptable to those with gatekeeping authority. Sharing the CSAAS became centrally important to me as I tried to find the way to say it right, but on being rejected I was willing to retract it and give up. In further analogy to the plight of the child, the CSAAS depended on intervention by a sensitive, experienced professional to invite eventual disclosure.

The publication history is important also for the fact that the text of the CSAAS represents the author's experience up to the fall of 1981, more than two years before its eventual publication, with clinical anecdotes derived from consulting experience preceding 1980. The large majority of those first consultations involved incestuous abuse, which then became a convenient model for lecture presentation. Despite intervening contacts with every known form of child sexual victimization, all of which reinforced the accommodation concept, the written persistence of the original anecdotes allows for the misleading impression that the accommodation phenomenon is specific to father-daughter incest.

The CSAAS originated, then, not as a laboratory hypothesis or as a designated study of a defined population. It emerged as a summary of diverse clinical consulting experience, defined at the interface with paradoxical forensic reaction. It should be understood without apology that the CSAAS is a clinical opinion, not a scientific instrument.

ABUSES

Contrary to its resoundingly constructive clinical reception, lawyers and a few clinical expert witnesses have tended to seize on the CSAAS as a major weapon. Adversarial rivals seem determined either to enhance it or to destroy it according to their designated role. The CSAAS posed a threat to the traditional defense arguments that legitimate victims would fight back and complain, that any good mother would know if her child were a victim, and that retractions confirm the common sense assurance that children typi-

cally lie about sexual victimization. Prosecutors saw the CSAAS as a potential offer of proof that an inconsistent victim is truthful.

Some of the adversarial alarm and distortion stems from misunderstanding of the word *syndrome*. In medical tradition it means a list, or pattern of otherwise unrelated factors which can alert the physician to the possibility of disorder. Such a pattern is not diagnostic, and the cause-and-effect relationship among the factors themselves and with the possible problem is generally obscure. In court circles, *syndrome* seems to mean a diagnosis which an expert witness contrives to prove an injury. *Syndrome evidence* has become a generic term for diagnostic medical or psychological testimony which must be closely scrutinized for scientific reliability, lest the intrinsic authority of the expert witness improperly prejudice a jury through contrived or eccentric opinion. Any assertion that a victim-witness or a plaintiff suffers from a disorder that was caused by the claimed injury must be tested for scientific reliability in a so-called *Kelly-Frye* hearing. Had I known the legal consequences of the word at the time, I might better have chosen a name like the Child Sexual Abuse Accommodation *Pattern* to avoid any pathological or diagnostic implications.

Despite the potential for semantic misunderstanding, it should have been obvious to a careful reader that the CSAAS was not addressing an illness or disorder. The abstract of the monograph, which was written in the summer of 1983, expresses my last and most careful epitome of what I was trying to describe:

> Child victims of sexual abuse face secondary trauma in the *crisis of discovery*. Their attempts to reconcile their private experiences with the realities of the outer world are assaulted by the disbelief, blame and rejection they experience from adults. The *normal coping behavior* of the child contradicts the entrenched beliefs and expectations typically held by adults, stigmatizing the child with charges of lying, manipulating or imagining from *parents, courts and clinicians*. . . .
>
> Evaluation of the responses of *normal children* to sexual assault provides clear evidence that societal definitions of "normal" victim behavior are inappropriate and procrustean, serving adults as *mythic insulators* against the child's pain.

> Within this *climate of prejudice*, the sequential *survival options* available to the victim further alienate the child from any hope of outside credibility or acceptance. Ironically, the child's inevitable choice of the "wrong" options reinforces and perpetuates the *prejudicial myths*. (1983b, p. 177, emphasis added)

These are normal children making normal adjustments to an abnormal environment. The focus is not on the effects of sexual abuse itself but on the conflict between the child's experience and the perverse indifference of the outer, adult world. If there is pathology, it is in the denial and paradoxical demands of adults, not in the survival options found by the child. The words *identification, detection, diagnosis, symptom, disorder, illness* and *pathology*, which might infer a diagnostic focus, do not appear in the paper, nor is there a promise of verifying the alleged abuse with such words as *test, validate, evaluate, confirm*, or *prove*. The accommodation mechanisms listed in the third category are obviously not specific to sexual assault. Rather, they were selected to illustrate the misleading, self-camouflaging behaviors that inhibit recognition. The CSAAS is meaningless in court discussion unless there has been a disputed disclosure, and in that instance the ultimate issue of truth is the sole responsibility of the trier of fact. The CSAAS acknowledges that there is no clinical method available to distinguish "valid" claims from "those that should be treated as fantasy or deception" (p. 189), and it gives no guidelines for discrimination.

The capacity to listen and the willingness to believe, which the paper invites, is not an admonition to interrogate or to assume that every disclosure is real:

> The purpose of this paper then, is to provide a vehicle for a more sensitive, more therapeutic response to *legitimate* victims of child sexual abuse and to invite more active, more effective *clinical advocacy* for the child within the family and within the systems of child protection and criminal justice. (p. 179-180, emphasis added)

Even the word *advocacy* has a loaded meaning in forensic circles. An advocate is seen as a hireling paid to advance an adversarial view, or someone with a zealous mission who cannot be objective. So the CSAAS can be read by lawyers as a rallying cry for clinicians to go forth and diagnose more children as victims, toward the goal of making more money and putting more people in jail. Whether or not attorneys saw it that way at first, that is certainly the attack directed now against the CSAAS and its alleged minions, the *child advocates* or, more derisively, *child abuse finders* or *validators*, who are said to be conducting a *witch hunt* and creating an *epidemic of false allegations*, launched and fueled by the CSAAS. This *kill the messenger* rhetoric has given the CSAAS a taint of controversy which inhibits expert witnesses from drawing on the paper as supplementary authority. Clinicians may be warned specifically by attorneys to make no reference to the CSAAS, and even to deny being influenced in their training by the views of early theorists.

When CSAAS is not stigmatized outright, it may be attacked as being irrelevant in any disclosures other than those naming the father in an intact family system. This is a frank distortion both of the scope of the CSAAS and of clinical reality. Silence is intrinsic to the victimization process, not to family systems dynamics. A skillful neighborhood offender may be more immune from parental suspicion and victim disclosure than a relative. Experts who swear that a child would have no reason to conceal abuse by a teacher must be unimpressed by a case in Great Neck, N.Y., where a computer tutor enslaved some 400 boys and girls in pornographic exploitation and sadistic abuse over a span of 7 years with no disclosures, ever. Or the school bus driver in the same county who molested children going back and forth to school. Some 250 young children entered a bus twice a day to be molested, yet no teacher or parent heard a word of that ordeal.

While much of the destructive criticism was contrived to prevent any use of the CSAAS in court, some criticism has been a legitimate defense against improper use by prosecutors and expert witnesses called by prosecution. There has been some tendency to use the CSAAS as an offer of proof that a child has been abused. A child may be said to be *suffering from* or *displaying* the CSAAS,

as if it is a malady that proves the alleged abuse. Or a child's conspicuous helplessness or silence might be said to be *consistent with* the CSAAS, as if not complaining proves the complaint. Some have contended that a child who retracts is a more believable victim than one who has maintained a consistent complaint. Such absurd distortions fuel the fire against the CSAAS:

> Daffynition: *Child Sexual Abuse Accommodation Syndrome*: a brief synopsis. (1) When a child denies abuse, they have been abused. (2) When a child says they have been abused, they have been abused. (3) When a child recants an abuse, they have been abused. (4) Therefore, it is logical to conclude that all children have been abused and therefore all who have children have either abused their child or have allowed their child to have been abused. (VOCAL, 1988, p. 6)

The CSAAS is used appropriately in court testimony not to prove a child was molested but to rebut the myths which prejudice endorsement of delayed or inconsistent disclosure. Proper testimony is defined in California's *People v. Gray* (187 Cal. App. 3d 213: Cal. Rptr. - [Nov. 1986]). *Gray* translates a state Supreme Court decision into analogous guidelines for CSAAS testimony regarding child witnesses:

> . . . expert testimony may play a particularly useful role by disabusing the jury of some widely held misconceptions about (child sexual abuse and its) victims, so it may evaluate the evidence free of the constraints of popular myths. (*People v. Gray*, p. 218)
>
> . . . it was not error to admit expert testimony to the effect that it was common for child victims to delay reporting of incidents of abuse and to give inconsistent accounts of such incidents to different people, where such evidence was not offered to prove that a molestation in fact occurred, but rather was offered to rebut the inference proffered by the defendant that the alleged victim was being untruthful as shown by her delay and inconsistencies in reporting, by showing that such behavior is *not necessarily indicative of deceit* in children.

> Such expert testimony was proper so long as it was limited to discussion of *victims as a class* (e.g., children), and did *not* extend to discussion and diagnosis of the *witness in the case at hand*. (pp. 213-214, emphasis added)

Gray also defines CSAAS testimony as opinion, not scientific evidence, and therefore not subject to *Kelly-Frye* exclusion. "Thus, expert testimony, even where highly esoteric and controversial, is generally admissible, so long as not derived from a specific experimental or forensic procedure" (p. 214).

REDUCTIO AD ABSURDUM

The ultimate barrier to CSAAS testimony is to define it as something it is not, then to bar it for its failure to meet irrelevant conditions. If the CSAAS is labeled as a diagnostic instrument, then it must undergo a *Kelly-Frye* hearing to demonstrate its infallibility and its general acceptance in the scientific community in which it was developed. Since the author is a psychiatrist, it is tested against the psychiatric literature and the official diagnostic and statistical manual, in which, since it is *not* a diagnosis, it will never appear.

Working in the community gave me the privilege of learning about sexual abuse from those who knew: social workers, nurses, police, sociologists, psychologists, journalists and adult survivors. The greatest contribution from psychiatrists was an appreciation of the elitist avoidance that continues to isolate my profession from the interdisciplinary advances of child abuse awareness. The clinical expert best-qualified to testify about sexual victimization is likely to be a social worker, not a physician. Yet judges persist in empowering psychiatrists with sole dominion over human behavior.

The Supreme Court of Kentucky has reversed five consecutive sexual abuse convictions involving expert witness testimony, ruling each time that the CSAAS is not a generally accepted *medical* concept.

> However, the issue "has never been properly presented to us" said Kentucky Supreme Court Chief Justice Robert

> Stephens. The witnesses who testified about the syndrome were social workers and other non-medical personnel rather than traditional experts like doctors and psychiatrists, Stephens said. (Nance, 1991, p. A-9)

In January the court reviewed the ultimate test case. The defendant had been condemned to 50 years in prison for molesting and sodomizing his stepdaughter over a period of six years. Expert testimony was offered by Lane Veltkamp, a full professor of psychiatry and Director of the University of Kentucky Child Abuse Center. In his 23 years of experience he had evaluated and treated over 1000 children. His testimony avoided any reference to the CSAAS, but he was asked to comment on the child's six years of silence. He said in his experience "delayed disclosure was common among sexually abused children."

The Supreme Court interpreted that statement as a reference to the CSAAS! The entire testimony was nullified and the CSAAS was scapegoated *in absentia* because the expert's credentials were judged inadequate to address what the court insists is medical evidence. Professor Veltkamp, medical educator and sexual abuse expert *par excellence*, was not to be allowed to educate a jury. The Supreme Court reversed the conviction because he is *only* a Master of Social Work, not a Doctor of Medicine (Nance, 1992).

CONCLUSION

It has been 13 years since I observed that victims of sexual abuse are the object of prejudice because they do not meet our artificial standards of disclosure. I thought that better education would correct this secondary abuse. The CSAAS, written to address that prejudice, was drawn from community resources and published in the interdisciplinary, international journal for child abuse awareness. Nothing in that history implies that the CSAAS is a medical issue. There are infinite behavioral variations which can be subsumed under the five categories of the CSAAS, any of which may be vital to understanding a victim's dilemma. To take all such information away from those who can best express it, to consign it to a category of medical evidence because a psychiatrist once

tried to summarize it, and then to rule any and every part of such information forbidden to a trier of fact unless a physician can prove it qualifies as medical evidence is the ultimate expression of the very prejudice which the courts seem so reluctant to acknowledge.

Knowledge is not enough. Education is not enough. A good clinical framework like the CSAAS is not only not enough, it becomes worse than nothing if it offends those who are determined not to learn. It can be used as a lock on the secret instead of the key.

The problem is not with improper use of expert testimony. The problem is not with skeptical attorneys or recalcitrant judges; they all merely represent our continuing reluctance as an adult society to allow an honest view of our children's continuing silence.

The answer lies not in better research or better publications. Scientific progress is no match for prejudicial ignorance. The answer rests with broader acknowledgement that we all need to discard familiar reassurances and struggle together for better answers. We aren't yet willing as a society to prohibit the sexual abuse of children. Why not?

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