
**EVIDENCE ISSUES AND "LESSONS" FROM *STATE v. KELLY*:
LITIGATION OF ALLEGATIONS OF CHILD SEXUAL ABUSE**

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Usually, a child is the principal, if not the only, witness from whom information about a suspected offense must be obtained. When an allegation of sexual abuse is made, it provokes an immediate response that changes an otherwise "ordinary" case into a "special" case in which unique procedures and rules of evidence may apply, emotions escalate, and truth becomes difficult, if not impossible, to find. Too often, the "cause" supersedes the "case".

Litigation of the issues involved in these cases presents the lawyer with an extremely complex subject matter requiring a basic knowledge and appreciation of the interplay of several professional disciplines - law, social work, medicine, psychology - and the implications of each with regard to questions of evidence.

The bibliography attached to this manuscript contains professional literature which may be pertinent "learned treatise" material for evidentiary use, or for reference, and we recommend that anyone involved in litigation of child sexual abuse issues consult these sources.

B. UNIQUENESS OF LITIGATION INVOLVING CHILDREN AS WITNESSES

A rational view of the peculiarities of child nature, and of the daily course of justice in our courts, must lead to the conclusion that the effort to measure the a priori degree of untrustworthiness in children's statements, and to distinguish the point at which they cease to be totally incredible ... is futile and unprofitable.

Wigmore, 6 *Evidence in Trials at Common Law*, Section 509 (1935).

Unquestionably, the most unique, and the most treacherous, aspect of the *Kelly* case, and of similar cases, involves the use of child witnesses or child statements. To the extent the rules of evidence are intended to insure the presentation of reliable, competent information for the fact-finder, unusual and compelling legal and scientific (medical, social and psychological) issues surface in litigation involving allegations of child sexual abuse.

II. COMPETENCY, TRUTH, AND THE CHILD AS A WITNESS: HAVE WE PASSED "THROUGH THE LOOKING GLASS"?

In the past, children below certain ages were deemed to be incompetent as witnesses. Among the first reported trials in America permitting the testimony of children were the Salem Witch Trials in 1692. The results of those trials hardly served to encourage the use of children as witnesses. See Starkey, The Devil in Massachusetts (NY, Alfred Knopf, 1949). Some legal scholars, like Professor Wigmore, expressed opinions that children should be ruled incompetent as witnesses because of the unreliability of their testimony.

After years of debate and study, the current focus of the courts in determining the competency of a child witness is not the age of the child, but rather the child's ability to understand the obligation to tell the truth and to communicate what they know. During the past decade, increased research has been undertaken in an effort to determine the ability of children to remember and report accurately events they have experienced.

A. COMPETENCY OF CHILD TO BE A WITNESS

The Rules of Evidence contain a general prescription for competency determinations. The Court determines the "qualification" of a person to be a witness. Rule 104. The only guidelines for "competency" determinations are set forth in Rule 601. Under this Rule, every person is competent and qualified to be a witness unless the evidence rules provide otherwise, and a person is disqualified (or incompetent) only when incapable of expressing himself concerning the matter so as to be understood, either directly or through interpretation by one who can understand him, or when incapable of understanding the duty to tell the truth. (Special rules apply to expert witnesses and novel scientific evidence.)

There is no requirement that the child witness have a religious belief or understanding of the obligation to tell the truth, and the child need not fear retribution for not telling the truth. It is sufficient if the child "understands" the difference between truth and untruth and indicates an intention to tell the truth. *State v. Hicks*, 319 N.C. 84, 352 S.E. 2d 424 (1987).

There is no age below which one is deemed, as a matter of law, incompetent to testify. *State v. Jenkins*, 83 N.C. App. 616, 351 S.E. 2d 299 (1986).

Competency to testify is determined by the court at the time the witness is called to testify. *State v. Cooke*, 278 N.C. 288, 179 S.E. 2d 365 (1971). (If a challenge to a child's competency is filed pretrial, the determination may be made as a preliminary matter prior to the child's appearance as a witness). If voir dire on competency is not requested, it is deemed waived and can be determined in the jury's presence. *State v. Baker*, 320 N.C. 104, 357 S.E. 2d 340 (1987); *State v. Reynolds*, 93 N.C. App. 552, 378 S.E. 2d 557 (1989).

The Judge must observe and hear the child witness in making a competency decision. *State v. Fearing*, 315 N.C. 167, 337 S.E. 2d 551 (1985). His/Her discretion governs the

competency decision, and the decision is reversible on appeal only for an abuse of discretion. *State v. Hicks*, 319 N.C. 84, 352 S.E. 2d 424 (1987); *State v. Jenkins*, 83 N.C. App. 616, 351 S.E. 2d 299 (1986), *cert. denied*, 319 N.C. 675, 356 S.E. 2d 791 (1987).

B. THE "TEST" FOR TRUTHFULNESS AND COMPETENCY OF A CHILD

Often, a child's understanding of "truth" and the child's purported competency to be a witness will be "proved" by simplistic questioning and tests. One method frequently used is holding up an item and asking the child about its color. Another is questioning about the Bible and Jesus. All such questions are ultimately followed with some type of exhortation about the need to tell the truth. Sometimes a child will be asked a question such as "If I told you it was raining outside would that be the truth or a lie?" It is a rare child who cannot answer the typical questions used to determine competency. Upon giving the expected answers, the child is routinely accepted as a competent witness.

(The following is a portion of a child's testimony from the *Kelly* case and an example of the "test" for truthfulness employed in the case.)

- 2 Do you remember going to court school?
3 A (Nods head).
4 Q You went to court school, didn't you?
5 A (Nods head).
...
16 Q Let me see. I saw you yesterday, didn't I?
17 A (Nods head).
18 Q You and I met yesterday; your Nonna brought you down
19 to see me, didn't she?
20 A (Nods head).
21 Q And did you tell me yesterday who your teacher is
22 going to be?
23 A (Shakes head).
24 Q You didn't?
25 A (Shakes head).
...
23 Now, Brian, the lady who stood up front here, she
24 asked you to do something; what did she ask you to do?
25 You promised to do what? When the lady asked you
1 that question what did you promise to do?
2 A Tell the truth.
3 Q To tell the truth?
4 A (Nods head).
5 Q Okay. And if I said this pen is green, what -- is

6 that the truth or is that a lie?
7 A Lie.
8 Q Okay. If I said that you're sitting in your daddy's
9 lap right now, is that the truth or a lie?
10 A Lie.
11 Q If I said you are sitting in your mamma's lap, is
12 that the truth or lie?
13 A Truth.

...
Now, when you --

8 when people promise in court to tell the truth they usually
9 put their hand on the Bible, don't they?
10 A (Nods head).
11 Q What's the Bible about, Brian?
12 Who is the Bible about?
13 A Jesus.
14 Q And who is Jesus?
15 A (Indicating).
16 Q Where do you learn about Jesus?
17 A Sunday school.
18 Q Okay. And you go to Sunday school to learn about
19 Jesus; is that right?
20 A (Nods head).
21 Q Okay. You have to answer now. Remember that you
22 learned in court school that you can't shake your head,
23 you've got to answer; do you remember that?
24 A (Nods head).
25 Q Okay. And so do you learn about Jesus in Sunday
1 school?
2 A (Nods head).
3 Q Okay. Got to answer, right?
4 Can you answer me?
5 A Yes.
6 Q Okay. Now, where do you learn about Jesus?
7 A Sunday school.
8 Q I've got you. Okay.

...
24 Q Okay. So you have to answer, right?
25 A (Nods head).
1 Q And you learned that in court school, didn't you?
2 A (Nods head).
3 Q Did you talk about your case in court school?
4 A Yeah.
10 Q What did you learn to do in court school?

11 What was the most important thing that you learned?

12 A To tell the truth.

13 Q To tell the truth?

14 A (Nods head).

11 Q And just like you have promised to tell the truth,

12 you told your mamma the truth, didn't you?

13 A (Nods head).

14 Q Did you?

15 A Yes.

24 Q All right. Now, can we talk for a minute about the
25 things that happened at Little Rascals?

1 A (Shakes head). No.

2 Q Will you tell the jury now?

3 A (Shakes head).

16 Q Brian, if you don't tell the jury, who is going to
17 tell them?

18 A (Indicating), I don't know.

19 Q Nobody can, can they?

20 A (Shakes head).

21 Q And that's why you are here today, isn't it?

22 A (Nods head).

23 Q And you know that once you tell the jury you'll never
24 have to talk about it again, will you?

25 A No.

1 Q So all we have to do now is tell the jury and get it
2 over with, right?

3 A Yes.

4 Q All right. You ready to tell the jury?

5 A (Shakes head).

6 Q It's hard to do, isn't it?

7 A (Nods head).

8 Q What happened to you at Little Rascals, Brian?

9 A I don't know.

20 Q Now, where did Mr. Bob touch you, Brian?

21 A On my stomach.

22 Q Touched you on the stomach?

23 A (Nods head).

24 Q Where else did he touch you?

25 A Nowhere else.

(Ultimately, the prosecutor employed blatantly leading and suggestive questions, including exhortations that the child remember what he had told his mother, in order to have the child acknowledge offenses the prosecutor actually "testified" about. QUERY: When was the child being competent and truthful?)

It ought to be apparent that the typical "competency test" does little more than show that the child knows colors, or the difference between a rainy day and a sunny day, or that certain answers will be accepted by adult authority figures as truths. These tests do not address the child's **understanding** of "truth" as an abstract or compelling concept, nor do they probe the child's actual understanding or comprehension of the obligation to provide truthful answers regardless of what the questioner wants to hear, nor do they assess any other internal or external motivations which may influence the child's understanding or compulsion to be truthful.

Research studies have shown that bright young children will provide and fully endorse answers to nonsense questions such as "Which is faster, red or green?" or "Is milk bigger than water?". They will assure the questioner that the given answer is the "truth."

In a technical legal sense, the child's answer may very well be characterized as "truthful" - it is not a lie. The child does not know that the answer given is not "true" in an abstract or real sense.

Competency to testify does not require that the witness know the "truth"-- only that the witness understand that they must testify to what they believe is the truth. (Perjury is defined as a false statement under oath, knowingly, willfully and designedly made. *State v. Smith*, 230 N.C. 198, 52 S.E. 2d 348 (1949).

The assumptions that courts make about young children's abilities and comprehension regarding the obligation to testify truthfully, and in qualifying them to testify, are often as simplistic as the methods used to qualify them. In *State v. Davis*, the Court of Appeals approved a competency test for two "intellectually limited" children under Rule 601(b) which apparently only consisted of a *voir dire* in which the children were asked if they knew the difference between truth and falsehood (both said yes), and in which the children swore to tell the truth. __ NC App __, 418 SE 2d 263, 269 (1992).

The following testimony from the *Kelly* trial illustrates the unreliability of competency testing for children in the courtroom:

(Defense Cross-Examination of Seven year-old Prosecuting Witness.)

- Q: Now, you understand you were taught in court school about telling the truth, right?
A: Yes.
Q: And that everything you say has to be the truth, right?

A: Yes.
Q: Okay. Now, is it the truth about Mr. Bob and Ms. Betsy killing the babies?
A: Yes.
Q: Did they really kill real babies?
A: Sometimes.
Q: Sometimes. Well, now when you talked to Ms. Judy you didn't tell her that happened at the day care, did you?
A: No.
Q: You told Ms. Judy it happened in outerspace, didn't you? [Child], isn't that what you told Ms. Judy that Mr. Bob and Ms. Betsy killed the babies in outerspace?
A: Yes.
Q: And you told her that you went to outerspace with Mr. Bob and Ms. Betsy in a hot air balloon, right?
A: Yes.
Q: Did you really do that?
A: It was a spaceship.
Q: Okay. It wasn't a balloon; you went in a spaceship?
A: Yes.
Q: Is that the truth?
A: Yes.
Q: Is that the truth like all the other things you told us?
A: Yes.

(The following testimony was given by two children in the Little Rascals trial after passing a "color test" for competency. The child's testimony is contrasted with that of the child's parent concerning the child's prior statements on the same subject.)

(Cross-Examination of Child 1):

Q Have you ever seen animals in Mr. Bob's truck?
A No.
Q Did you tell your mom that you saw a tiger and an elephant in Mr. Bob's truck?
A No.

(Testimony of Child 1's Mother)

A We were sitting in a rocking chair talking about the day care and he, without being questioned, began telling me the same story about what happened, what Mr. Done -- Mr. Bob had done to him and to his other friends, and I asked him if Mr. Bob told him not to tell his mommy, and he replied, "It was a secret." And I asked him, "What was the secret?" And he whispered in my ear and said, "animals," whispered it real softly in my ear. And then he said, "The animals were in Mr.

Bob's truck." He said, "There were tigers, and elephants in cages like the zoo, mamma."

(Cross-Examination of Child 2)

Q Did you tell your mom that Mr. Bob and Ms. Betsy and Ms. Shelly put a fork, a knife, a brown stick, a stick with a star, and some pine straw in all the girls' hineys?

A No.

Q That wouldn't have been the truth, would it?

A No.

(Testimony of Child 2's Mother)

A He told me that Bob put a fork, a knife, a brown stick, and a stick with a star and pine straw in all the girls' hineys, but he didn't do it to the boys.

In *State v. DeLeonardo*, 315 N.C. 762, 766, 340 S.E. 2d 350 (1986) the Court quoted the following statement with approval concerning a child witness:

Unsoundness of mind does not per se render a witness incompetent, the general rule being that a lunatic or weak minded person is admissible as a witness if he has sufficient understanding to apprehend the obligation of an oath and is capable of giving a correct account of the matters which he has seen or heard with respect to the questions at issue. The decision as to the competency of such a person to testify rests largely within the discretion of the trial court.

The question that should be addressed at a competency hearing is whether the child has an adequate understanding of the concept of "truth" so as to appreciate the cognitive difference between "truth" and "falsehood" and so as to satisfy and convince the Court of an intention/commitment to tell only the truth.

In *State v. Stutts*, 105 N.C. App. 557, 414 S.E. 2d 61 (1992), a four year old child was held unreliable (incompetent?) as a witness, and the child's hearsay statements were not admitted as residual exceptions, because she could not understand the difference between truth and falsehood nor what was reality and what was imagination.

Recent research tends to show that by age 4 most children have developed some capacity to deceive. See Ekman, **WHY KIDS LIE** (Scribners:New York, 1989); Ceci, et al, "Motives to Lie", Paper presented at biennial meeting of American Psychology/Law Society, Williamsburg, Virginia, March 16, 1990. Furthermore, the literature indicates that children as young as 3 have an ability to take into account another person's perception of their own.

truthfulness when they lie to that person. Ceci & DeSimone, " 'I know that you know that I know who broke the toy': Recursivity in three-year-olds", **Cognitive and Social Factors in Preschoolers' Deception** edited by Ceci and others (Erlbaum:New Jersey, 1992). The research into children's concepts of "truth" is limited, but the studies support a prudent pessimism about children's competency and truthfulness as a witness.

Although it might be more prudent to have qualified experts assess and determine a child's competency and suggestibility before allowing the child's testimony, there is authority that the trial judge is not required to hear witnesses other than the child in making a determination of the child's competency. *State v. Roberts*, 18 N.C. App. 388, 197 S.E. 2d 54, cert. denied, 283 N.C. 758, 198 S.E. 2d 728 (1973).

III. LEADING QUESTIONS vs. SUGGESTION

A. LAW vs. SCIENCE

Every jurisdiction permits the direct examination of children by the use of leading questions. Although objectionable in most circumstances if the witness is an adult, this style of questioning is allowed on the theory or assumption that it is necessary in order to elicit the "truth" from a child and to develop testimony..

"Leading" is not defined by the Rules of Evidence (See Rule 611) or any other statute, but the case law indicates that a leading question is one that "suggests" the answer desired of the witness. See 1 **Brandis On North Carolina Evidence**, section 31 (Third Edition, 1988).

It is within the sound discretion of the trial judge to allow leading questions on direct examination, and in cases involving children...the judge is accorded wide latitude to exercise that discretion. The children in the instant case were extremely young; their ages ranged from two to five years. Additionally, the children were required to testify about sexual matters which, for young children, are presumably difficult to understand or communicate without assistance. Leading questions were necessary in order to elicit from them details of alleged offenses. *State v. Chandler*, 324 NC 172, 376 SE 2d 728 (1989).

Numerous scientific studies indicate that this judicial exercise of discretion and latitude may not be serving the "truth seeking" function intended or desired. The majority of the scientific literature, and the advice of professionals specializing in child interviews, confirm that leading and suggestive questioning of young children is the method least likely to produce valid or reliable details from the child's actual memory and is most likely to contaminate the child's responses and memory. This is truest of preschoolers. See generally,

Doris (editor), **The Suggestibility of Children's Recollections: Implications for Eyewitness Testimony** (American Psychological Association, 1991).

...[I]nappropriate interviewing, especially that with a suggestive, pressurising or leading style, can bias the child's report. ... In particular, younger children's replies have sometimes been found to be more biased by poor questioning.

Research demonstrates that both adult and child [witnesses'] responses to leading questions can be more the result of the questioning than of valid remembering. Bull, "Obtaining Evidence Expertly: The Reliability of Interviews with Child Witnesses", 1 **The International Digest of Human Behaviour, Science And Law** 5 - 12 (1992).

Children who testify in sexual abuse litigation have generally been involved in extensive and multiple pretrial interviews conducted by social workers, medical doctors, psychologists, parents, police officers, and prosecutors. Each of these interviewers has a special agenda in speaking with a child about allegations or suspicions of abuse. Consciously, or unconsciously, each may influence and distort the child's memory and subsequent testimony in court. There are few "neutral" parties in most trials - there are none in child abuse trials. Given the scientifically established susceptibility of young children to memory distortion by leading and suggestive questioning, the reliability of their testimony in response to leading questions must remain suspect.

B. EXAMPLES OF LEADING QUESTIONS FROM STATE vs. KELLY

The overwhelming bulk of the testimony of the children in the *Kelly* case with regard to the alleged acts of abuse came in response to direct, suggestive and/or leading questioning by the prosecutors. All of the children had been subjected to multiple pretrial interrogations by numerous questioners. The parents were some of the most persistent interrogators of their children. One parent developed a nightly bedtime routine with her child at which she solicited and encouraged damning statements about "Mr. Bob". All of the parents were requested to maintain diaries for the purpose of recording accusations and statements by their children regarding "abuse". One parent began her diary with the words "Suffer Not The Little Children." In short, there was a continuing environment of suggestiveness and condemnation which enveloped the children long before they ever appeared as witnesses in court. The extent to which these influences shaped and distorted the children's testimony is debateable, but probably will never be known for certain.

(The following examples are illustrative of the typical style of questioning by the prosecutors. The final example indicates the frightening potential for unreliability induced by leading and suggestive questions.)

(Example #1)

8 Q What happened to you at Little Rascals, Brian?

9 A I don't know.

10 Q Did someone touch you at Little Rascals?

11 MR. MILLER: Objection.

12 THE COURT: Overruled.

13 A (Nods head).

14 BY MR. WILLIAMS:

15 Q Brian, did someone touch you at Little Rascals?

16 A (Nods head).

17 Q What? You have to answer now?

18 A Yes.

19 Q Who touched you at Little Rascals?

20 A Bob.

...
20 Q Now, where did Mr. Bob touch you, Brian?

21 A On my stomach.

22 Q Touched you on the stomach?

23 A (Nods head).

24 Q Where else did he touch you?

25 A Nowhere else.

...
1 Q Nowhere else?

2 A (Shakes head).

3 Q Well, is it bad to be touched on the stomach?

4 A (Shakes head).

5 Q Um, where else did he touch you, Brian? Did he touch
6 you anywhere else?

7 A (Shakes head).

8 Q What did he touch with you?

9 A His hand.

10 Q All right. And how did he touch you on the stomach
11 with his hand?

12 A Because he wanted to.

13 Q Because he wanted to?

14 A (Nods head).

...
20 Q How did he touch you with his hand?

21 A Because he wanted to.

22 Q Okay. But how did he do it? Did he --

23 A Spanked me.

24 Q He spanked you?

25 A (Nods head).

1 Q Where did he spank you?

2 A On my stomach.
3 Q On the stomach?
4 Why did he spank you?
5 A Because.
9 Q Because why?
10 A He just wanted to.
11 Q Had you been bad?
12 A (Shakes head).
13 Q What were you doing to get spanked?
14 A Nothing.
15 Q Where -- do you know where you were when you got
16 spanked?
17 A (Shakes head). Uh-uh.
18 Q Were you at Little Rascals or were you somewhere
19 else?
20 A Little Rascals.
21 Q Now, did Mr. Bob touch you anywhere else?
22 A Uh-uh. (No)
23 Q Do you remember telling your mamma that he touched
24 you some places?
25 A (Nods head).

...
2 Where did you tell your mamma that he touched you?
3 A I've forgotten.
4 Q Have you forgotten or do you just not want to talk
5 about it?
6 A Don't want to talk about it.
7 Q Did you say that you'd forgotten or did you say where
8 he'd touched you? Where did he touch you? Where did you
9 tell your mamma that he had touched you?
10 A I said I had forgotten.
11 Q You have forgotten. Well -- and you say -- have you
12 really forgotten or do you not want to talk about it?
13 A I don't want to talk about it.
14 Q Well, how is the jury going to know if you don't talk,
15 about it?
16 A (Indicating) I don't know.
17 Q Well, you know no one else can tell, don't you?
18 A (Nods head).
19 Q And when you promise to tell the truth, you promise
20 to tell all of the truth, don't you?
21 If you leave parts of it out is that telling the
22 whole truth?
23 A (Nods head).

24 Q It is?
25 Huh?
1 A (Shakes head).
2 Q Okay. Brian, did you tell your mamma that Mr. Bob
3 put his finger somewhere?
4 A Uh-uh. (No)
5 Q You didn't? Did you know that your mamma wrote
6 things down that you said?
7 A (Nods head). Yes.
8 Q And did you know that your momma had written down
9 things that said Mr. Bob touched you somewhere he shouldn't?
10 MR. MILLER: Objection.
11 THE COURT: Overruled.
12 A Yes.
13 BY MR. WILLIAMS:
14 Q Do you know where it was that your mamma wrote down
15 that Mr. Bob touched you?
16 A I don't know.
17 Q You say that you told Matthew (his Brother) these things?
18 A (Nods head).
19 Q That happened to you?
20 A (Nods head).
21 Q Do you remember what you told Matthew?
22 A (Shakes head).
23 Q Do you remember telling Matthew about having to stand
24 in line at the day care?
25 MR. MILLER: Objection.
1 THE COURT: Overruled.
2 BY MR. WILLIAMS:
3 Q Did you, Brian, tell Matthew that?
4 A (Nods head).
5 Q What happened --
6 A Yes.
7 Q -- when you had to stand in line?
8 A Nothing.
9 Q Who was there when you had to stand in line?
10 A Nobody.
11 Q Was Mr. Bob there?
12 A (Shakes head), no.
13 Q Well, who made you stand in line?
14 A Nobody.
15 Q Brian, do you remember talking -- your mamma asked
16 you -- your mamma asking you if you wanted her to be in
17 court?

18 A (Nods head).
19 Q Do you remember that? Did you want your mamma to be
20 here in court with you?
21 A (Shakes head).
22 Q How come? Why didn't you want your mamma to be here?
23 A I don't know.
24 Q Was it because you said that you hadn't told
25 everything yet?
1 A Uh-uh.
2 MR. MILLER: Objection.
3 THE COURT: Overruled.
4 BY MR. WILLIAMS:
5 Q Have you told everything that happened to you at
6 Little Rascals, Brian?
7 A (Nods head).
8 Q Have you told everything here in court that happened
9 to you?
10 Do you remember telling your mamma that -- that Mr.
11 Bob put his finger in your hiney?
12 MR. MILLER: Objection.
13 A (Nods head).
14 THE COURT: Overruled.
15 BY MR. WILLIAMS:
16 Q Did you tell your mamma that, Brian?
17 A Yes.
18 Q Did he do that, Brian?
19 A Yes.
20 Q Did he do that at Little Rascals, Brian?
21 A Yes.
22 Q Okay. Now, take Killer down so we can hear you. Do
23 you remember telling your mommy that Mr. Bob stuck his ding
24 dong in your mouth?
25 MR. MILLER: Objection.
1 THE COURT: Overruled.
2 A (Shakes head).
3 BY MR. WILLIAMS:
4 Q You didn't tell you mamma that?
5 A Uh-uh.
6 Q Did Mr. Bob do that?
7 A Uh-huh.
8 Q Do you remember telling Matthew that you had to stand
9 -- everybody had to stand in line and touch Mr. Bob's ding
10 dong?
11 MR. MILLER: Objection.

12 THE COURT: Overruled.
13 A (Nods head).
14 BY MR. WILLIAMS:
15 Q Did everybody have to stand in line and do that,
16 Brian?
17 A Yes.
18 Q Did you have to stand in line and do that?
19 A (Shakes head).
20 Q Did you see that happen?
21 A No.
22 Q Okay. How do you know it happened?
23 A Because.
24 Q Because why?
25 A Because I saw them doing it.
1 Q You saw them do it?
2 A (Nods head).
3 Q Brian, do you remember one -- one morning when you
4 woke up and your mamma came into the room and you were just
5 laying there in bed looking up at the ceiling?
6 A (Nods head).
7 Q Do you remember that, and your mamma asking you what
8 you were thinking about?
9 A (Shakes head).
10 Q Do you remember telling your momma that you were
11 thinking about all the bad things that happened at Little
12 Rascals?
13 MR. MILLER: Objection.
14 THE COURT: Overruled.
15 BY MR. WILLIAMS:
16 Q Do you remember that Brian?
17 A (Shakes head).
18 Q You told your mamma that day that Mr. Bob stuck his
19 finger in your hiney, didn't you?
20 MR. MILLER: Objection.
21 THE COURT: Overruled.
22 A (Nods head).
...
15 Q Do you remember your mamma asking you if you ever had
16 to touch Mr. Bob?
17 MR. MILLER: Objection.
18 A Uh-uh.
19 THE COURT: Overruled.
20 BY MR. WILLIAMS:
21 Q Did you ever have to touch Mr. Bob?

22 MR. MILLER: Objection.
23 THE COURT: Overruled.
24 BY MR. WILLIAMS:
25 Q What did you say, Brian?
1 A No.
2 Q You never had to touch him anywhere?
3 A (Shakes head).
4 Q Okay. Did Mr. Bob make you touch him somewhere?
5 A Uh-uh.
6 Q Do you remember your mamma asking you if you ever had
7 to touch Mr. Bob's ding dong and you telling her that you
8 had to touch it with your hand?
9 MR. MILLER: Objection.
10 A (Nods head).
11 THE COURT: Overruled.
12 BY MR. WILLIAMS:
13 Q Do you remember that, Brian?
14 A Yes.
15 Q And did you have to touch Mr. Bob's ding dong with
16 your hand?
17 MR. MILLER: Objection.
18 THE COURT: Overruled.
19 A (Shakes head). Uh-uh.
20 BY MR. WILLIAMS:
21 Q You did not?
22 A (Shakes head).
23 Q Do you remember your momma asking you if you touched
24 him with anything else besides your hand?
25 A Uh-huh.
1 Q Do you remember turning around and licking your lips,
2 Brian?
3 MR. MILLER: Objection.
4 THE COURT: Overruled.
5 A (Shakes head).
6 BY MR. WILLIAMS:
7 Q Do you remember telling your momma that he made you
8 put your mouth on it?
9 MR. MILLER: Objection.
10 A Uh-uh.
11 THE COURT: Overruled.
12 BY MR. WILLIAMS:
13 Q Brian, are you saying you don't remember these things
14 or you don't want to talk about it?
15 MR. MILLER: Objection.

16 A Don't remember.
17 THE COURT: Overruled.
18 BY MR. WILLIAMS:
19 Q You don't remember? Are you saying they didn't
20 happen or you don't want to talk about it?
21 A Just don't remember.
22 Q You don't remember?
23 A (Shakes head).
24 Q Okay. When you told your mamma these things were you
25 telling the truth?
1 A Yes.
2 Q When you told Michelle these things were you telling
3 the truth?
4 A Yes.
5 Q Do you remember one night in the restaurant with your
6 Nonna?
7 A Yes.
8 Q Do you remember what you told your Nonna that Mr. Bob
9 does?
10 A Uh-uh.
11 Q Do you remember telling your Nonna that Mr. Bob puts
12 his figure in your hiney?
13 MR. MILLER: Objection.
14 A Yes.
15 THE COURT: Overruled.
16 BY MR. WILLIAMS:
17 Q You did tell your Nonna that?
18 MR. MILLER: objection.
19 A Yes.
20 THE COURT: Overruled.
21 BY MR. WILLIAMS:
22 Q And did Mr. Bob do that?
23 A Yes.

(Example #2)

25 Q Okay. Do you remember telling Ms. Judy that you had
1 to lay on top of Brooke?
2 MR. MILLER: Objection.
3 THE COURT: Overruled.
4 A No, sir.
5 BY MR. WILLIAMS:
6 Q Did you have to lay on top of Brooke?
7 A Um, yes, sir.

8 Q And when you were laying on top of Brooke, where was
9 your private?
10 a I forgot.
11 Q Do you remember telling Ms. Judy that you had to put
12 your private next to her private?
13 MR. MILLER: Objection.
14 THE COURT: Overruled.
15 BY MR. WILLIAMS:
16 Q Did you have to do that, Adam?
17 A No, sir.
18 Q What did you say?
19 A No, sir.
20 Q Did you say no or yes?
21 A Yes, sir.
22 Q What's the truth, now?
23 A Yes, sir.
24 Q Okay. You had to put your private next to Brooke's
25 private?
1 A Yes, sir.

(Example #3 - This is the child's testimony that establishes the harmful potential of leading questions. Through leading questions, the child "testified" about an offense which was never charged and which had never been alleged in any of the child's previous "statements" to therapists, parents or prosecutors. What actually occurred is that the prosecutor became confused about the offense and behavior she wished the child to acknowledge, and she reversed the offense conduct. Instead of asking the child about "Mr. Bob licking" the child's hiney, the prosecutor asked the child if he had to lick Mr. Bob's hiney. It didn't bother the child at all to say "yes" to the leading and suggestive question. The pertinent portion is highlighted.)

8 Q Do you remember telling your momma about having to
9 put your penis in Mr. Bob's mouth?
10 MR. MILLER: Objection.
11 A No, ma'am.
12 THE COURT: Overruled.
13 BY MS. LAMB:
14 Q Did that happen to you, did you ever -- did Mr. Bob
15 ever make you put your penis in his mouth?
16 A Yes, ma'am.
17 Q And you told Doctor Betty about this?
18 A Yes, ma'am.
19 Q And you told your momma about it, too, didn't you?

20 A Yes, ma'am.
21 Q And do you remember Mr. Bob ever -- whether Mr. Bob
22 ever put his penis in your mouth?
23 A No, ma'am.
24 Q You don't remember that?
25 A No, ma'am.
1 Q Did Mr. Bob ever put his penis in your mouth and you
2 didn't want that to happen?
3 MR. MILLER: Objection.
4 THE COURT: Overruled.
5 BY MS. LAMB:
6 Q You said what now?
7 A Yes, ma'am.
8 Q And did he do something when he put his penis in your
9 mouth?
10 A No, ma'am.
11 Q Did you tell your mother about that happening to you?
12 A Yes, ma'am.
13 Q And do you remember a time where you ever had to do
14 anything to Mr. Bob's hiney with your mouth?
15 A No, ma'am.
16 Q Do you remember telling Doctor Betty that one time
17 you had to lick Mr. Bob's hiney?
18 MR. MILLER: Objection.
19 THE COURT: Overruled.
20 BY MS. LAMB:
21 Q Did that happen? Did you ever have to do that that
22 you didn't want to do it?
23 A Um, yes, ma'am.

IV. PRIVILEGE

Relevant evidence that is privileged is not discoverable unless the interests of justice outweigh the privilege. *Shellhorn v. Brad Ragan, Inc.*, 38 N.C. App. 310, 248 S.E. 2d 103, *disc. review denied*, 295 N.C. 735, 249 S.E.2d 804 (1978). Too often, counsel becomes embroiled in a "Catch 22" situation with regard to discovering and using evidence which may be subject to a privilege. Until the material subject to a claim of privilege is reviewed by one with a sensitivity to an advocate's needs and strategies, it is difficult for a Court to determine relevancy and the "interests of justice", and the privilege is used as a sword/shield to prevent or frustrate this review.

Typically, trial counsel will want to review all of the medical, psychological, counseling, therapy, and social services records for a child. All of these records will be subject to a claim of privilege which must be overcome, either by means of statutory pretrial discovery, "interest of justice claims", or constitutional assertions.

In the *Kelly* case, the State provided very limited pretrial discovery with regard to medical or therapy records. Only specially prepared "summaries" (orchestrated by the prosecutors) of therapy were delivered. The session notes and underlying data were not provided. No social services records or records of interviews of the children were provided pretrial. Although Judge Bradford Tillery, the original trial judge assigned to the case, had ordered a pretrial *in camera* review of all of the "privilege" evidence which contemplated a more thorough pretrial disclosure of evidence, his orders were disregarded by the State and the new trial judge assigned in the matter. Every effort by the defense to obtain more complete information pretrial, and at trial, was resisted. While this might not be as problematical in a case involving 1 or 2 children, cases involving allegations of multiple victims, and multiple perpetrators, and multiple interviewers, and more than 400 charged offenses (Mr. Kelly was charged with in excess of 245 offenses involving 30 children) present special considerations and concerns if anything approaching a fair trial and competent defense is to be assured.

If one is to have any hope of offering a jury an explanation and proof of defenses based on suggestibility, improper interviewing techniques, contamination of stories and memories, and social contagion and hysteria, it is absolutely essential that the information supportive of these defenses be obtained, notwithstanding the fact that much of the information may be privileged.

Rule 501 of the Rules of Evidence prescribes that privileges other than those constitutionally protected shall be determined by State law under existing statutory and common law. Chapters 7A and 8 of the General Statutes codify and establish a variety of privileges concerning information gained by physicians, clergymen, psychologists, marital/family therapists, social workers, school counselors and counselors in the course of rendering professional services. Rule 104 (a) provides that the Court shall determine whether a privilege exists.

A. Is There a Privilege?

G.S. 8-53.1, 8-53.3, and 7A-551 expressly state that the physician-patient and the psychologist-client privileges do not apply to exclude evidence of abuse or neglect in any judicial proceeding in which a juvenile's abuse or neglect is in issue. "In essence, the physician-patient privilege [and psychologist-client privilege are] not available in cases involving child abuse." *State v. Eford*, 309 N.C. 802, 309 S.E. 2d 228 at 230 (1983); *accord*, *State v. Etheridge*, 319 N.C. 34, 352 S.E. 2d 673 (1987).

This statutory abrogation of the privileges is not limited to any particular parties' use or benefit, and applies equally in favor of the defendant according to the statutory grant and language. Thus, a valid argument exists that there is no privilege under the express terms of NCGS 7A-551.

An additional basis for contending that no privilege exists may arise when the prosecution "creates" the relationship giving rise to the claim of privilege. Where an examination or evaluation of a child is for trial purposes, i.e., preparing evidence, the privilege should not exist. The privilege is intended to protect only those communications which are necessary for obtaining the benefits of the professional relationship, not the benefits of producing expert evidence or opinions for prosecution. When a prosecutor or other governmental agent/investigator/officer selects, appoints, or makes a referral to a therapist or medical doctor for the purpose of deriving some evidentiary benefits, the information secured should not come within any privilege. See 8 Wigmore, **EVIDENCE**, §2383 (McNaughton Revision); *State v. Hollingsworth*, 263 NC 158, 139 SE 2d 235 (1964); McCormick, **EVIDENCE**, §102; *State v. Jensen*, 174 NW 2d 226, 230 (Minn. 1970); *State v. Clark*, 301 NC 176, 270 SE 2d 425 (1980).

B. Is There a Waiver of the Privilege?

Privileges can be waived by disclosures, as well as by express or implied conduct indicating a waiver. See 1 Brandis, **NORTH CAROLINA EVIDENCE** §54, §63 n.57 (3rd Ed. 1988); *Cates v. Wilson*, 321 NC 1, 361 SE 2d 734 (1987); *Neese v. Neese*, 1 NC App 426, 161 SE 2d 841 (1968).

In *Cates*, the North Carolina Supreme Court made clear that the physician-patient privilege is not absolute, that the privilege is not held by the provider of services, that if any of the privileged relationship information is disclosed the privilege "evaporates", and that one cannot assert the privilege so as to permit disclosure of some information and prevent disclosure of other information.

When, however, the the patient breaks the fiduciary relationship with the physician by revealing, or permitting the revelation of, the substance of the information transmitted to the physician, the patient has, in effect, determined it is no longer important that the confidences which the privilege protected continue to be protected. Having taken this position, the (patient) may not silence the physician as to matters otherwise protected by the privilege. ... (W)e find no statutory basis for allowing a patient to waive his privilege as to information gained by his physician while maintaining it as to his physician's opinions. ... A patient who discloses that which he has a right to keep confidential loses the right to claim the statute's protection. ... (Patients may not) use the privilege offensively to suppress the truth in litigation.

Cates v. Wilson, 321 NC 1, 361 SE 2d 734, 742-743 (1987).

In *Kelly*, the children (through their parents) permitted disclosures of their privileged information to numerous third-parties, but refused disclosure to the defense.

C. Is Disclosure of Privileged Material Necessary to a Proper Administration of Justice?

Each statutory privilege set forth in Chapter 8 contains authority to void the privilege in the interest of justice, and authorizes a presiding or resident judge to compel disclosure, prior to trial. If a fair trial is "a proper administration of justice", then it can be forcefully argued that the privilege should not exist, particularly in child abuse litigation where a decision has been made to involve the child's purported statements or evaluations in the litigation. Even posing the question seems a rhetorical exercise.

The trial court is afforded wide discretion in determining what is necessary for a proper administration of justice. "Judges should not hesitate to require the disclosure where it appears to them to be necessary in order that the truth be known and justice be done." *Sims v. Charlotte Liberty Ins. Co.*, 257 NC 32, 39, 125 SE 2d 326, 331 (1962), quoted with approval in *State v. Efird*, 309 NC 802, 309 SE 2d 228 (1983).

The court has the inherent authority to compel disclosures in the proper administration of justice and prior to any hearing or trial, in addition to the statutory grant of authority. *State v. Taylor*, 327 NC 147, 393 SE 2d 801 (1990); *In re: Superior Court Order*, 315 NC 378, 338 SE 2d 307 (1986).

D. Do Constitutional Rights Mandate Disclosures of Privileged Information?

An accused has state and federal constitutional rights to due process, confrontation and compulsory process which are considered fundamental to a fair trial. See, *Pointer v. Texas*, 380 US 400, 403, 85 S Ct 1065, 1067 (1965). The rights of confrontation and to compulsory process consist of more than just the opportunity to confront witnesses physically - they extend and secure to a defendant the opportunity to cross-examine witnesses and to expose facts from which jurors could draw inferences relating to a witness' reliability. *Davis v. Alaska*, 415 US 308, 94 S Ct 1105 (1974). The right of confrontation is an absolute right which mandates that a defendant must be accorded a fair opportunity to investigate and produce evidence, and to prepare and present his defenses. *State v. Watson*, 281 NC 221, 188 SE 2d 289 (1972); *State v. Whitfield*, 206 NC 696, 175 SE 93 (1934); *State v. Whisnant*, 271 NC 736, 157 SE 2d 545 (1967); *State v. Kelly*, 554 A 2d 632 (R.I. 1989); *Hospital Corporation v. Superior Court*, 157 Ariz. 210, 755 P 2d, 1198 at 1202-1203 (1988); *Sledge v. State*, 763 P 2d, 1364 (Alaska 1988); *Commonwealth v. O'Brien*, 27 Mass App Ct 184, 536 NE 2d 361 (1989).

Certain principles have remained relatively immutable in our jurisprudence. One of these is that where governmental action seriously injures an individual, and the reasonableness of the action depends on fact findings, the evidence used to prove the government's case must be disclosed to the individual so that he has an opportunity to show that it is untrue. While this is important in the case of documentary evidence, it is even more important where the evidence consists of the testimony of individuals whose memory might be faulted or who, in fact, might be perjurers or persons motivated by malice, vindictiveness, intolerance, prejudice, or jealousy. We have formalized these protections in the requirements of confrontation and cross-examination.

Greene v. McElory, 360 US 474, 496, 79 S Ct 1400, 1413 (1959).

The rights of due process and of confrontation have been held paramount to doctrines of confidentiality and privilege. *Davis v. Alaska, supra*. In *United States v. Nixon*, the U. S. Supreme Court held that the privilege and privacy rights of the President of the United States must yield to the due process, confrontation and compulsory rights of an accused defendant in a criminal proceeding.

The right to production of all evidence at a criminal trial has constitutional dimensions. The Sixth Amendment explicitly confers upon every defendant in a criminal trial the right "to be confronted with the witnesses against him" and "to have compulsory process for obtaining witnesses in his favor". Moreover, the Fifth Amendment also guarantees that no person shall be deprived of liberty without due process of law. It is the manifest duty of the courts to vindicate those guarantees, and to accomplish that it is essential that all relevant and admissible evidence be produced.

...

The interest in preserving confidentiality is weighty indeed and entitled to great respect. ... On the other hand, the allowance of the privilege to withhold evidence that is demonstrably relevant in a criminal trial would cut deeply into the guarantee of due process of law and gravely impair the basic function of the courts. ... (T)he constitutional need for production of relevant evidence in a criminal proceeding is specific and central to the fair adjudication of a particular criminal case in the administration of justice.

United States v. Nixon, 418 US 683, 711-713, 94 S Ct 3090, 3109-3110 (1974).

A witness' privileges and right to privacy must be weighed against and subordinated to a criminal defendant's right to bring exculpatory facts to the jury's attention. See, for example, *Pennsylvania v. Ritchie*, 480 US 39, 107 S Ct 989 (1987); *State v. Bailey*, 89 NC App 212, 365 Se 2d 651 (1988); *Pennsylvania v. Lloyd*, 567 A 2d, 1357 (Pa. 1989); *State v.*

Hufford, 533 A 2d 866 (Conn. 1987); *Massachusetts v. Jones*, 535 NE 2d 221 (Mass. 1989).

In balancing these competing interests, courts have utilized *in camera* reviews of the confidential or privileged information for the purpose of determining information necessary to protect and preserve a defendant's constitutional rights and defense. These reviews have been based upon federal constitutional due process principles (See *Ritchie, Jones, Hospital Corp.*, and *Bailey, supra*), as well as on independent state constitutional due process, confrontation, and compulsory process requirements (See *Lloyd, Hospital Corp., Kelly*, and *Hufford, supra*). In each of the cited cases, only a minimal showing of need by the defendant was required before the court became obligated to undertake the review of the privileged materials. See also, *State v. Paradee*, 403 NW 2d 640 (Minn. 1987); *State v. District Court*, 795 P 2d 525 (Okla. Ct. Cr. App. 1990). In *Bailey*, the North Carolina Court of Appeals stated that the "trial court (has an) obligation to release information material to the fairness of the trial". *State v. Bailey*, 89 NC App 212, 365 SE 2d 651, 657 (1988). The trial court is mandated to protect a criminal defendant's constitutional rights, and it is reversible and prejudicial error if the court fails to do so. See *State v. Voncannon*, 49 NC App 637, 272 SE 2d 153 (1980) and 302 NC 619, 276 SE 2d 370 (1981).

E. Should Child Witnesses Be Required to Undergo Evaluation by Defense Experts?

A large portion of the foundation for child sex abuse prosecutions is dependent upon professional examinations and evaluations of the child witness. These examinations and evaluations by purported experts are usually conducted for the purpose of corroborating the child's statements concerning the alleged events, and for the purpose of developing expert opinion evidence which may be presented at trial. The "experts" who examine the children on behalf of the State become allies of the prosecutor. They assist in collecting statements and allegations in support of the prosecution, and frequently participate in the formulation of prosecution strategies and evidence.

In *Kelly*, the therapists were chosen from "approved" lists and by recommendations of the prosecution team. These therapists then proceeded to collect allegations using interviewing and "therapeutic" methods which have been severely criticized in the scientific and professional literature. Each of the defense experts who reviewed the records which were provided during the course of the trial were shocked by the poor quality and methodology employed by the state's experts. All agreed that the methods used by the state's therapists (who were paid by a unique application of state funding) were likely to cause false allegations of abuse. All developed independent opinions that the children's allegations were probably false.

The defense attempted to obtain an order of the court compelling the children to submit to independent evaluations by defense experts in psychology and pediatrics. The parents and the state objected to this request, and the Court denied the defense motion.

Without access to the children, how does a defendant establish a critical part of a viable defense that no abuse occurred, that the children's statements are the product of influence or suggestion, that experts disagree in their opinions regarding whether a child has been abused, and that the physical medical evidence does not support a medical diagnosis of sexual abuse?

At present, in North Carolina, an accused is at a severe disadvantage in presenting any defense dependent upon evaluations or examinations of children. See *State v. Fletcher*, 322 NC 415, 368 SE 2d 633 (1988), *State v. Looney*, 294 NC 1, 240 SE 2d 612 (1978), *State v. Clontz*, 305 NC 116, 286 SE 2d 793 (1982), *State v. Joyce*, 97 NC App 464, 389 SE 2d 136 (1990), and *State v. Hewitt*, 93 NC App 1, 376 SE 2d 467 (1989) which appear to close the door on any independent defense evaluations or examinations of alleged child victims. (However, note Chief Justice Exum's persuasive concurring opinion in *Looney* and his dissent in *Clontz*, which support discretionary authority in the trial court to order such examinations. Also language in *Hewitt* appears to hold that the authority exists upon a sufficient showing of need for the examination. Finally, compare the decision in *State v. Hunt*, 64 NC App 81, 306 SE 2d 81 (1983) *discr. rev. denied* 309 NC 824, in which the Court held that where questions concerning a witness' "mental reliability, stability, and suggestibility" were raised, a defendant was constitutionally entitled to an independent psychiatric examination of the witness!) This is an area of the law which is undergoing substantial development and "re-thinking" in large measure because of the explosion in child abuse litigation.

Recently, the New Jersey appellate courts have reversed that state's prior decisions and have held that defense access for evaluations of children in criminal cases can be mandated under constitutional provisions. See *State of New Jersey v. Margaret Kelly Michaels*, 1993 Superior Court Appellate Division Slip Opinion, Docket No. 199-88T4; *State of New Jersey v. D.R.H.*, decided April 2, 1992, Supreme Court of New Jersey Slip Opinion; No. A-26. In *D.R.H.*, the Court held that trial courts may order the physical examination of a child sex-abuse victim by defense experts only when satisfied that the defendant has made a sufficient showing that such an examination can produce competent evidence that has substantial probative worth, and if admitted and believed by the jury, that evidence would refute or neutralize incriminating evidence or impugn the credibility of prosecution witnesses.

Many other jurisdictions permit a trial court to order a prosecuting witness to submit to defense examinations and evaluations. See numerous case citations in *State v. Clontz*, 286 SE 2d at 796. In child sexual abuse cases, where expert testimony is often crucial and frequently used to "diagnose" the offense, it is time for the North Carolina courts to acknowledge the necessity and entitlement for independent defense evaluations of the child.

V. CHILD HEARSAY ISSUES.

Often an effort is made to offer as evidence the out of court statements of a child who has not testified either because they have been deemed incompetent to be a witness or a

decision has been made that it is preferable to avoid having the child testify. In such situations, the rules governing hearsay exceptions become a focal point in the defense. In criminal cases, the constitutional right to confrontation imposes some additional restraints on the exceptions which are not "firmly-rooted". See *In re Lucas*, 94 NC App 442, 380 SE 2d 563 (1989)[Decided prior to *Idaho v Wright*]; *Idaho v. Wright*, 110 S. Ct. 3139 (1990); *White v. Illinois*, 116 L. Ed. 2d 848 (1992). As suggested by *Lucas*, deciding which of the statutory hearsay exceptions, or which portions of an exception, are "firmly-rooted" may be a determinative issue when applying the confrontation clause hearsay rules to child statements. Statements falling within "firmly-rooted" exceptions are presumptively (not conclusively) reliable; those within the "unrooted" exceptions are presumptively unreliable, and reliability of the statement must be proven from the totality of the circumstances surrounding the making of the statement. Other corroborative evidence cannot be used to establish or bolster reliability of an "unrooted" statement. Are child statements to psychologists or social workers or psychiatric nurses "firmly-rooted"? Are statements of "identity", "cause", or "fault" and statements made for the purpose of "diagnosis" within the firmly-rooted exceptions?

A. Hearsay Exceptions

Many child sex abuse cases are tried without the appearance of the principal witness -- the child. One "lesson" of the *Kelly* case is that more prosecutions may involve the appearance and testimony of the child. Twelve child witnesses testified. All twelve were well-prepared for their testimony, having attended "court school" and frequent preparatory meetings with counselors and prosecutors. None seemed traumatized by the experience.

Contrary to the fears expressed by some, the alleged victims may speak more; however, it is doubtful that the traditional hearsay witnesses will speak any less. See Billings, C.J., dissent in *State v. Aguallo*, 317 NC 590, 603, 350 SE 2d 76, 83 (1980) and Widenhouse, "The Victim Speaks No More", 16 *NCATL TrialBriefs* 9 (1985).

Children can be very compelling witnesses, not so much for what they testify about, but simply for the impact their testimony provides and the doors opened for "corroboration" by other witnesses, including emotional parents. The hearsay exceptions will remain useful prosecution tools, but may become more important as strategical reinforcement of the child's trial testimony. In *Kelly*, hearsay statements of the children were admitted principally as corroboration [North Carolina has an extremely lenient rule concerning corroboration - see *State v. Ramey*, 318 NC 457, 349 SE 2d 566 (1986)] and pursuant to the medical diagnosis/treatment exception. Corroborative hearsay is not "substantive" evidence; hearsay exception evidence is substantive and need not be corroborative at all. †

Still, one should anticipate the likelihood of encountering the child's statements through "hearsay" witness' testimony rather than from the child. In this regard, the three most frequently used hearsay exceptions in child sexual abuse cases are the "excited utterance", the medical diagnosis or treatment, and the "residual" exceptions. †

The rationale underlying the hearsay exceptions is that some statements have sufficient circumstantial guarantees of trustworthiness (indicia of reliability) adequate to permit the judge/jury to hear the statement through some witness other than the declarant and to make an independent assessment of credibility. *State v. Vestal*, 278 N.C. 561, 180 S.E. 2d 755 (1971), cert. denied, 414 U.S. 874; *Brandis on North Carolina Evidence*, §144 (2d Ed. 1988).

The hearsay exceptions present unique problems when applied to statements by children, and the underlying rationale for admissibility is often nonexistent. For example, what impact does the "excitement" of an event have upon the accuracy or truthfulness of a child's statement? Does a three or four year old child really understand the necessity for truthfulness when speaking to a doctor or psychologist so that he will receive proper treatment?

A related concern is the use of the hearsay exceptions to promote goals never intended by the underlying rationale. At a recent seminar, individuals involved in the medical examination of children for sexual abuse encouraged the attendees (social workers, prosecutors, therapists, parents, medical doctors) to tell the examining doctor anything they want incorporated in the medical history so that the physician could then testify to those matters on behalf of, and in the place of, the child.

Often the argument is advanced that we should be liberal in allowing hearsay statements by children in order to avoid unnecessary trauma to the child by compelling them to appear and testify in court. There is little in the scientific literature that addresses the question of what impact giving testimony has upon a child. What has been published provides little empirical data to support a general conclusion that testifying is harmful to a child. In fact, one study has found that juvenile court testimony may be therapeutic and cathartic for the child rather than harmful. (The same study found that children tend to be adversely affected by lengthy delays in resolution of the case rather than by having to testify). Runyan, D. et al., *Impact of Legal Intervention on Sexually Abused Children*, 113 *J. Pediatrics* 647 (1988).

1. Excited Utterances

The "excited utterance" exception to the hearsay rule is codified as Rule 803(2) of the Rules of Evidence. The rule provides for the admission of a statement, relating to a startling event or condition, made while the declarant was still under the stress of excitement caused by the event or condition. In *State v. Smith*, 315 N.C. 76, 337 S.E. 2d 833 (1985), the Court reviewed cases from other jurisdictions applying this exception to children's statements and held that a statement made to the child's grandmother two to three days after the event was an "excited utterance". The rationale was that the judgment as to spontaneity should focus on whether the delay in making the statement provided an "opportunity to fabricate", rather than on the time lapse between the event and the statement. The Court also noted the statement of the Wisconsin Court of Appeals that a "broad and liberal interpretation" of the excited

utterance exception should be given when dealing with young children. The Wisconsin court apparently assumed that stress and spontaneity is often present for longer periods of time in young children than in adults. This assumption was in turn related to the court's "observations" that: (1) a child is likely to repress the incident; (2) the child is not likely to report this kind of incident to anyone but his/her mother; (3) the characteristics of young children tend to produce declarations free from conscious fabrication for a longer period of time after the event than with adults. *Smith, supra*, at 87-88.

These fanciful conclusions, while perhaps attractive to jurists, find little support in the scientific research dealing with the effect of stress upon children's ability to accurately recall and relate an event. See generally, Doris (ed.), The Suggestibility of Children's Recollections (APA 1991).

2. Medical Treatment or Diagnosis

Evidence Rule 803(4) permits the introduction of hearsay statements made for purposes of medical (and psychological) diagnosis or treatment and which describe:

- (1) medical history; or
- (2) past or present symptoms, pain, or sensations; or
- (3) the inception or general character or the cause or external source of any of the foregoing;
- (4) insofar as reasonably pertinent to diagnosis or treatment.

The Supreme Court has held that a grandmother's statement to a physician relating her grandchild's statements (double hearsay!) are admissible under this exception where the statements to the grandmother immediately resulted in the child receiving medical treatment. *State v. Smith, supra*. The Court also rejected the contention that identity of the perpetrator was irrelevant to medical diagnosis or treatment and held in *Smith* that it was permissible to allow the grandmother to testify to the child's statement as to the identity of the person who abused her.

Application of the medical diagnosis or treatment exception is particularly troubling with the very young child. There is a substantial question as to the extent to which the child appreciates the relationship between the statements made to the doctor and the treatment or diagnosis that will be received.

Frequently these exams are not performed so much for diagnosis or treatment as they are to gather or produce evidence. In the Little Rascals trial the primary medical testimony came from doctors who examined the children at the request or suggestion of the prosecution. Many of the children had been examined by their local board certified pediatricians before seeing the doctors called as prosecution witnesses. In some instances more than a year had elapsed since the alleged events for which the child was being examined. All of the children

had been extensively questioned by police, parents, social workers and "therapists" before their contact with the doctor. Factors such as these raise substantial questions as to whether the rationale for the exception is present in many sexual abuse cases involving young children.

Physicians who regularly perform this type of exam and appear as prosecution witnesses are well aware of this hearsay exception and the role it allows them to play in the trial of a case in which sexual abuse is alleged. Dr. Desmond Runyan, Director of the Child Medical Examiner Program has written that physicians should view court testimony as a means of protecting the child by corroborating or speaking for the child, and that the medical diagnosis exception allows physicians to play a special role in the introduction of evidence. The medical exam protocol at the UNC-Memorial Hospital clinic emphasizes to the child the medical importance of the exam for the purpose of ensuring that the hearsay exception can be used. Runyan, *Guidelines for Medical Testimony*, Feedback, November 1990.

In the same article, Dr. Runyan refers to the role of the medical exam in criminal cases and notes that it may help prompt the defense to plead. The rationale for the medical diagnosis or treatment exception is undermined when used by a physician as a prosecution or credibility tool to help fashion the nature and source of testimony at a future trial.

In the *Kelly* trial, the state's medical doctors' use of 803(4) statements to justify diagnostic statements of abuse were startling. In most instances, the only basis for a doctor's medical diagnosis of sexual abuse was a hearsay statement - there were absolutely no physical findings diagnostic of abuse.

There are several methods of attempting to exclude the admissibility of the medical treatment/diagnosis hearsay statements.

First, as suggested by Professor Robert Mosteller of Duke University in an excellent article analyzing Evidence Rule 803(4), [and as suggested in *In re Lucas, supra*] the statutory hearsay exception for medical "diagnosis" (as distinguished from "treatment") is not a "firmly-rooted" hearsay exception; therefore, statements made for the purpose of obtaining a "diagnosis" of sex abuse do not meet the constitutional requirements for admissibility under the Confrontation Clause hearsay rule, absent proof of "particularized guarantees of trustworthiness" based upon the "totality of the circumstances that surround the making of the statement." See Mosteller, "Child Sexual Abuse and Statements for the Purpose of Medical Diagnosis or Treatment", 67 *N.C. Law Review* 257 (1989); *Idaho v. Wright*, 497 U.S. ___, 110 S.Ct. 3139 (1990); *White v. Illinois*, ___ U.S. ___, 112 S.Ct. 736 (1992) (which overrules and denies any requirement under the Federal Confrontation Clause for "unavailability" determinations when firmly-rooted exceptions are involved); *State v. Roper*, 328 NC 377, 402 SE 2d 600 (1991); *In Re Lucas*; 94 NC App 442, 380 SE 2d 563 (1989). [For a description of some factors to be considered in determining whether hearsay statements possess indicia or guarantees of trustworthiness, see *Idaho v. Wright, supra*; *State v. Stutts*,

105 NC App 557, 414 SE 2d 61 (1992); *State v. Roper*, 328 NC 337, 402 SE 2d 600, 613 (1991).].

Second, if the statement wasn't really made for medical diagnosis or treatment, but was made to provide evidence for the State's use in its prosecution, AND IT CAN BE PROVED, then the statement will not be admissible. The appellate courts have given some guidance as to pertinent factors to be considered in making this determination. See *State v. Stafford*, 317 NC 568, 346 SE 2d 463 (1986); *In Re Lucas*, supra; *State v. Jones*, 89 NC App 584, 367 SE 2d 139 (1988); and, *State v. Reeder*, 105 NC App 343, 413 SE 2d 580, 585 (1992).

Third, if the statement was made after the physical examination instead of prior to the exam (*Smith*), or if made to a physician after having been treated for the condition on a prior occasion (*Hollingsworth*), or if it was made to someone who was not part of the "medical evaluation team" (*Smith*), it may not be admissible. *State v. Smith*, 315 NC 76, 337 SE 2d 833 at 840 (1985); *State v. Hollingsworth*, 78 NC App 578, 337 SE 2d 674 (1985).

Finally, if the statement attributes fault or identifies a perpetrator, that portion may be attacked as not being pertinent to medical diagnosis or treatment. However, under certain circumstances, our Supreme Court has held that statements identifying the alleged perpetrator are admissible under the medical exception. *State v. Aguillo*, 318 NC 590, 350 SE 2d 76 (1986). It is submitted that a proper analysis of the historical foundation for this decision ought to limit its application to incest-type cases only. Citing an 8th Circuit federal appellate court decision, *US v. Renville*, our Supreme Court allowed such statements to be admitted under Rule 803(4) reasoning that: 1) a proper "diagnosis" of a child's psychological problems will often depend on the abuser's identity; and, 2) information that the abuser is a member of the child's household is pertinent to the course of "treatment" that includes removing the child from the home. The *Aguillo* case involved a household member who was accused of the abuse. The *Renville* decision, which formed the basis for the *Aguillo* holding, made clear that it was "creating" an exception to the general rule of inadmissibility of such statements in the "unique context" of child abuse where the named abuser was a member of the child's immediate household. *US v. Renville*, 779 F.2d 430, 436-438 (8th Cir. 1985). See also, *US v. Iron Shell*, 633 F.2d 77, 84 (8th Cir. 1980). Properly applied, this judicially created "exception" should be invoked only for identifications of household or family members, and should not extend to identifications of non-family or non-household members. Professor Mosteller concludes statements of identity should be admitted only if they are relevant to the perceived selfish interest of the declarant to receive treatment.

3. Residual Exceptions

Rules 803(24) and 804(b)(5) are referred to as the "residual exceptions" to the hearsay rule. The two rules are identical except that "availability" of the witness to testify is irrelevant under 803(24).

Rule 804 mandates that a witness be "unavailable", as defined in 804(a), before the residual exception under 804(b)(5) may be utilized.

State v. Smith, supra, set forth the procedure and the mandatory findings that the trial court must follow before a statement may be admitted under 803(24). *State v. Triplett*, 316 N.C. 1, 340 S.E. 2d 102 (1986) holds that the same findings must also be made under 804(b)(5) in addition to a determination of "unavailability". The requirements set forth in *Smith* are:

- a. Has proper notice been given?
- b. Is the hearsay not specifically covered elsewhere?
- c. Is the statement trustworthy?
- d. Is the statement material?
- e. Is the statement more probative on the issue than any other evidence which the proponent can procure through reasonable efforts?
- f. Will the interests of justice be best served by admission?

A finding unsupported by the record may constitute reversible error, and a failure to make the findings is reversible error. *Smith, supra. In re Gallinato*, 106 N.C. App. 376, 416 S.E. 2d 601 (1992).

These Rules can have an interesting interplay when a child is held to be unavailable as a witness because incompetent to testify.

In *State v. Stutts*, the trial court conducted a voir dire to determine whether a 4 year old child's hearsay statements to adults should be admitted under Rule 804(b)(5), the "residual exception" which requires unavailability of the witness. The trial court found the child unavailable to testify because she could not understand the difference between truth and falsehood and because she was unable to understand what is reality and what is imagination. The trial court then found that the child's hearsay statements possessed the required guarantees of trustworthiness and admitted them through the testimony of three adult witnesses. On appeal, the Court of Appeals held the findings of the trial court to be "inconsistent", stating as follows:

It is illogical that one be held unavailable to testify due to an inability to discern truth from falsehood or to understand the difference between reality and imagination and yet have their [earlier] out-of-court statements ruled admissible because they possess circumstantial guarantees of trustworthiness. The very fact that a potential witness cannot tell truth from fantasy casts sufficient doubt on the trustworthiness of their out-of-court statements to require excluding them. We hold that finding a witness unavailable to testify because of an inability to tell truth from fantasy prevents that witness' out-of-court statements from possessing guarantees of trustworthiness to be admissible at trial under the residual exception set forth in Rule 804(b)(5).

State v. Stutts, 105 N.C. App. 557, 563, 414 S.E. 2d 61, 64-65 (1992). This decision seems to overrule (or overlook) several prior decisions in which an "incompetent" child was held to be "unavailable" and hearsay statements of the child were admitted through other witnesses. See, *State v. Deanes*, 323 NC 508, 374 SE 2d 249 (1988); *State v. Gregory*, 78 NC App 565, 338 SE 2d 110 (1985), *disc. rev. denied* 316 NC 382, 342 SE 2d 901 (1986), reversed on other grounds 900 F 2d 705 (4th Cir. 1990). [The concept of "unavailability" under the federal rules and constitution is now of no importance when "firmly-rooted" exceptions are involved. See *White v. Illinois*, 112 S Ct 736 (1992).]

Shortly after the decision in *Stutts*, the Court of Appeals distinguished its application. In *State v. Holden*, 106 N.C. App. 244, 416 SE 2d 415 (1992), a six year old rape victim's statement naming the defendant as her abuser was held to possess circumstantial guarantees of trustworthiness so as to be admissible under residual exception of Rule 803(24) when the child was found to be unavailable due to "fear and trepidation". The trial judge's statement that child "did not seem to understand the consequences of not telling the truth" standing alone and not made the basis for finding that the child was unavailable was insufficient to overcome the circumstantial indicia of reliability properly found by the trial judge.

The court distinguished the *Stutts* case, *supra*, on the basis that the child in *Stutts* was found unavailable because she could not distinguish truth from fantasy. Here the child was found unavailable because of fear and trepidation. The trial judge's statement that the child did not understand the consequences of not telling the truth was held insufficient to overcome the circumstantial indicia of reliability found by the trial judge in his order. It is difficult if not impossible to reconcile this holding with the language from *Stutts* that:

The very fact that a potential witness cannot tell truth from fantasy casts sufficient doubt on the trustworthiness of their out-of-court statements to require excluding them." *Stutts* at 563.

Although Judge Wells concurred in the result in *Holden* because the same evidence came in without objection through the mother and doctor, he found it difficult to distinguish *Holden* from *Stutts*.

Thus, any finding at the time of trial that a witness is "unavailable" based upon inability to understand the duty to tell the truth renders previous hearsay statements **untrustworthy** (unreliable) and inadmissible -- at least under the residual exceptions. The same reasoning and logic ought to apply to the "firmly-rooted exceptions".

B. Competency and "Firmly-Rooted" Exceptions

Interesting issues arise if a child was not competent as a witness at the time statements were made to a medical doctor or psychologist, but the statements are sought to be admitted at time of trial as hearsay exceptions and substantive evidence under Rule 803(4), and the

child is competent at the time of trial. How do you challenge the presumption of reliability and trustworthiness under the "firmly-rooted" exceptions?

At a minimum, based upon *Stutts*, the issue should be asserted and a request made for a preliminary determination under Rule 104(a). The "presumed" reliability extended to firmly-rooted exceptions should not be conclusive in a criminal trial. The presumed reliability of statements within the "firmly-rooted" hearsay exceptions is based upon the judicially-assumed premise that: (1) such statements have circumstantial guarantees of trustworthiness which exist at the time the statements are made; and, (2) that adversarial testing by cross-examination is expected to add little to a determination of the statements' reliability. Thus, any evidence of circumstances which might tend to show that the declarant was incompetent when statements were made should be admissible in a *voir dire* seeking to exclude such statements. If a declarant was incompetent when the statement was made, the circumstantial guarantees of trustworthiness underlying the presumed reliability disappear, and the statement should not be admissible. See *Huff v. White*, 609 F. 2d 286 (7th Cir. 1979) which was cited with approval in *State v. Smith*, 315 N.C. 76, 337 SE 2d 833 (1985).

C. Helpful Publications

For purposes of applying rules of law and evidence, counsel should consider and recognize the distinctions among the rules concerning "competency to be a witness", "unavailability as a witness", and "indicia of reliability/trustworthiness of statements" -- each has specific and distinct legal meanings and consequences when considering the Rules of Evidence, applicable constitutional requirements, and particular testimony.

The following materials are helpful for further reading on the hearsay problems in these cases.

1. Mosteller, "*Child Sexual Abuse and Statements for the Purposes of Medical Diagnosis or Treatment*", 67 *N.C. Law Review* 257 (1989).

2. Myers, et al. "*Expert Testimony in Child Sexual Abuse Litigation*" 68 *Nebraska Law Review* 1 (1989) [This is an excellent article covering legal issues relating to medical and psychological expert witness testimony. It was co-authored by a lawyer, pediatrician, psychologists, psychiatrist and social worker.]

3. Goldman, "*Not so 'Firmly Rooted': Exceptions to the Confrontation Clause*", 66 *N.C. Law Review* 1 (1987).

4. *State v. Barone*, Slip Opinion in No. 01-C-01-9008-CR-00196, Tennessee Court of Criminal Appeals, Nashville, Tennessee, filed Oct. 2, 1991. [Decision holds that statements to psychologists do not come within the medical exception to hearsay. Rule 803(4) is strictly construed.]

VI. FACTORS AFFECTING CREDIBILITY OF CHILD WITNESS

A. "Children Don't Lie About Sexual Matters"

The premise that children don't lie about sexual matters is the latest variation on the previous assertions and themes - "children don't lie" and "believe the children" - promoted in years past by some who dealt with allegations of child sexual abuse. The rationale for the premise is that very young children don't have sexual knowledge; therefore, if a child speaks of sexual matters or exhibits "sexual behavior" the child must have been exposed to sexual material or conduct at a minimum and sexual abuse at a maximum. In addition, some experts contend that "children lie to get out of trouble, and not to get into trouble."

This is another area where assertions by "experts" concerning what is and is not normal for a child of a given age find little support in controlled scientific studies of normative sexual behavior of children. Two of the studies which have been done in this area are included in the bibliography. (Friedrich; Gordon) These studies indicate that there is a fairly wide range of sexual behaviors and knowledge exhibited by children who are believed to be non-abused.

Given the present state of scientific knowledge in this area, it is not logical to assume that a particular sexual behavior is "abnormal" or that it is the product of sexual abuse. A related area of uncertainty is the extent to which sexual knowledge is learned by young children through exposure to either explicit or sexually suggestive materials on television, videos and movies. Studies indicate that children watch from 14 to 23 hours of television a week with the highest level among preschoolers. About a third of them do so without parental involvement in what they watch. Bernard-Bonin, et al., *Television and the 3- to 10-Year Old Child*, 88 *Pediatrics* 48 (1991).

Effective use of "learned treatise" evidence may be critical to educating jurors about the counter-intuitive "reality" of children's knowledge of sexual matters.

B. Suggestibility of Children

"Suggestibility" refers to the creation, distortion, or alteration of memory for an event, as well as situations where a child is motivated to say an event occurred despite the child's awareness that it did not. There are numerous psychological, cognitive and social factors which contribute to the suggestibility of children.

Children may be confused by negatively worded statements. They may also be eager to please, anxious to provide the "right" answer, and may have a tendency to choose either the first or the last option when given a number from which to select. Therefore, it is essential that clearly worded questions that encourage children to provide answers that will be viewed nonjudgmentally are used. **Correct answers or**

scenarios should not be suggested as children may be influenced and are prone to suggestibility.

The Child as a Witness, 89 *Pediatrics* 513, 514 (March 1992) [Emphasis added].

Two recent studies illustrate the suggestibility of children under circumstances that do not approach the level of intensity found in the investigation of an allegation of sexual abuse.

The first study has been referred to as the "Chester the Molester" study and involved 5 and 6 year old children. The study was designed to assess how children who experienced an ambiguous event interpreted that event after being interviewed in a suggestive manner. An individual posing as a janitor named Chester interacted with some of the children in the study by coming into the room and cleaning. While cleaning a doll he would engage the child in the event. He would say things such as: "This doll is dirty. I'd better see if it's dirty under here (picking up the dolls dress). I better straighten out its arm. I'd better clip off this thread".

Some of the other children saw a more malicious janitor who played with the doll saying things such as "I like to play with dolls. I like to spray them in the face with water. I like to look under their clothes."

The the children were interviewed on 3 separate occasions following their exposures to Chester. The first interview would either be neutral, or incriminating (suggesting that the janitor had played with the doll rather than having cleaned it), or exculpatory (suggesting that the janitor had not played with the doll but had only cleaned it). A second interview was then conducted which either matched the tone of the first interview or was in contrast to it. Finally the child's parent asked the child what the janitor had done with the doll.

The results showed that two-thirds of the children adopted the interviewer's interpretation of the event rather than reporting what had actually occurred. The inaccurate reports were maintained when they told their parents what they had seen. Ninety per cent (90%) of the children answered at least part of the final interview questions consistent with the manner in which they had been questioned rather than consistent with what they had actually observed. Goodman, et al., *Suggestibility In Children's Testimony: Implications for Sexual Abuse Investigations*, in The Suggestibility of Children's Recollections 92 (J. Doris ed. 1991).

The second study dealt with the issue of how repetitive suggestive questioning can affect a child's recall and statements about an event. (The study was conducted by Dr. Stephen Ceci at Cornell University and was the subject of testimony by Dr. Maggie Bruck in the Little Rascals Day Care trial.)

This study involved three to six year old children who attended a day care. A college student visited the daycare class twice a week for ten minutes during one month. During the

visits, the student talked to the children about his friend Sam Stone. Sam was portrayed in the conversations with the children as being a very clumsy individual who was always breaking or damaging something. At the end of the month, during a reading session, the student announces to the kids, "Hey, guess who's here? Here is my friend Sam Stone". Sam then stands up and says "Hi", and he looks at the book being read and he says, "That's a neat book." The visit is timed so that Sam is there for two minutes. The next day when the children come to school the book is ripped and a teddy bear that the children have never seen before has been soiled with melted chocolate and left in the classroom. The children are shown the book and the teddy bear and are asked if they know who did it.

Twenty-five per cent of the children initially say they don't know who did it, but express that it might have been Sam Stone. The children are interviewed for two minutes by the college student once a week for ten weeks. During the interviews, two misleading questions are used such as, "I wonder if Sam got Teddy dirty by accident or on purpose? I wonder what color pants Sam was wearing when he ripped up the book?" At the conclusion of the ten weeks, a new interviewer was introduced who tells the children that she has never been there before but she has heard that something happened in the classroom. The new interviewer asks if the children can tell her what happened. Seventy-five per cent (75%) of the three and four year old children said that Sam had ruined the teddy bear or the book. Half (50%) of the three and four year old children said that they saw Sam do it. The children then provided very elaborate details of what they believed had happened. They said things like: "Oh, yeah, I saw Sam do it. He took the paint brush and melted the chocolate and he painted it on the teddy bear." "Oh, he took the book into the bathroom and he soaked it until it fell apart." The children commented on where they had seen Sam - "in the bathroom", "in the hall", "in the housekeeping section", "at the corner store buying ice cream to melt all over the teddy bear...". They commented on Sam's actions - Some of them made claims that the teacher interacted with Sam, that he was very naughty and she put him in the time-out corner, or she asked him to leave because he was very naughty. Some of the children said that there wasn't just one Sam Stone, there were four Sam Stones. Some of the children claimed that Sam Stone had trashed the classroom. Some of the children claimed that Sam Stone actually came to their own houses. (This summary of the "Sam Stone" study is based on the testimony of Dr. Bruck in *State vs. Kelly*).

Only a small percentage of the five and six year old children claimed to have seen Sam damage the items. Although it appears that age plays a role in suggestibility, there are numerous studies showing that adults are also suggestible. (See the Loftus study cited in the Bibliography)

The Doris book provides an excellent discussion of suggestibility as it relates to children as witnesses. It can be ordered from **APA Order Department, P.O. Box 2710, Hyattsville, Maryland 20784.**

C. Creation, Alteration, Distortion of Memory

The accuracy of all unfabricated testimony concerning past events depends upon:

- (1) the ability to store and recall an initial accurate memory created by the impact of the event upon the senses; and,
- (2) the memory not becoming inaccurate as a result of distortion or alteration by the influence of either internal or external factors:

The event itself and other factors occurring at the time of the event may influence the accuracy of the original memory. An event is interpreted through the senses of the individual observing it, and is subject to interpretation in light of that individual's past experience. We do not remember every detail of a particular event. Core events, the central focus of an event, tend to be more memorable than peripheral details. Stress experienced at the time of the event has an impact on the ability to accurately recall the event. Some studies indicate that high levels of stress cause low levels of recall and greater susceptibility to suggestion. (Contrary to the rationale that underlies the "excited utterance" hearsay exception discussed earlier.)

Post-event factors, such as other events that occur during the passage of time after the event to be recalled, discussions with others about the event, and interviews about the event are all factors that carry the potential for altering the initial memory of the event.

Interviews are of particular concern in child sexual abuse cases because of the danger that suggestive or leading questioning during the interview process can produce false or exaggerated allegations of abuse. In this regard, see the scathing dissent of Justice Stewart in **State v. Bullock**, 791 P. 2d 155, 161-182 (Utah 1989) which contains a brilliant and insightful legal and scientific analysis of problems encountered.

Children in sexual abuse cases are frequently subjected to multiple interviews by parents, social workers, law enforcement officers, "therapists", lawyers, doctors, guardians, and others involved in the court process. Each interview carries the danger that, if improperly performed, it may suggest something to the child that never occurred.

Almost all professionals in the field will concede that interviewing children, particularly preschool children, is a very difficult task. Unfortunately, many people involved in the field are either not qualified to properly interview children or simply fail to conduct a proper interview.

The most critical interviews in a child sexual abuse case are the first interviews. All too often these are not properly conducted. Generally, there is little or no record of the initial interview other than conclusions of the interviewer or a summary statement. It can be very

difficult at a later time to determine the extent that the interview technique employed by the interviewer may have influenced the statements by the child.

1. Cognitive Problems

In any assessment of a child with regard to sexual abuse it is important to be aware of the fact that children are not miniature adults who utilize the same reasoning skills, perceptual abilities, and communication processes as adults. Children not only vary in chronological age, but in developmental age as well. At different ages and developmental stages their language and communication skills vary, their ability to reason in abstract terms and their ability to separate fantasy and reality vary. These factors must be assessed for each child as an individual.

2. Known or Intentional False Statements by Child

There are cases in which children consciously and intentionally make false allegations of sexual abuse to further their own motives or those of another person. There is some data that indicates that the highest rate of false allegations of sexual abuse may be in child custody cases. Custody cases are fertile ground for implanting the seeds that motivate a child to make or participate in making a false allegation of abuse.

It is important to consider whether a child has a motive to fabricate. The motives can be related to threats, avoidance of potential punishment, inducements or rewards, meeting perceived adult expectations, protection of others, winning admiration or interest of others, avoiding awkwardness or embarrassment, demonstrating power over an authority, peer pressures and conformity, revenge, concern about home stability or personal safety. Ekman, P., *Why Children Lie* (Scribners: New York 1989). "[C]hildren may be convinced that when a lie serves a 'noble purpose' they are not really doing something wrong." *The Child as a Witness*, 89 *Pediatrics* 513, 514 (March 1992).

The particular motivations for a child may be extremely simple, i.e. pleasing an adult, or more complex, i.e. conforming to group pressures. Frequently, the concern about false allegations of sexual abuse arise in connection with allegations that are induced by social or emotional factors.

Children being interviewed by a person of perceived authority provide "answers" in accord with what they perceive is expected, rather than in accord with what actually occurred. The perception of authority may be related to the official position of the interviewer, such as a police officer, but it can also occur simply because the interviewer is a "grown-up". The status of the interviewer can have an effect upon the responses of the child. This effect is further complicated and compounded if the interviewer uses repetitive questioning. Studies indicate that children often feel that if they are asked the same question more than once it is because they answered "wrong" at first. In such situations, the child is motivated to change the answer to that which they perceive is expected by the adult questioner.

There is an additional danger in repeated or extensive questioning that the child will assume the expectation for additional information, and will attempt to comply with the adult by producing more details without regard to accuracy.

Extended or repetitive questioning can in effect be coercive in that the child feels compelled to respond by giving whatever the interviewer is perceived as wanting.

3. Open-ended Questioning and Free Recall

Generally, the scientific studies indicate that permitting a child to tell what they know in a narrative form elicited by open-ended questions, such as "Tell me about your family?", "Tell me about that?", produce the most accurate recall. Although the information recalled is more accurate, the specific details elicited are fewer than in more directive, focused questioning.

Young children's communication and articulation skills on free recall are limited. As a result, studies reveal that even experienced child interviewers who have been cautioned not to use leading or suggestive questioning resort to such interview techniques with young children. The danger of leading or suggestive questions becomes increasingly great as the questions become more and more focused in an attempt to elicit information the child may have.

The younger the child, the more susceptible the child is to suggestion and memory or recall distortion; the younger the child, the more likely it is that the interviewer will resort to focused, directive, and suggestive questioning techniques that could contaminate the process.

4. Tone of Questioning

In addition to the nature of the questions, the emotional tone of the interviewer's questioning style can affect the information elicited and can affect accuracy. In the Little Rascals trial, after repeated questioning of her child, a mother became frustrated because he would not tell her that he had been abused at the day care. Mom began to cry in the child's presence causing the child to ask her why she was crying. When she told him that she was crying because he couldn't talk to her about Mr. Bob, the child looked at her and said, "I'll talk to you, mommy, but you talk." There was also testimony that the police officer who conducted the initial child interviews would on occasion do so "with tears in her eyes".

One does not need a degree in psychology to understand the obvious influence this can have on a child who has been giving negative responses when asked whether they have been abused.

5. Interviewer Bias and Non-verbal Cues

The beliefs or bias of the interviewer is a fundamental factor that can influence the responses obtained from a child in an interview. It is well recognized that interviewer bias is one of the fundamental concerns in determining the accuracy of the interview. Goodman, *The Child Witness: Conclusions and Future Directions for Research and Legal Practice*, 40 (No. 2) *J. of Social Issues* 157 (1984); White, et al., *Influences of an Interviewer's Behaviors in Child Sexual Abuse Investigations*, 17 *Bull. Am. Acad. Psychiatry & Law* 45 (1989).

A great amount of communication between people is subtle and often "non-verbal". Without a videotape, or the ability to witness the questioning process, it is impossible to judge the nature and effect of these cues. The non-verbal messages can be as simple as a frown or smile in acknowledging a child's statement, or as blatant as using anatomical dolls to illustrate sexual activity to a child.

6. Anatomical Dolls and Other Props

Sometimes various materials or props are utilized in the interview process. These can be "educational" materials about sex, sexual abuse or anatomy, puppets and stuffed animals used for "talking" to or for the child, and anatomically detailed or sexually explicit dolls. By far, the sex dolls are the most common props employed in investigations of child sexual abuse. Police officers, medical providers, and therapists used the dolls repeatedly with the children in the Little Rascals case.

Controlled studies of the effect of stuffed animals, good-touch/bad-touch stories and similar materials have not yet documented the impact they have upon children being evaluated for sexual abuse. There have been several scientific studies concerning the impact of the dolls, and the results are somewhat confusing if not disquieting. The attached bibliography contains the major studies to date.

In the *Kelly* case, it was common practice for some of the "therapists" upon receiving a perceived "victim" to provide the child with stories having sexual abuse themes which were to be read each night for a week or more during the time the child was being questioned by parents and the "therapist" about sexual abuse. Often these materials were passed on to other parents who began to use them with their children without seeking any professional advice at all. There is an obvious danger of suggestion in this approach and nothing that provides scientific support for it. The use of stuffed animals or puppets to "talk" for the child provides an opportunity for the child to engage in fantasy rather than reality.

Anatomical dolls came into use in child sexual abuse evaluations in much the same manner as all too many other techniques in the field. The dolls were initially employed without any research as to their efficacy or suggestiveness. They quickly gained widespread use by people with little or no training in their use. See Boat & Everson, *Use of Anatomical Dolls Among Professionals In Sexual Abuse Evaluations*, 12 *Child Abuse & Neglect* (1988).

No criteria or standards for use existed. Since their appearance, there have been efforts to determine the extent to which the dolls are suggestive and to establish guidelines for their use. As of this time, research has not addressed the issue of whether they are in fact effective as a tool for evaluating a child who has been alleged to have been sexually abused.

None of the published studies support use of the dolls as a "diagnostic test" for sexual abuse. There is nothing that sexually abused children do with the dolls that would reliably differentiate them from non-abused children. Thus, one cannot look at a child's behavior with the dolls and conclude that the child has been abused based on the child's conduct with the dolls. The few reported cases in North Carolina approving the use of the dolls as evidence in child sexual abuse litigation have not cited any scientific authority regarding the efficacy of the dolls, have not considered the potential for suggestion in the use of the dolls, and have not made any determination about the scientific acceptance and reliability of the dolls as tools for making a sexual abuse diagnosis. The cases seem to approve of the dolls as "corroboration" and illustration evidence for child testimony and social worker testimony, and overlook the issue of suggestibility and reliability of the method. See *State v. Chandler*, 324 NC 172, 376 SE 2d 728, 738-739 (1989). Based on the materials reviewed in the *Kelly* case, it is clear that the dolls played a critical role in the numerous interviews and conclusions of the investigators and therapists, and were a factor in convincing parents that their children had been abused.

There has been substantial controversy within the American Psychological Association over the use of the dolls. The APA finally issued a "Statement on the Use of Anatomically Detailed Dolls in Forensic Evaluations" in February 1991. The statement notes that dolls may be useful in helping children communicate when their language skills or emotional concerns preclude direct verbal responses. The statement says that neither dolls nor their use are standardized or accompanied by normative data. The conclusion is that psychologists who undertake use of the dolls in sexual abuse evaluations should be competent to do so and able to explain the scientific rationale for their use. One must assume that since no standards exist for use of the dolls, an argument can be made that virtually any manner of use is "competent". The statement recommends that when using the dolls, psychologists should document the use by videotape whenever possible.

No definitive research as to how the dolls should be used yet exists and one of the fundamental problems is that the dolls are often used "in the field" in ways that have not, and probably will not be, attempted in scientific research. In his testimony in *Kelly*, Dr. Mark Everson conceded that the dolls can be suggestive as used in the interview process although he disputes that they are suggestive in and of themselves.

Regardless of the scientific status of doll use, the fact remains that they are heavily relied upon by a great many of the people who are the first to interview a child following an allegation of sexual abuse. Issues that one should be aware of in connection with use of the dolls are:

1. Are the dolls suggestive in and of themselves?

2. Are the dolls suggestive as used?
3. How and why were the dolls used in the particular case at issue?
4. What protocols were employed, and what is the user's level of competence?

The research to date raises more questions than answers. It is very difficult to separate the issue of the suggestive nature of the doll itself from the issue of how it is used. In spite of the comparatively large number of studies that have been done in this area, it is difficult to assert many firm conclusions because the samples and methodology have varied from study to study.

A recent study, and one that can be expected to be frequently cited, was done by Drs. Barbara Boat and Mark Everson of UNC-CH. The study is entitled "*Sexualized Doll Play Among Young Children: Implications for the Use of Anatomical Dolls in Sexual Abuse Evaluations*", 29 *J. Am. Acad. of Child and Adolescent Psychiatry* 736 (1990). In this study children of ages two through five for whom there was no suspicion of sexual abuse were interviewed using the anatomical dolls. The dolls were placed in front of the children and they were told these were some dolls to look at and to touch. They were then allowed a short period of time to explore the dolls on their own. This was followed by use of a doll to have the child identify the body parts and their function. The children were then allowed another period of free play with the dolls. Finally some of the children over two were left alone with the unclothed dolls so their behavior in the absence of an adult could be observed.

Manual exploration of the doll's breasts, genitals and anus was common among all the children. Mouthing of the male doll's penis occurred as well. Thirty-seven percent (37%) of the children placed the dolls in a position the authors termed "suggestive" of sexual intercourse when an adult was present. Only fifteen percent (15%) did so in the absence of an adult. The authors speculate that the difference may be attributable to the adult's prompt "Show me what the dolls can do together" and "Show me what else they can do together?". Dr. Everson has testified that these questions were intended "to push them to do something sexual" and that these questions possibly provoked suggestive intercourse positioning of the dolls by the children.

Only rarely would this neutral interviewer behavior be reproduced in a "real life" situation. The presentation of dolls and questions asked while using the dolls is seldom, if ever, so benign. If such neutral and emotionally-sterile questions can provoke such child behavior, then one must wonder what happens in actual cases which involve a much more intense, emotional and suggestive atmosphere.

Two percent of the children placed the dolls in a position that was deemed to be clear sexual intercourse. Demonstrations of anal intercourse, although they occurred were not common.

Dr. Everson stresses that the only children in the study who engaged in what were deemed to be acts of clear sexual intercourse were black males from low socio-economic

backgrounds. He speculates that they do so because of exposure to sexuality or "cultural issues" and contends that most cases that go to court that are contested are going to involve middle- and upper-class white children rather than low income black boys. (Remarks by Dr. Mark Everson to American Professional Society on the Abuse of Children Seminar: *Evaluating Young Children For Possible Sexual Abuse* (1991). It is difficult to find anything in the data published in the study that supports this position.

When one considers the lack of standards for use of the dolls or for evaluating a child's behavior with the dolls, the fact that non-abused children engage in behaviors that can be perceived as "sexual" with the dolls and our lack of knowledge concerning a great many of the other factors that occur in doll assisted interviews, it would be very risky to assume that a child has been abused because of their interaction with an anatomical doll.

The potential dangerous impact of reliance on the dolls is highlighted by a Boat & Everson study in which child protection workers, mental health professionals, physicians and law enforcement officers were surveyed to determine what behaviors they thought a "normal" non-abused child would engage in with anatomical dolls. These are professionals who can be expected to be among the first in contact with the child when there is a suspicion of sexual abuse. Only 12% (mental health professionals) to 23% (physicians) of those surveyed considered fondling or digital penetration of the doll to be "normal". Boat & Everson, *Research and Issues In Using Anatomical Dolls*, 1 *Annals of Sex Research* 191 (1988). When these results are compared with the findings in the later normative study by Boat & Everson, discussed above, which indicates that these can be very common behaviors in non-abused children (Ranging from 48 percent of five year old children to 87 percent of two year old children), the danger of engaging in speculation rather than relying upon facts produced by scientific research in this area should be apparent.

The "sexually explicit" dolls used in any interviews should be examined by anyone who is concerned with the potential impact of anatomical dolls in a sexual abuse evaluation. There are no uniform standards for manufacture of the dolls and a wide variety are in use. The dolls used in the initial interviews of children in the Little Rascals case had abnormally large vaginal and anal openings, and the adult male doll had a permanently erect penis.

As a follow-up to their normative study of non-abused children's behaviors with anatomical dolls, Drs. Boat and Everson interviewed mothers of the children in the study to determine if the mothers of the children perceived any more sexually focused behaviors in the children after their exposure to the anatomical dolls. This follow-up survey revealed that 37% of the mothers of the three and four year old children reported that their children said or did things that the mother thought were caused by the child's exposure to the dolls. These behaviors ranged from asking questions about genitals to one child who took his clothes off while playing with a three year old girl. Boat and Everson conclude that only the incident involving the three year old boy taking off his clothes was a behavior that could be interpreted as sexual acting out or that might be interpreted as an indication of sexual abuse. They recognize that the children's behaviors might be seen differently by parents involved in

a non-experimental situation. Boat, et al, "Maternal Perceptions of Nonabused Young Children's Behaviors After the Children's Exposure to Anatomical Dolls" 69 Child Welfare 389 (1990).

One has to wonder - If anatomical dolls are not "suggestive", then where did these behaviors [which the mothers attributed to the dolls] actually come from if not the dolls? Do kids have more sexual knowledge and behavior than adults realize? Remember, the Boat & Everson use of the dolls was very neutral and sterile in all aspects. What happens when the stakes are higher and the enterprise is charged with the emotions and motivations that may be present in a criminal investigation or custody dispute and when the dolls are used by social workers or police officers with little experience, in child development, interviewing, etc.?

In the Little Rascals case the dolls were repeatedly used by everyone from police officers to psychologists. They were used with preschool age children and also with infants. They were used when children would not make a statement of abuse in the initial interview. In at least one instance, the child's mother and therapist jointly questioned the child while the mother manipulated the penis of the male doll. None consistently used the dolls in accord with any of the "suggested" guidelines for use of the dolls. In the absence of clear standards and hard data on the use and effects of the dolls, they seem to be used in undocumented interviews in whatever manner the interviewer pleases.

One mother in the *Kelly* trial testified that before her child was interviewed by the police officer with the anatomical dolls the child did not know about sexual matters; however, after the doll interview, the mother reported that he had a very clear understanding of sexual intercourse.

One should be aware that some people involved in sexual abuse evaluations or "therapy" use charts or drawings of satanic or occult symbols with children. In the Little Rascals trial, some children were questioned using charts from books on witchcraft. Also used were play figures based on movies such as "Willow" or the "Ninja Turtles". Newspaper photographs of the defendants were used with the children. Children were often assigned tasks involving drawing something about abuse. Some children were given "homework" which involved pressure to talk to their parents about sexual abuse. It pays to be very thorough in determining the nature of all of the materials used by anyone who has been interviewing or talking with the child about sexual abuse issues. While the materials and props may be considered "illustrative" evidence by the court, they may also be tools of suggestion and distortion which should be explored. See Realmuto & Wescoe, *Agreement Among Professionals About A Child's Sexual Abuse Status: Interviews With Sexually Anatomically Correct Dolls As Indicators Of Abuse*, 16 Child Abuse & Neglect 719 (1992).

7. Peer Pressure

Peer group pressure, or the desire to be accepted by or a part of one's peer group, is a factor that should be considered when there is an allegation of sexual abuse involving

multiple victims. Children in Edenton who never attended the daycare, but who had peers who attended, claimed to have been abused at the day care.

During her testimony for the defense, Dr. Maggie Bruck described a scientific study in which two actors went into a classroom of twenty-eight children to give a talk. During the talk one of the actors knocked a large birthday cake off of a piano. Seven children had been removed from the room and did not observe the event. Later when the children were interviewed six of the seven children who had not been present not only claimed to have been there but described the event as if they had been present.

VII. EXPERTS and EXPERT TESTIMONY IN CHILD SEXUAL ABUSE CASES

The legal test for admissibility of expert testimony is basically one of "helpfulness" to the fact-finder. However, the practical and strategical use of expert testimony in child abuse litigation is to introduce child statements with adult articulation, and to enhance credibility of the child's accusation.

Although credibility testimony by experts is purportedly prohibited by Rules 405(a) and 608(a), it seems naive to assume that juries are able to make the technical distinctions about credibility testimony that our court has established. In essence, the testimony of a pediatrician or a psychologist that a child's behavior is consistent with sexually abused children and that children in general do not lie about sexual abuse is designed to enhance the credibility of the child before the fact-finder and is a not-so-subtle comment on the child's credibility.

In this jurisdiction, experts have been allowed to testify in criminal cases during the State's direct evidence that the behaviors exhibited by a specific child are typical of, or consistent with, behaviors exhibited by sexually abused children, that the child was "genuine", that children in general do not lie about sexual abuse, that a child responded to questions in an honest fashion, that mothers of abused children usually do not believe the child and that it is a good sign for the victim to have told the grandmother that the defendant abused her, and that the child has no mental condition which would prevent the child from distinguishing reality from fantasy. *State v. Oliver*, 85 NC App 1, 354 SE 2d 527 (1987); *State v. Kennedy*, 320 NC 20, 357 SE 2d 359 (1987); *State v. Heath*, 316 NC 337, 341 SE 2d 565 (1986); *State v. Love*, 100 NC App 226, 395 SE 2d 429 (1990); *State v. Speller*, 102 NC App 697, 404 SE 2d 15 (1991). Compare, *State v. Bowman*, 84 NC App 238, 352 SE 2d 437 (1987).

Also, pediatric and psychological experts have been permitted to give an opinion on the ultimate issue that a particular child was sexually abused. *State v. Speller*, *supra*; *State v. Bullock*, 320 NC 780, 360 SE 2d 689 (1987).

Other jurisdictions are developing a more restrictive approach to expert testimony in this field, see *Commonwealth v. Dunkle*, January 22, 1992 opinion of Supreme Court of

Pennsylvania and *State v. J.Q.*, November 14, 1991 unpublished opinion of the New Jersey Appellate Division, which have taken a more rigorous, scientific view of expert testimony in the child abuse litigation.

The recent decision of the North Carolina Supreme Court in *State v. Hall*, 330 N.C. 808, 412 S.E. 2d 883 (1992) is encouraging in this jurisdiction; however, it remains to be seen if the Court will retreat from many of its past opinions about expert testimony in the area of child sex abuse. [In the *Hall* case, evidence that a prosecuting witness suffered from post-traumatic stress disorder (PTSD) was not allowed for the "substantive" purpose of proving that a sexual assault occurred. Mark Montgomery of the Appellate Defender's Office has written an excellent article exploring the implications of the *Hall* case in 24 *NCATL TRIALBriefs*, No. 2 (1992).] In *Kelly*, one of the state's recommended therapists, a psychiatric nurse, diagnosed a child as suffering from PTSD notwithstanding the fact that she had not interviewed the child and had only been in the child's presence for approximately 15 minutes.

A. BASIS OF EXPERT'S OPINION

Rules of Evidence 702 through 705 control the admissibility of an expert's opinion and disclosure of the basis for the opinion. It is important to keep in mind that an expert can form an opinion based upon, and sometimes testify to, matters that would not otherwise be admissible in evidence. See the discussion by M. Gordon Widenhouse, Jr. in 24 (No. 3) *NCATL TRIALBriefs* (1992).

An expert's opinion should never be accepted at face value. If thoroughly familiar with the learned treatises in the area of purported expertise, one will often find that there is little, if any, scientific research that supports the expert's position. Often the literature relied on by the expert simply does not support his/her assertions, or is poor authority for the proposition asserted.

For example, in the *Kelly* trial, Dr. Mark Everson testified that exhibiting a "fear of men" was a behavior that appeared in greater frequency with abused children than with non-abused children. To support this proposition, he cited a book by Dr. Lenore Terr in which she described a case of a sexually abused child who developed a fear of men. He conceded that this was not a scientific study but was a report by Dr. Terr of one child she believed had been abused who reportedly exhibited "fear of men". This hardly supported his assertion that "fear of men" was a behavioral symptom statistically found with greater frequency in abused children than in non-abused children.

Sometimes the expert does not base his opinion on any scientific foundation, but relies solely upon "clinical experience", or anecdotal reports. For example, many experts will testify that some behaviors are "conclusive" or "diagnostic" or "indicative" of sexual experiences and/or sex abuse. However, a study by Dr. Jon Conte, cited with approval by Dr.

David Finkelhor in a recent article [in attached bibliography] indicates that only "7%" of sexually abused children show such behaviors. Others have urged extreme caution in using "behaviors" of children in diagnosing sexual abuse. See, Weissman, *Forensic Psychological Examination of the Child Witness in Cases of Alleged Sexual Abuse*, 61 *Amer. J. Orthopsychiatry* 48 (1991); *State v. J.Q.*, Slip Opinion in Appellate Division Docket #A-325-88T4, Decided November 14, 1991 (Unpublished Copy); Hibbard, R. & Hartman, *Behavioral Problems in Alleged Sexual Abuse Victims*, 16 *Child Abuse & Neglect* 755 (1992); *Commonwealth of Pennsylvania v. Dunkle*, Slip Opinion in Supreme Court of Pennsylvania, Middle District, Docket #J-97-1991, Decision filed January 22, 1992 (1992); Beitchman, J. et al., *A Review of the Short-Term Effects of Child Sexual Abuse*, 15 *Child Abuse & Neglect* 537 (1991); Horner & Guyer, *Prediction, Prevention, and Clinical Expertise in Child Custody Cases in Which Allegations of Child Sexual Abuse Have Been Made* (2 articles), *XXV Family Law Quarterly* 217 and 381 (1991).

Review carefully the literature in the field or scientific studies relied upon by the expert. Is the study one that was conducted with accepted scientific procedures, or is it simply a report of "clinical experience"? Many studies being relied upon by experts have been disproved or seriously questioned by other studies; many conclusions drawn by experts have not been supported by the scientific data; and "laboratory conditions" used in the study lack "ecological validity" or were not sufficiently comparable to "real life" to permit generalizing the results of the study to actual events.

By examining the structure of a particular study closely, one can detect so many variable factors which occur in real life situations that it requires a great leap of faith to say that the study can provide reliable information about how people will behave in actuality.

B. THE EXPERT'S ROLE

One of the most critical factors in evaluating a child for sexual abuse is the role of the evaluator. An evaluation should be performed by someone who is not only well qualified, but also who has clearly defined their role in the case and has the ability to objectively confine themselves to that role. It is important to look carefully at the expert's role at the time they became involved in the case.

The roles of evaluating a child for sexual abuse; of treating a child for symptoms caused by abuse, and of assisting in the investigation, prosecution or defense of a case to be litigated, all have different and frequently contradictory goals.

Treatment or therapy for a child often involves a process of building trust and rapport between the mental health professional and the child. The objective is to support the child and make the child feel comfortable with the therapist. The process of therapy is inconsistent with the role of a neutral evaluator and can seriously compromise the accuracy of statements made by the child. These roles are frequently confused by professionals. The child is often

told in the initial interviews that they have done nothing wrong, that it's alright to tell, that they will feel better if they tell the secret. These statements may be fine - once a determination has been made that the child has been abused - but once used, one can no longer rely on the child's statements as being products of an objective interview process.

The same is true with regard to the use of techniques or materials designed to educate the child about "good touch/bad touch" or "good secrets/bad secrets". The American Academy of Child and Adolescent Psychiatry has taken the position in its *Guidelines for the Clinical Evaluation of Child and Adolescent Sexual Abuse* that the evaluator and therapist should be two different individuals in order to clarify roles and to preserve confidentiality in treatment. This position is not shared by APSAC, which is a multi-disciplinary organization of professionals involved in child abuse issues, usually in a proactive or child advocacy role.

C. SEX ABUSE EVALUATIONS

The evaluation process should be designed to learn what the child knows while making every effort to minimize the extent to which the process itself contaminates the information elicited by imparting information or ideas to the child. This is one of the reasons that it is extremely important that the evaluation process in any case that may be litigated be thoroughly documented. Interviews should be videotaped if at all possible and audiotaped at a minimum. There simply is no legitimate excuse for not having an audiotape of the evaluation interviews. See, 7 *Journal of Interpersonal Violence* 277-288 (June 1992) for an interesting pro/con debate between two District Attorneys (!!) on the issue of videotaping child interviews.

Statements by the child indicating sexual abuse should not be reinforced by praise or other rewards during the evaluation process.

Look carefully at the techniques and statements of the evaluator to see if they approached the child with an open mind and a willingness to entertain the prospect that the child's statements may not be true; that where the statements appear to indicate sexual abuse, alternative explanations for those statements have been explored. In the Little Rascals case, there were numerous instances documented in the available records showing that the "therapist" had formed a belief that the child had been sexually abused before any interview of the child had been conducted. In some instances, a diagnosis of post traumatic stress disorder was made without any diagnostic testing or interview of the child being conducted. In one instance, a child who was failing to make allegations of abuse was taken into therapy with another child for the purpose of encouraging that child to make statements about sexual abuse.

A good article on the factors involved in maintaining a neutral role as an evaluator is White, "Investigatory Independence in Child Sexual Abuse Evaluations: Conceptual Considerations", 16 *Bull. Am. Acad. Psychiatry & Law* 269 (1988).

One should also determine whether the evaluator took an adequate psychological and social history of the child. Look to see if the expert made an assessment of the child's developmental status. One cannot begin to make a rational assessment of whether a child has experienced sexual abuse without an understanding of the child's developmental history, behavioral history, cognitive abilities, communication abilities and knowledge of anatomy and sex.

The evaluator should have engaged in reality testing when appropriate. "Reality testing" refers to what should be an ongoing assessment during the interview of a child to insure that the child can distinguish between fact and fantasy.

Reality testing is related to what is known as "source monitoring" or "reality monitoring" which refer to the ability to distinguish between those things in the memory which are there because they were perceived and actually occurred, and those things which were simply imagined or suggested. There is an interesting study by Harris, Brown, Marriott, Whittall, and Harmer published in 1991 which shows that while preschool children may say they understand that ghosts, monsters etc. are not real, this claimed ability to distinguish between reality and fantasy is not well defined nor maintained by young children.

The content of the child's initial statement should be critically examined. Minor inconsistencies in a story over a series of interviews are to be expected from both adults and children. However major inconsistencies are a cause for concern and further evaluation to determine why they occur. Was there any effort to corroborate facts related by the child by outside sources?

Criteria Based Content Analysis (CBCA) is a method of analyzing the content of a witness' statement using specific criteria found to have psychological and scientific reliability. It is based on the premise that accounts of events that have actually been experienced differ in content and quality from statements based on suggestion, invention or fantasy. The method involves taking a complete statement as soon as possible after an event or the making of allegations, and before any interim interviewing. The statement is video- or audio-recorded for later analysis using specific criteria. Although the technique has not yet been "tested" for *Frye*-reliability purposes in U.S. courts, it has been used and accepted by courts for many years as a mandatory procedure in child abuse cases in Germany and it is being implemented in Israel. Currently, a study sponsored by the National Institute of Health is being conducted utilizing CBCA in abuse case interviews. This study may yield sufficient data to assist in meeting the scientific reliability standards for CBCA expert testimony in court. Regardless of whether or not it eventually appears in court through expert testimony, the criteria utilized in CBCA may prove useful in evaluating a child interview and cross-examining interviewers.

The criteria can be found in an article by Drs. Raskin and Esplin in Doris (ed), **The Suggestibility of Children's Recollections: Implications for Eyewitness Testimony** (APA 1991).

There are **Specialty Guidelines for Forensic Psychologists** which should be reviewed in cases where the evaluation has been performed by a psychologist. These contain guidelines that apply to any psychologist doing forensic evaluations. They cover record keeping requirements, competence, disclosure of reliance on hearsay, and personal independent verification of data relied upon for opinions.

D. EXPERT OPINION and DIAGNOSIS OF SEXUAL ABUSE

Sexual abuse is an event or a description of criminal behavior -- it is not a diagnosis. Some experts disagree and "diagnose" sex abuse, usually as a component of some DSM-III-R category such as "Anxiety Disorder due to Sexual Abuse". North Carolina appellate decisions indicate that pediatricians and psychologists are allowed to express opinions on the ultimate issue, i.e., that a child has been sexually abused.

There is no diagnostic category of "sexually abused child" in DSM-III-R. Such a category was specifically rejected by the professional associations responsible for promulgating the DSM-III-R. A minority of professionals seek such a category -- the minority formed their own "splinter" group, the American Professional Society on the Abuse of Children (APSAC), which is a multi-disciplinary association of professionals interested in child abuse issues. The association is attracting much attention and support, and publishes newsletters and a journal which are widely circulated among the proactive child advocacy professionals.

The frequently used "cubbyhole" categories relied upon by experts in their written reports in sex abuse cases -- Post Traumatic Stress Disorder (PTSD), Anxiety Disorder, and Conversion Reactions -- are not limited to, or specific for, sexual abuse. Making such diagnoses requires circular reasoning -- the symptoms reported do not diagnose sexual abuse; and, in order to make the "cubbyhole" diagnosis, the underlying question of whether there has in fact been sexual abuse is always assumed as true. See *State v. Hall* discussed above.

There are no syndromes, profiles, symptoms, or behaviors which are specific to or diagnostic of sexual abuse.

One frequently cited "syndrome" is the Child Sexual Abuse Accommodation Syndrome. Many social workers and APSACers utilize this characterization, and it has been referred to in North Carolina court opinions. It has no scientific basis or validity as a diagnostic tool! Dr. Roland Summit, a community psychiatrist at Harbor-UCLA Medical Center in Torrance, CA, "created" this concept. He regularly travels around the country advising prosecutors in child sex abuse cases and is a frequent speaker at social worker and child abuse seminars. Interestingly, Dr. Summit has little or no direct clinical experience in child sex abuse evaluations or treatment. Also, he has admitted (under oath) that he does not keep up with the scientific literature in the field of child sexual abuse. His "expertise" is principally based upon the clinical or case reports of other professionals with whom he

communicates. He has testified in a deposition that the Accommodation Syndrome is his impressionistic collection of observations based upon clinical experiences others have reported in evaluating or treating children alleged to have been sexually abused. The "syndrome" is not a true syndrome in the medical sense (e.g., battered child syndrome) -- it is not diagnostic of abuse. The concept is based upon Dr. Summit's subjective impressions of incest cases and it has been criticized extensively by other medical and psychological professionals. Any diagnostic use of the concept to prove abuse is improper. (See Coleman, "False Allegations of Child Sexual Abuse: Have the Experts Been Caught with Their Pants Down?" Forum (January-February 1986).

E. MEDICAL EXPERTS

1. Introduction

As a result of the increasing public awareness and comment concerning child sexual abuse, increased pressure has been exerted upon social service agencies, legislators, law-enforcement, prosecutors, psychologists, social workers, and the medical profession to develop definite and aggressive policies, procedures, guidelines and approaches for protecting children and punishing offenders.

The pressure on the medical profession was made evident by the testimony by Dr. Desmond Runyan, a UNC-CH physician who is the director of the State of North Carolina Child Medical Evaluation Program (CMEP), in the *Kelly* trial. He testified that the forms used in conducting and reporting child sex abuse CMEP evaluations were revised in order to force physicians to make a diagnostic statement about the occurrence of abuse because, as Dr. Runyan stated, "some doctors need(ed) to have a spinal transplant".

Pediatricians are providing critical expert testimony for the prosecution in child sex abuse cases. However, much of the testimony is based upon poorly developed medical and scientific principles or studies, or upon isolated clinical experiences. Many expert statements are made wholly out of context and are difficult to reconcile with the available scientific studies. Only by having a good knowledge of the medical literature and the medical issues emerging in this area can one properly defend a client against the prosecution's medical expert testimony.

As a resource for research and education in this area, a bibliography of some pertinent medical articles is attached to this paper. The listed articles should provide sufficient information to become better educated in this area and to prepare a more effective defense regarding medical evidence.

Most lay people (if not all), a substantial number of defense attorneys, and even a large number of medical doctors (including pediatricians) are unaware of the weak scientific foundation upon which much of the medical evidence in child sex abuse cases is based.

Nowhere is the uncritical respect and acceptance accorded medical "opinions" and testimony more dangerous than in trials involving allegations of child sexual abuse. The ability to show weaknesses in the medical evidence may be the basis for a more appropriate resolution of a case.

2. THE CHILD ABUSE MEDICAL EXAMINATION

Because of the respect traditionally accorded medical science and its practitioners, those involved in assessing allegations and accusations of child abuse look to medical doctors for assistance in "diagnosing" and establishing cases of child sexual abuse. In the vast majority of cases, the M.D. is asked to conduct an examination, not for the purpose of diagnosing and treating in the traditional medical sense, but for the purpose of corroborating and validating allegations of abuse by finding and describing physical evidence of the abuse or by giving a medical opinion that the findings are consistent (or, "not inconsistent") with abuse having occurred. Rarely does a doctor actually provide conventional medical treatment in these cases.

Some injuries resulting from forceful penetrations may require suturing or other medical treatment, but they seem to be the exceptions. In cases where there is an obvious genital or anal injury, the issue involves determining who caused the injury and how it occurred, instead of determining if the alleged act actually occurred in the first place.

According to much of the available literature, most incidents of child sexual abuse involve fondling or oral/genital contact, and do not involve acts of force or penetration; therefore, in the majority of cases there will be no apparent physical signs of the abuse which might be detected in a medical examination. Even in instances of abuse by digital penetration of the vagina or anus, there may not be any physical findings indicating the abuse.

The type of sexual act, the force used in the act, the age and physical development/characteristics of the child, the passage of time between the act and the medical exam, and the use of lubrication are important factors in considering whether or not one would expect some physical damage to be present upon medical examination. Except in those cases where there has been a forceful penetration of the vagina or anus, unless the child is seen within 24-72 hours after the alleged abuse, it is unlikely that there will be any physical findings in the medical examination which are "diagnostic" of, or which clearly indicate, sexual abuse or trauma to the child. Often, the only physical findings in the "fresh" case may be bruises or lacerations which could be consistent with non-sexual trauma.

Even in cases where there are allegations of rape or penile penetration (Remember, under NC law, penetration requires only penetration of the vulva -- Rupturing of the hymen or entry into the vagina are not required), there is a dispute among reputable medical experts about the physical findings one should expect in a medical examination. Again, the passage of time between the alleged act and the medical examination may be critical. A recent

medical article indicated that the hymen heals rapidly and that any evidence of the penetrating trauma to the hymen may be difficult to detect after several months. (McCann, Pediatrics, 1992).

In child sex abuse cases, the medical examiner becomes part of the prosecution's evidence gathering team. In fulfilling this function, the M.D. relies primarily upon two sources of information in forming his/her medical opinion and diagnosis: (1) The Patient "History" or "Statement"; and (2) The Objective Findings from the Physical Examination and any Laboratory Tests.

a. HISTORY or STATEMENT of PATIENT

As a preliminary to the physical examination, the doctor, nurse and/or social worker generally takes a medical "history" from the patient. In child abuse matters, the "history" is usually provided by an adult parent, caregiver, or social worker, although the medical team may also try to get a statement from the child.

(The use of the word "history" is inappropriate. It carries a connotation which should be avoided in these cases. "History" is a report of known or documented facts or events. Allegations that are crucial to and form a factual issue for the jury in child abuse prosecutions should not be elevated to the status of "history". This should be labelled the "patient statement", "patient report" or "patient allegation" component of the medical exam, instead of "history".)

Typically, the information sought as part of the patient history involves some statement about the events, people, causes, or problems which brought the patient to the doctor, any past medical conditions that may be pertinent, some family background, and any behavioral problems or sequelae which might be corroborative of the condition for which diagnosis or treatment is sought (i.e., regressive behaviors, sexual acting out, nightmares, night terrors, enuresis, encopresis, withdrawal, aggression, fear of men, excessive masturbation, etc.). The spontaneity, "purity" (lack of contamination by leading or suggestive questioning or improper interview procedures), and the temporal proximity-to-incident of such statements must be scrutinized. Medical histories which are given only after several weeks or months of parental interrogation, social services interrogations, and/or law-enforcement, therapist and prosecutor questioning should be scrutinized carefully and are suspect.

Because the Rules of Evidence accord statements of medical history a special status as "reliable" evidence at trial, it is important to fully explore and assess how the statement or "history" was developed. Sometimes, statements to physicians go through an "evolution" ("mutation" might be a better description), and, by the time of the medical examination, the "history" may bear little similarity to earlier statements or to known facts. People interested in the prosecution of an individual often develop very selective and biased memories of past events. As they discover the types of information that will assist in the prosecution of the accused, parents and other interested caregivers seem suddenly to "remember" a litany of

"serious" problems that plagued the child (Notwithstanding the fact that such "problems" did not merit any professional attention or advice at the alleged time of occurrence).

Most university hospitals and medical centers that routinely perform child sex abuse exams operate on a multi-disciplinary team concept. There is an evaluation team assigned to do the exams using established protocols and written report forms. The initial interviewer who takes a history may be a social worker or psychologist rather than a medical care provider. A nurse practitioner or a resident may do the actual physical exam under "supervision" of the main physician. Because of the extremely liberal interpretation currently afforded the medical exception to the hearsay rule in this state, as long as the statements are taken as part of the medical examination process, the exception's requirements will be satisfied.

As part of the UNC-Chapel Hill medical evaluation, a social worker generally participates in the initial intake interview process. From experience, this portion of the medical evaluation process does not involve the taking of a "medical history"; instead, it seems to be an "allegation and accusation" collection and verification process in which the social worker uses the sex dolls to obtain statements from the child about acts of sex abuse and to identify the accused. However, the medical doctors will testify that it is a "vital" part of their "medical history".

Some initial interviews and "history" statements are audio- or video-taped. UNC-CH has video equipment, but has no established protocol for its use. If one suspects there are audio- or video-tapes of medical history statements, they should be requested in pretrial discovery motions. (In criminal cases, they are a part of the medical examination, testing and reporting process and should be discoverable under NCGS 15A-903.)

Because most cases will have no physical findings clearly indicating that sex abuse has occurred, the "history" component becomes the critical piece of medical evidence. Assuming that the statements come in as substantive evidence under the hearsay exception, or as non-substantive corroboration evidence of a child's trial testimony, any and all weaknesses inherent in the statement and the process by which the statement was developed must be vigorously reviewed.

Physicians on the sex abuse evaluation teams at UNC-CH will testify that they are "definite" in their medical diagnosis of child sexual abuse based solely upon the medical history given to them, even in the absence of any objective physical findings supporting the statements they have been given.

In short, if a child says it happened, or, if a parent or an interviewer says a child said it happened, then the UNC MDs will give expert testimony and a medical diagnosis that it did indeed happen. Thus, the very allegations and statements of the sexual offense which are often the only real evidence to be assessed by the fact-finder, are elevated by the "medical

diagnostic process" and are given enhanced credibility through a seemingly objective professional person.

What might otherwise be unreliable and inadmissible hearsay is transformed into admissible substantive evidence of the alleged acts.

A criminal case tried recently in Wake County (*State v. Bynum*, 91 CRS 020146 & 027460), involving accusations against a step-father of committing indecent liberties by fondling a child, provides a good example of how "medical history" is being used (or abused!). In that case, Dr. Desmond Runyan testified for the prosecution that in his expert opinion the 7 year old female child had been sexually abused by the defendant. From his sworn testimony, it appears that he based this "expert medical opinion" upon the following factors:

- (1) A physical examination of the child, conducted by a nurse practitioner and which he reviewed, that was well within normal limits and revealed absolutely no evidence of physical harm or injury to any portion of the female genitalia (Hymen was intact with no sign of trauma or injury; 2mm hymenal opening).
- (2) An interview of the child conducted by a social worker, which he did not observe or review, but which was apparently discussed in a brief conversation with the social worker prior to the physical exam. (Dr. Runyan had no independent memory of the conversation or any of its particulars at the time he testified, but he was relatively certain that was the procedure he followed.) The child made no independent statement to him or the nurse practitioner.
- (3) His opinion that children do not fantasize or lie about sexual acts.

Interestingly, Dr. Runyan also testified to a "vague" awareness that the child had accused a neighborhood boy of touching her private parts; however, that bit of "medical history" seemed to have absolutely no importance in his "medical diagnosis" that the defendant sexually abused the child.

Most doctors do not engage in any critical evaluation of the statements given to them. Such statements are accepted at "face-value" and taken as true. The fact that the child may have made inconsistent statements in the past, or that the medical "history" statements developed only after repeated interviews of the child in which suggestive or pressured or coercive questioning was used, is not considered by the physician. Indeed, the medical examinations performed at Chapel Hill are usually done without reviewing any past medical records from the child's pediatrician or treating physicians. Thus, for example, in the Little Rascals' case, the Chapel Hill doctors accepted a mother's statement that her child's dysuria and hematuria (pain and bleeding on urination) began during the child's attendance at the daycare, when in fact the child's past medical records revealed a long-term medical history

for those conditions, and other significant genital problems, which predated attendance at the daycare.

b. THE PHYSICAL EXAMINATION

The actual physical examination of a child in a medical evaluation for sexual abuse generally takes less time than the interviewing and history taking. Some doctors may take an hour or more in conducting the exam, but at Chapel Hill, the actual genital and anal exams usually take only 10-15 minutes.

In the routine physical examination performed for the medical diagnosis of an injury or disease, the physician is looking for objective physical signs, conditions or evidence which is consistent with the reported medical problem.

However, sex abuse exams are different!

Although the physician is looking for physical evidence of some type of trauma to the genital or anal area of the child which is consistent with the reported acts of abuse, a failure to find such evidence is apparently of little significance. According to UNC-CH medical experts who testify for the prosecution, a lack of any physical findings is nevertheless "consistent with sexual abuse". Sometimes they will report that the lack of physical findings is "not inconsistent with sexual abuse". Rarely, if ever, do they make a written report that a lack of physical findings is consistent with no abuse, or not inconsistent with no abuse. (Usually, one can get this concession at trial on cross-examination -- long after parents, therapists, and prosecutors have cemented their opinions based upon the "consistent with" written report, long after the child has been labelled a "victim" and has been treated as such, and long after an accused has been personally and financially damaged.)

The diagnostic formulation and statement seems always written or delivered in a fashion that supports an allegation of abuse, or at least does not detract from such an allegation.

These subtle semantic creations proffered as part of a medical diagnosis are difficult to accept or defend in trials where significant liberty and family interests are at stake. Such semantic charades by the medical profession in these cases are some evidence of a deliberate and calculated policy by professionals who have become biased advocates of pro-prosecution interests rather than impartial, objective medical examiners.

1). Examination Techniques/Positions

There are 3 basic examination techniques/positions used in examining a female child's genital area: the supine labial separation technique; the supine labial traction technique; and the knee-chest technique. It is essential that one knows which technique has been used by the

doctor because the particular position/technique can result in different observations and reports of the hymenal/vaginal/perineal anatomy. The shape, contour, opening size, and general configuration of the same hymen can vary greatly based upon the methods used in the examination. See McCann, 85 *Pediatrics* 182 (Feb. 1990); and, Bays, 3 *Adolescent & Pediatric Gynecology* 34 (1990).

In cases in which there is any question about sexual abuse and injury to the hymen, and especially where the findings involve subjective decisions about configurations or shapes of hymen (e.g., rounding or irregularity of the hymen edge, angularity, attenuation, asymmetry of the hymen, size of opening or width of tissue, notches or clefts in the hymen, thickness of the hymen edge, etc), the leading medical experts advise that the knee-chest position/technique should be employed together with a supine examination method.

Some doctors will claim that the knee-chest position is "difficult", "uncomfortable" or "frightening" to a child as a reason for not using the position. However, the position is no more problematic than many other routine medical procedures employed in treating or examining children. While such statements might be acceptable in a routine examination situation, they ought not go unchallenged, nor should they be acceptable excuses, in the context of a medical exam being conducted for the purpose of gathering and presenting reliable evidence in court. The published medical studies clearly indicate that a correct and accurate assessment of hymenal anatomy requires that the knee-chest position be used.

A male child's genitalia is generally examined in the standing or supine position.

Examination of the anus can be conducted in the supine position, but the knee-chest is preferable for a thorough exam. The knee-chest position will often cause some anal "winking", gaping, or dilation of the opening. The speed and size of such dilation is considered of some medical significance, but is not a specific sign of sexual abuse since rapid and large dilations in the knee-chest position are reported in the medical literature for nonabused children. The presence or absence of stool in the rectum is also an important factor in assessing the importance of any dilation.

Most university and large hospital teams doing child sex abuse examinations utilize a **colposcope** in the examination process. The instrument was developed originally for use by OB/GYNs in conducting intra-vaginal and cervix examinations of adult patients. As adapted for use in child sex abuse exams, this instrument simply provides the examiner a well-lighted, non-invasive and magnified view of the genital or anal area being examined, and it also allows magnified photography of the area being examined. **CONTRARY TO RUMORS ORIGINATING IN NORTHEASTERN NC, IT DOES NOT DETECT SEXUAL ABUSE!** In fact, the medical literature and the experts at UNC are in agreement that an examination without the colposcope is as adequate and reliable as an exam performed with the colposcope. The colposcope does not increase the examiner's ability to make a physical finding. The instrument's primary value in the forensic medical evaluation for sexual abuse is its photographic capability.

Medical colposcopic photographs of the child's genitalia and anus are the only hope of obtaining a good second opinion about the contemporaneous physical findings reported by the examining experts. (Under current NC case law, in criminal court a defendant cannot compel a physical or psychological examination of an alleged child victim. Constitutional due process issues appear to be lurking in this area.)

2). Physical Findings

Most of the medical literature concerning the various physical findings in child abuse evaluations is limited to the female genitalia and to the anus. Indeed, most reported abuse seems to involve female children and male perpetrators, although there is a significant concern that much abuse of male children is going unreported or undetected. Other than acute bruising, chafing or minor lacerations which heal rapidly and completely, because of the nature of sexual abuse involving the male genitalia (penis and scrotum) there is rarely any physical evidence diagnostic of the abuse. Some of the articles cited in the attached bibliography discuss medical issues in sexual abuse of boys and should be consulted for more information.

a). Hymenal Anatomy

The hymen is a mucous membrane-like tissue which extends across a portion of the entrance to the vagina. In the prepubescent child, it is generally unestrogenized and very sensitive (i.e., painful to touch). It can be very thin and almost translucent, or it can be thick. All female children are believed to be born with hymens of some type.

Because of its location and its susceptibility to injury by acts of sexual abuse, the condition of the prepubescent child's hymen has been the primary focus of medical study and the medical literature in child sex abuse evaluations. Surprisingly, most of the scientific study of the hymen relating to sex abuse has been undertaken within the last 5-6 years. The first real scientific study of normal hymenal anatomy was not published until 1990.

Prior to the publication of Dr. Emans article in 1987, most of the medical information about normal and abnormal hymenal anatomy was based upon anecdotal or clinical statements circulated at medical seminars. There wasn't much resembling the scientific method. A few medical doctors began to question the status of the medical knowledge in the field, and some harbored serious doubts about the validity and reliability of the medical information which was being circulated in dogmatic fashion. Many were concerned that there were no studies of normal populations and normal hymens upon which to base medical determinations of what was and was not normal in hymen anatomy. In 1990, Dr. John McCann published the best scientific study to date about normal hymenal anatomy. His study revealed that many of the so-called hymenal abnormalities used as diagnostic indicators of sexual abuse, and which were being used by doctors in court testimony as evidence of abuse, were actually present in substantial percentages of normal, nonabused children. (How many people have been

convicted or lost parental rights based upon questionable medical evidence and testimony developed prior to the normative studies?)

In examining the integrity and condition of the hymen, physicians are looking at: hymen type, shape or configuration (crescentic a/k/a posterior rim; annular a/k/a concentric or circumferential; and, redundant, fimbriated or denticulate are the usual terms applied to shape or type of hymen); the edge of the hymen; the symmetry of the hymen; any scars, notches, clefts, or tears of the hymen; synnechia (these are adhesions of tissue - usually hymenal tissue which has been torn and which adheres or attaches to other surrounding tissue, either vaginal or labia minora); mounds, tags, projections or bumps on the hymen, particularly on its edge; thickness of the hymen tissue; attenuation (this is a marked narrowing or reduction of hymenal tissue); vascularity (increased blood vessels - thought to be a sign of a healing process); friability; and, transverse or horizontal measurement, in millimeters (mm), of the size of the hymenal opening. Each of these is of varying significance depending upon the type of abuse alleged, the time period that has elapsed, and the combination of findings. The articles attached give a thorough discussion of these matters and the relative importance of each.

In describing hymen anatomy, physicians use the clock-face method for describing the location of the injury or condition. Generally, in supine or on-the-back examinations, the physician is most concerned with the area of the hymen from the 3 to 9 position. This is the area of hymen that is most frequently damaged by sexual abuse.

There is much controversy in the medical profession about what constitutes an enlarged hymenal opening outside the range of normal -- the assumption being that an enlarged opening might be an indicator of trauma or penetration. The transverse or horizontal measurement of the opening is considered the most significant.

Prior to 1989, based upon reports from a poorly conducted study by Dr. Henrika Cantwell, many physicians were convinced that a transverse or horizontal opening greater than 4mm in a prepubertal child was significant evidence of possible abuse. (1mm = 1/25th of an inch; The width of the tip of your little finger is approximately 10mm; The width of the average adult penis is 32mm). Some physicians were skeptical since there had not been any normative studies in which hymens of nonabused children had been measured. In 1987 and 1990, the Emans and McCann articles were published in Pediatrics. These articles reported the beginning attempts at developing some understanding of the normal ranges in hymen anatomy and sizing. Dr. David Muram of the University of Tennessee in Memphis has also commented on size in several of his published articles. Dr. David Ingram of Wake Medical Center has published a study as well. (13 Child Abuse & Neglect 1989, but the study had methodological flaws and is criticized in the same publication by Dr. Jan Paradise. The doctors from Chapel Hill and Raleigh like to quote Dr. Ingram's study.)

At this time, there is no clear consensus about the significance of hymenal opening sizes because of the wide range of measurements found in the normal population. However,

a consensus may develop as more normative studies are published and findings are correlated with known cases of abuse. At the 1993 San Diego Convention on Child Maltreatment, the developing consensus of the leading medical experts seemed to be that the size of the hymenal opening was of little or no significance in sexual abuse evaluations. (Statement of course leader, Dr. Astrid Heger. The only doctor in the audience who voiced any disagreement was from Wake Medical Center in Raleigh!) There will continue to be significant problems in assessing measurement reliability (how the measurements are taken, position and technique used in the exam, relaxation of the child, age of the child, type of hymen, measurement instruments, variance of size of same hymen in sequential exams, and interrater reliability can affect the reports of size). Dr. McCann's recent article (Pediatrics 1992) indicates significant sizing differences in the same hymens over time. Drs. Runyan and Smith of Chapel Hill, in their pamphlet for non-medical professionals, suggest that an opening greater than 6-7mm is significant. Dr. Muram suggests that an opening equal to or greater than 10mm is of medical and legal significance. A recent draft report circulated by a committee of medical doctors concerned with standardization of medical terminology in child abuse evaluations suggested that only openings larger than 8mm be considered "enlarged" (APSAC Draft Report, 1991). Dr. McCann's 1990 study had ranges up to 8mm for preschool age children, 9mm for early school age, and 11mm for preadolescents; the mean measurements were approximately 4-5.5mm for children under 8 (measures varied with exam technique).

As an isolated finding, the transverse measure of the hymen opening has little diagnostic or predictive value as evidence of child sexual abuse. However, extremely large openings, or openings greater than 5-6mm in conjunction with findings of other hymenal "abnormalities", will usually be considered of medical and legal significance by doctors:

Just as noses, ears, and other parts of the anatomy vary in shape, thickness, size, etc., so do hymens. The hymen has some limited elasticity, but the limits are not precisely known. Some hymens may not be elastic or stretchable at all. In any case, be very cautious in accepting broad or general medical statements based on the studies or isolated clinical observations when proffered as evidence about the nature of a particular child's hymen (the doctors at Chapel Hill will testify about a case in which one of them conducted a physical exam which appeared to be within normal limits, but that they subsequently discovered a used condom in the child's vagina - thereby evidencing the elasticity of the hymen and that a normal exam does not mean there was no penetration).

The unique individual quality or nature of the hymen is very important. Pediatricians do not chart hymen development or morphology, so there is generally no base-line information to make comparative judgments in any case. There are also no longitudinal studies about the development process of normal hymens (Drs. Heger and Berenson have undertaken such a study). It is not possible for anyone to look at a particular hymenal condition and, from the condition, to accurately diagnose the precise cause of the condition with certainty. Abnormal conditions of the hymen are generally consistent with a number of

potential causes, one of which may be sexual abuse, but many of which have nothing to do with abuse.

b). Posterior Fourchette (PF)

The PF area is the area located below the point where the bottom margin of hymen is attached. Generally, it is the area closest to the vaginal opening between the vagina and anus, and where the labia minora come together. This area of non-hymenal, non-vaginal tissue is sometimes torn or scarred when the vagina is penetrated or when there has been a forceful rubbing or chafing (digital manipulation or vulvar coitus) in the area. Unless there has been a skin-deep tearing or laceration of tissues, the area heals quickly without evidence of injury. Sometimes, there will be friability in this area (superficial bleeding upon examination which occurs when the tissue is stretched in the exam). Typically, friability has little predictive or diagnostic value, except it may indicate some recent trauma or chronic chafing. Also, there is some concern that the bleeding may actually be caused by normally-occurring tiny labial adhesions which are torn apart by even very careful exams.

Labial adhesions are essentially a growing together of the labia minora in the posterior fourchette area. Poor hygiene or naturally occurring irritation in the area is the suspected cause of these adhesions, although some physicians will speculate that abuse can be a factor. Labial adhesions are very common in children up to age 7. In any child that has a history of labial adhesions, there is a potential for scarring in the PF area if the adhesions are torn apart. Because the adhesions are in the midline of the PF, any scars or conditions outside the midline must be assessed carefully. However, this is an area, unlike the hymen, which can be affected by various normal gymnastic or other chafing activities by the child. Straddle injuries can cause such a scar. Also, depending on the strength of the labial adhesions, the adhered tissue may be more resistant to tearing than the surrounding tissue. Thus the surrounding skin may actually tear apart leaving a scar out of the midline.

c). Anus

In conducting the examination of the perianal area, the physician is looking for changes in the skin pigmentation, erythema (redness), scars, abrasions, lacerations, hematomas, fissures, venous congestion, unusual rugae (skin folds of the anus) patterns, anal laxity, sphincter tone, and anal sphincter dilatation. Because a child's anus is capable of accommodating the passage of large stools, and because it usually heals rapidly and completely, physical evidence of abuse to this area is rarely detected in medical examinations.

As with the hymen, there is little normative data concerning the anus. In 1989, Dr. McCann published the results of the principal study describing conditions found in perianal exams of nonabused prepubescent children. (McCann, 13 Child Abuse & Neglect 179) As in

his hymen study, the results indicated that many of the conditions thought to be diagnostic of anal abuse were found in the normal population:

1. ERYTHEMA - found in 41 % of nonabused sample.
2. INCREASED PIGMENTATION - found in 30%.
3. INCREASED VENOUS CONGESTION - found in 7% at initial stage of exam and 73% by end of exam.
4. SMOOTH AREAS ON OR NEAR MIDLINE VERGE - 26%.
5. ANAL SKIN TAGS/FOLDS - 11%, all but one were located anterior to the anal orifice.
6. PERIANAL SCARS - 2% (4 of 240), 3 were in the midline at 12 o'clock position, 1 at the 2 o'clock position.
7. NO FISSURES, LACERATIONS, ABRASIONS, or HEMATOMAS were found.
8. ANAL SPHINCTER DILATATION - found in 49% (130 of 267) of the sample. The range of dilatation was from 1mm to 24.9mm vertical, with a mean of 10mm, and 1mm to 20mm horizontal, with a mean of 5.7mm. A vertical dilatation measurement above 20mm without the presence of stool in the rectal ampula was considered unusual (only 1 subject). The presence of stool is seen as a causative factor in dilatation. An almost equal number of subjects had dilatation between 15mm and 20mm regardless of the presence of stool (7 of 35 w/stool; 6 of 23 w/o stool). (The speed of dilatation may have significance, but there are no studies confirming same. 30% of the subjects dilated w/in 30 seconds, with mean time for dilatation being 65 seconds for initial and 2 minutes for maximum. Once dilated, the anus remained open in 38%, and opened and closed intermittently in 62%. Anal dilation may be more likely to occur in knee-chest position)

In assessing anal findings, it is necessary to know about the child's toileting history, particularly with regard to diarrhea, constipation, passage of large stool, and hygiene. As Dr. Muram and Dr. Paul have noted in their publications, many of the so-called anal abnormalities are just as likely to be caused by occurrences unrelated to abuse.

3. THE DIAGNOSTIC STATEMENT

"Child sexual abuse" is not a medical diagnosis or a medical condition -- it is a description of criminal behavior or events. The medical findings may be consistent with the behavior or the event, but the event does not constitute a diagnosis in the medical sense. (Doctors don't make a medical diagnosis of "automobile accident"!)

Nevertheless, many physicians will give diagnostic statements of "child sexual abuse"; some will even testify to their degree of certainty that sexual abuse has occurred. Such statements ought not be sanctioned in court proceedings. In trials, doctors ought to be limited in their testimony to descriptions of physical findings and medical conditions. While their medical experience

qualifies them to state that certain conditions could have or might have been caused by (or are consistent with) sexual trauma, doctors should not be allowed to state factual or legal conclusions traditionally reserved for a jury or judge. Still, under the guise of medical opinion, many doctors are being allowed to give testimony that they are definite or certain in their medical diagnosis that a child has been sexually abused.

The program at UNC-CH and the State CMEP forms categorize levels of certainty of child maltreatment, one of which must be marked as part of the medical diagnosis and conclusion. The levels are:

1. No Maltreatment
2. Possible Maltreatment
3. Probable Maltreatment
4. Definite Maltreatment

There are absolutely no written standards or criteria for determining which category should apply in a given case. Such determinations are left to the subjective assessments of each examining physician. Consequently, different physicians conducting independent assessments of the same child may reach different medical conclusions about the appropriate category to be marked. This actually occurred in the *Kelly* trial -- and the physicians were on the same medical staff in the child abuse program at UNC-CH! In another exam, a physician testified he concluded that there was "definite maltreatment" (by sexual abuse) based solely upon parent statements of what the child reportedly said, without any corroborative physical or medical findings -- in fact, results of the physical exam were entirely normal. The doctor told the parent that the physical exam was consistent with sexual abuse.

It's difficult to understand why medical education, training and experience are necessary at all if the diagnosis is reduced to this simple knee-jerk process. Based upon the diagnostic model employed by physicians at UNC-CH, it does not appear that physical examinations are required for the medical diagnosis if there is an oral statement of abuse (whether from a parent, child or a third-party). In short, the medical diagnosis in child sex abuse cases often has little to do with science or medicine. It can be a very arbitrary and subjective process that defense lawyers should expose in cross-examination and/or should highlight in the direct evidence from the defense medical expert.

F. EXPERT TESTIMONY ON PEDOPHILIA and USING PENILE PLETHYSMOGRAPH

Frequently, the issue arises concerning the admissibility of evidence regarding the defendant's lack of deviant sexual arousal, attraction to children, and failure to meet diagnostic criteria for "pedophilia" or other paraphilias. The state's position is typically that such evidence is expert evidence of a "character" trait which is inadmissible, or that the

scientific community does not accept or regard the testing protocols employed as being reliable. For several years, the California courts struggled with the issue of admission of "profile" type evidence regarding a defendant's lack of pedophile traits. See *People v. Stoll*, 49 Cal 3d 1136, 783 P 2d 698 (1989); . They ultimately decided that such evidence was admissible under the terms and provisions of the California Evidence Code, and penile plethysmography was expressly approved as reliable scientific evidence. The North Carolina appellate courts have not yet addressed the issue squarely, but it appears that such evidence should be admissible in defense of a child abuse allegation.

The opinion and other testimony of a properly qualified expert witness regarding scientific, technical, or other specialized knowledge is admissible if it will assist the trier of fact to understand the evidence or to determine a fact in issue. Rule 702, NC Rules of Evidence. A person with the expertise to diagnose pedophilia and normal human sexual functioning is an expert within the meaning of Rule 702 and *State V. Wilkerson*, 295 NC 559 (1978). See COMMENTARY to Rule 702.

All relevant evidence is admissible, unless specifically excluded by constitution, statute, or evidentiary rule. Rule 402, NC Rules of Evidence. "Relevant evidence" is that which has any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. Rule 401, NC Rules of Evidence. The COMMENTARY states that the fact to be proved may be an ultimate, intermediate, or evidentiary fact which is of some consequence in the determination of the action. In any case in which a defendant is charged with the offense of indecent liberties, the gravamen of which involves deviant sexual arousal, an expert's opinion concerning the defendant's lack of deviant arousal ought to be relevant and admissible evidence.

The facts and information forming the basis of an expert's opinion may be those perceived by or made known to him at or before the trial, and the facts or data relied upon by him need not be admissible in evidence if of the type reasonably relied upon by experts in the particular field. Rule 703, NC Rules of Evidence; *State v. DeGregory*, 285 NC 122 (1974); *State v. Barranco*, 73 NC App. 502 (1985).

An expert's opinion is not objectionable because it embraces an ultimate issue to be decided by the jury. Admissibility of the expert opinion depends not on whether it invades the jury's province, but rather on whether the expert is in a better position to have an opinion than is the trier of fact. Rule 704 and COMMENTARY, NC Rules of Evidence. The opinion may be given without any disclosure of the underlying data or facts, unless the adverse party requests otherwise. Rule 705, NC Rules of Evidence.

1. **Pedophilia and Expert Evidence**

a. **Pedophilia is a Recognized Physical/Mental Disorder Within Psychology/Psychiatry**

A "pedophile" is one who acts upon and seeks to satisfy his recurrent intense sexual urges and sexually arousing fantasies involving sexual activity with prepubescent children. It is a recognized physical and mental condition and disorder which is capable of diagnosis by the psychiatric and psychological professions. The disorder of "Pedophilia", like "Post Traumatic Stress Disorder", is recognized by and contained within the diagnostic criteria and schedules of the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised, Category Section Number 302.20 (American Psychiatric Association, 1987) (Commonly referred to as the DSM-III-R.) Evidence relating to human sexual arousal and pedophilia, or lack thereof, is thus properly considered as relating to a diagnosis concerning a professionally recognized mental disorder.

b. **North Carolina Courts Have Admitted Evidence Concerning Pedophilia in Child Sex Abuse Prosecutions**

Expert opinion testimony relating to the disorder of pedophilia and human sexual arousal is appropriate under the evidence rules. It is not "character" evidence. In *State v. Helms*, testimony by a psychologist that a defendant did not have the mental or physical indicators associated with a pedophile was upheld as relevant and admissible evidence. 93 NC App 394, 378 SE 2d 847 (1989). In *State v. Britt*, ___ NC App ___, 377 SE 2d 79, 81 (1989), Dr. Bob Rollins testified that the defendant did not meet the psychological profile of one who sexually abuses children. Also, such evidence has been admitted in trials in the Superior Courts of Cumberland, Buncombe, Mecklenberg, and Alamance Counties. (Report of Paul Herzog, Esq., Assistant Public Defender for Cumberland County.) Other jurisdictions have likewise ruled the evidence as admissible. See *People v. Stoll*, *supra*; *State v. Shearer*, 792 P.2d 1215 at 1217 (Oregon 1990) [in which the appellate court allowed expert testimony that an accused did not fit the psychological profile of a pedophile.]

c. **Basis for Admissibility of the Evidence Under North Carolina Law**

This expert testimony does not concern moral attributes, the opinion of peers, reputation, or credibility issues, and therefore the prohibition of expert testimony on "character" traits in Rule 405(a) does not apply. The testimony simply involves pertinent and diagnosable mental/physical conditions based upon reliable professional methods recognized within the field of psychology and human sexuality. Defendant's physical reaction to sexual stimuli is not a character trait like truthfulness or violent temper or honesty or being law-abiding or lying. Mental capacity or condition has always been provable by expert opinion.

In *State v. Heath*, the NC Supreme Court held that an expert could not give an opinion that "...there was nothing in the record or current behavior that indicates [a person] has a record of lying", but the Court clearly stated that an expert could testify by opinion as to whether a person "...was afflicted with any mental condition which might cause [the person] to fantasize about certain [behavior] in general...". 316 NC 337, 341 SE 2d 565, 567-568 (1986) [Emphasis added]. If the prosecution is entitled to submit evidence of an alleged

victim's mental condition by expert opinion testimony, clearly a defendant can do the same. Thus, under the *Heath* decision, a defendant is allowed to submit evidence that there is nothing in his physical/mental (psycho-sexual) condition consistent with the sexual arousal pattern of a pedophile. The expert, however, is not allowed to comment on the credibility of the defendant's testimony or give an opinion as to whether the defendant committed or did not commit a specific act or offense.

The Supreme Court expanded upon its *Heath* holding in *State v. Kennedy*. In *Kennedy*, expert witnesses (psychologist and pediatrician) testified that the victim responded to personality and IQ tests in an "honest fashion", that the victim was "greatly afraid" of the defendant (the child's father), and that the victim exhibited symptoms and characteristics consistent with those of a sexually or physically abused child. In overruling the defendant's objection on the grounds that such evidence was expert opinion on character traits and credibility prohibited by Rule 405(a), Justice Martin stated the opinion of the Court as follows (in pertinent parts):

The mental and emotional state of the victim before, during and after the offenses as well as her intelligence, although not elements of the crime, are relevant factors to be considered by the jury in arriving at its verdicts. Any expert testimony serving to enlighten the jury as to these factors is admissible under Rule 702 of the North Carolina Rules of Evidence.

...[A] statement by a trained professional based upon personal knowledge and professional expertise that the test results were reliable because the victim seemed to respond to the questions in an "honest fashion" [is admissible and is not an expert opinion as to character and credibility].

...The fact that this evidence may support the credibility of the victim does not alone render it inadmissible. Most testimony, expert or otherwise, tends to support the credibility of some witness.

...Furthermore, expert opinion on an ultimate issue is admissible.

320 NC 20, 357 SE 2d 359, 366-367 (1987).

The expert testimony concerning deviant arousal/pedophilia offered by a defendant does not involve any new or novel scientific procedures. The methods employed are not new to psychology or the law, and the "modified-*Frye*" rule does not apply. The standardized tests and the penile plethysmograph are recognized scientific psychological procedures which have a history of reliability and general acceptance in the relevant professional community as a tool in diagnosing pedophilia. Each test has been subject to critical scientific scrutiny for more than 20 years, and each has an excellent reliability index.

Even assuming that the North Carolina standards for admissibility as set forth in *State v. Bullard* and *State v. Pennington* apply, the proffered testimony is admissible. A new scientific method of proof is admissible at trial if the method is sufficiently reliable. *State v. Bullard*, 312 NC 129, 148, 322 SE 2d 370, 381 (1984); and, *State v. Pennington*, 327 NC 89, 393 SE 2d 847, 852 (1990).

Reliability of a scientific procedure is usually established by expert testimony, and the acceptance of experts within the field is one index, though not the exclusive index, of reliability. North Carolina does not adhere exclusively to the *Frye* formula, and in this jurisdiction the appropriate inquiry is one of reliability of the method rather than popularity within the scientific community. The North Carolina Courts focus on the following indices of reliability:

1. The expert's use of established techniques;
2. The expert's professional background in the field;
3. The use of visual aids before the jury so that the jury is not asked to sacrifice its independence by accepting the scientific hypotheses on faith; and,
4. Independent research conducted by the expert.

See *Pennington*, 393 SE 2d at 852-853; *Bullard*, 312 NC at 150-151, 322 SE 2d at 382.

Moreover, there is no requirement that numerous experts testify in order to establish reliability of a scientific method. Indeed, the expert whose testimony and method is at issue may alone establish sufficient reliability and meet the test for admissibility of the evidence.

In *Bullard*, the trial and appellate courts were faced with a method of footprint identification by a physical anthropologist based upon a technique of comparison pertaining to the size and shape of the foot print in 4 areas. The expert contended that by comparing known footprints with unknown footprints she could determine if they were made by the same person. The expert in *Bullard* was the only person in the country at that time who was advancing or professing expertise in the particular scientific methodology of footprint identification sought to be admitted as evidence, and the particular scientific method under review presented a case of first impression in North Carolina. The very expert whose testimony was at issue in *Bullard* provided the only evidence of the method's reliability.

Likewise, in *State v. Green*, the NC Supreme Court accepted a single expert's testimony to substantiate the reliability of his particular scientific method of identification. 305 NC 463, 290 SE 2d 625 (1982). Other courts have followed the same course concerning admissibility and reliability of expert evidence based solely on the testimony of a single expert. See *State v. Temple*, 302 NC 1, 273 SE 2d 273 (1981) and *State v. Crowder*, 285 NC 42, 203 SE 2d 38 (1974).

d. **Fundamental Constitutional Principles and Guarantees
Supercede Any Conflicting State Rules and Mandate
Admissibility**

Finally, even if one were to assume that the expert testimony being offered by a defendant constitutes some type of character evidence, the evidence would still be admissible on constitutional grounds.

Any prohibition of such expert testimony would violate the defendant's rights to due process of law, confrontation, equal protection of the law, and effective assistance of counsel as guaranteed the defendant under applicable provisions of the state and federal Constitutions. Any conflict between North Carolina evidence or statutory rules and the state or federal Constitution concerning admissibility of evidence requires that the evidence or statutory rules yield. *Mississippi v. Chambers*, 410 US 284 (1973).

To deny the defendant the opportunity to present this expert evidence would deprive him of his ability to effectively confront the accusations against him and to introduce evidence relevant to a proper determination of the charges against him.

The offered expert evidence tends to show that the defendant is not sexually aroused by children. In cases where the defendant is accused of multitudes of serious sexual offenses against prepubescent children over a long period of time, it is absolutely imperative that he be allowed to establish that he is not a pedophile. Moreover, a defendant

...in a criminal prosecution has a constitutional right to confront his accusers with other testimony. Every defendant is entitled to prepare his defense. This includes the right...to investigate as well as present his defense. This right must be accorded every person charged with a crime.

State v. Hill, 280 NC 1, 9(1970) rev'd on other grounds, 272 NC 547.

The right of an accused to offer testimony is a basic ingredient of the right to present a defense, i.e., the right to present the defendant's version of the facts, as opposed to the prosecution's, so that the jury may decide where the truth lies. "...This right is a fundamental element of due process of law." *State v. Wells*, 290 NC 485 at 490-491, 226 SE 2d at 329 (1976); *State v. House*, 295 NC 189, 244 SE 2d 654 (1978). This issue presents a question of law, and is not one of discretion in the trial court. *State v. Brower*, 289 NC 644, 660, 244 SE 2d 551 (1976).

Expert witnesses are considered an integral part of a criminal defendant's constitutional due process right to prepare and present a defense. Without the assistance of psychological expert testimony, "...the risk of an inaccurate resolution of [mental condition] issues is extremely high." *Ake v. Oklahoma*, 84 L.Ed. 53, 65 (1985). Defendant's due process rights are violated if such testimony is excluded.

2. How Wide a Door is Opened by Expert Evidence on Pedophilia?

Once this evidence is presented by the defense, is the door then opened to the prosecution to present any available evidence of the defendant's past sexual history no matter how remote or how bizarre? If the Kelly case offers a lesson on this issue, one clear teaching is that everything about a defendant's sexual habits and practices may become relevant and admissible rebuttal evidence for which the only protection is the prejudice test imposed by Rule 403. See *State v. Haskins*, ___ NC App ___, 411 SE 2d 376 (1991) for an excellent discussion of the procedure to be employed in asserting the Rule 403 argument in the context of Rule 404(b) "other crimes" evidence.

Because the defense offered evidence through Dr. Henry Adams that Mr. Kelly was not aroused by or attracted to children as sexual objects and was not a pedophile, the trial court permitted the prosecution to present the testimony of Mr. Kelly's ex-wife about his sexual habits, his enjoyment of X-rated films and magazines, and her claim that she discovered "child pornography" in his post office box. [This was the only mention of any child pornography connected to Mr. Kelly. It should be noted that, despite her testimony about Mr. Kelly's conduct during their marriage which terminated in 1976, his ex-wife agreed in a Consent Order entered after their separation that Mr. Kelly should have custody of their two children.]

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