From Report to Court: Psychology, Trauma and the Law

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Introduction

The content of this paper has been informed by our clinical work at the Haven sexual assault referral centres in London and the issues that we have faced working with clients going through the criminal justice system. Over the past five years we have made progress in encouraging professionals working for the Crown Prosecution Service (CPS) and the Metropolitan Police to accept that they need to improve their understanding of the psychological sequelae of rape and sexual assault and the subsequent impact on mind and behaviour. In the teaching we provide for CPS lawyers and Sexual Offences Investigative Team (SOIT) officers, we have shifted our focus from challenging commonly held rape myths and stereotypes to exploring the impact of psychological difficulties on what is expected of clients going through the criminal justice system (from report to court). However, we recognise we still have a long way to go, particularly in relation to expert psychological evidence, which is currently inadmissible in UK courtrooms.

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Overview

As trauma specialists, we know a vast amount about the psychological impact of trauma, about the impact of rape and sexual assault more specifically, and our understanding is informed by an ever-expanding evidence base; We know that, relative to other traumatic events, such as natural disasters and road traffic accidents, people who experience rape and sexual assault have been found to have high prevalence rates of Post-Traumatic Stress Disorder (PTSD); We know that traumatic experiences can have an impact on how we retain, store, process and retrieve memories and a profound impact on how we feel able to engage with the world in the aftermath.

The *expectations* of clients who choose to report their experience of rape or sexual assault to the police and ultimately give evidence in court are often incommensurate with what we know: We ('we' being members of society, journalists, jurors, professionals working within the criminal justice system..) often expect no delay in reporting to the police despite the known impact of PTSD, fear and shame on behaviour; We expect a detailed, coherent, consistent account of the traumatic event despite the known impact of trauma on memory; And we expect clients to engage in therapy despite the (CPS recommended) limitations to clinical practice and confidentiality.

There is, it seems, a division, a lack of cohesion between what we know and what we expect of clients going through the criminal justice system and between the

psychological and legal disciplines. We aim to highlight the difficulties, the discrepancies, and we hope to stimulate discussion so that psychology, trauma and the law can, albeit slowly, become more integrated.

What We Know

1. Psychological responses to trauma

a) Memory

The British Psychological Society (BPS) guidelines on memory and the law (Conway & Holmes, 2008) are an excellent resource capturing the key facts pertaining to memory theory and research and the implications for clinical practice (specifically for clinicians involved in legal work). The guidelines have been derived from a review of the scientific study of human memory and a detailed consideration of the relevant legal issues including the role of expert evidence. The key points are summarised as follows:

- Memories are records of people's experiences of events and are not a record of the events themselves
- Memory is not only of experienced events but it is also of the knowledge of a person's life
- Remembering is a constructive process
- Memories for experienced events are always incomplete
- Memories typically contain only a few highly specific details
- Recall of a single or several highly specific details does not guarantee that a memory is accurate or even that it actually occurred
- The content of memories arises from an individual's comprehension of an experience, both conscious and non-conscious
- People can remember events that they have not in reality experienced (these are often referred to as 'confabulations')
- Memories for traumatic experiences, childhood events, interview and identification practices, memory in younger children and older adults and other vulnerable groups all have special features
- A memory expert is a person who is recognised by the memory research community to be a memory researcher

Memories are defined as *'mental constructions that bring together different types of knowledge in an act of remembering'* (Conway & Holmes, 2008). It is important to emphasise that memory is prone to error and can be easily influenced by the recall environment, such as during police Achieving Best Evidence (ABE) interviews and during cross-examination in court. It is common for memories to feature forgotten details and gaps, and this is not an indication that the memory is a confabulation or that the account is false. Accounts of memories that do *not* feature gaps and have details missing or forgotten are considered to be highly unusual. Detailed recollection of the specific time and date of experiences is also normally poor, as is highly specific information such as the precise recall of spoken conversations. The BPS guidelines state that the content of memories can be further modified and changed by subsequent recall and from a legal perspective, this does *not* necessarily entail deliberate deception.

b) PTSD and Memory

It is widely reported that people who have been raped or sexually assaulted are much more susceptible to developing PTSD than any other trauma. Rothbaum et al (1992) reported that 65% of victims met criteria at 1 month and 47% at 3 months and Capuzzo, Heke & Petrak (2007) found that 64% of victims had symptoms of PTSD within 1 month at the Havens SARCs in London.

PTSD is a diagnosable disorder (APA; DSM-IV, 1994) and occurs when a person has experienced, witnessed or has been confronted with an event that involved actual or threatened death or serious injury or a threat to physical integrity of self or others and the person's response involved intense fear, helplessness and horror. Symptoms can include persistent re-experiencing of the trauma (such as thoughts, images, flashbacks and nightmares evoking extreme feelings of distress and fear), persistent avoidance of stimuli associated with the trauma (such as talking or thinking about what happened) and numbing of general responsiveness, as well as persistent symptoms of increased arousal (such as concentration and memory problems, irritability, being easily startled and hypervigilant to threat).

People with PTSD commonly experience vivid and intrusive parts of the trauma memory in their mind, which come back involuntarily, often when they are reminded of what happened (in either an obvious or more innocuous way). Intrusive traumatic memories are typically visual images but can also include sounds, smells, tastes and physical sensations that were present during the traumatic event.

Research suggests traumatic memories are likely to be fragmented into several key 'hotspots' (e.g. Grey, Holmes & Brewin, 2001). Hotspots are typically the 'worst moments' for the person during the traumatic event, and it is these moments that tend to come back as intrusive memories. While the hotspots may be recalled in a jumbled, non-sequential order, they are generally remembered as vivid and clear, whereas other details of the traumatic event may be more difficult to recall. Thus, it is common for there to be gaps in the trauma narrative and, in some cases, inaccuracies.

c) Dissociation

Dissociation during traumatic events is a well recognised phenomena (Holmes et al., 2005; Murray, Ehlers & Mayou, 2002; & Ozer et al., 2003). The term dissociation encapsulates a range of responses for victims of traumatic experiences and involves a partial or complete disruption of the normal integration of a person's conscious or psychological functioning (Dell & O'Neill, 2009). Dissociative reactions can include a person's tendency to spontaneously *'go blank'*, *'switch off'* or *'leave'* their bodies (often known as an out-of-body experience) in an attempt to distance themselves from the distress they are feeling. Consequently, their memory of the traumatic experience (or parts of that memory) can become inaccessible to conscious awareness (e.g. Wright et al. 2006).

Dissociation can disrupt the trauma victim's ability to remember and provide a coherent, detailed account of the entire event. If there are gaps in the victim's memory, or they fail to recall particular details of the event either initially or consistently over time, this can have significant implications for reporting and providing a statement to the police and subsequently being asked to provide a

similarly detailed, coherent and consistent account, when giving in evidence in court (which can be up to a year later). In a recent study by Hardy, Young & Holmes (2009) participants who reported higher levels of peri-traumatic dissociation (*'transient changes in sensory-perceptual experience such as confusion and time distortion'*) during a sexual assault perceived their trauma memories to be more fragmented during police interview.

d) Anxiety, Hyperarousal and Fear

According to DSM-IV (APA, 1994), PTSD is classified as an anxiety disorder and although other emotions are key in peoples' responses to trauma and the subsequent development of PTSD, anxiety and hyperarousal can significantly influence peoples' ability to engage with the criminal justice system. This can be from a purely physiological perspective where anxiety may be triggered by any deliberate recount of the traumatic event, or it can lead to avoidance. For instance, victims may not feel able to re-visit the site of a sexual assault, as is sometimes required, or may be too anxious to report for reasons such as fear of retribution, further attack or not being believed.

The difficulty in reporting can be compounded by feelings of intense fear, associated with re-experiencing symptoms (such as flashbacks), which tend to be triggered by reminders of the traumatic event in the environment. It is well-known that fear is associated with the specific behaviours of escape and avoidance (e.g. Ohman, 2000). Fear involves a heightened sense of threat and danger and victims of rape commonly report recurrent thoughts about being at serious risk of harm (even when in a very safe and secure environment) and behavioural responses in order to protect themselves from harm (such as locking themselves away and avoiding any social contact). This heightened sense of threat and danger and consequent withdrawal can compound a victim's ability to report to the police, especially as their fear often relates more specifically to imagined catastrophic consequences associated with reporting an assailant to the police (such as the assailant raping or killing them).

e) PTSD and Shame

Attempts to emphasise the role of shame in traumatic events have been made by clinical and research psychologists such as Lee, Scragg and Turner (2001). Their clinical model of *'Shame-based PTSD'* proposes that shame can perpetuate trauma (and symptoms of PTSD) through the interpretation and salience of the traumatic event, resulting in engagement of avoidance strategies (such as attempts not to think and talk about what happened) in order to cope with the painful experience. What is considered to be shameful to an individual is believed to be represented in schemas of self, world and others and ultimately varies according to what the person has learned to feel shameful about within their culture and family.

Andrews, Brewin, Rose & Kirk (2000) interviewed 157 victims of violent crime within one month of the incident and asked directly about shame experiences. At six month follow-up, shame was the only independent predictor of PTSD symptoms. In addition, Talbot, Talbot & Tu (2004) examined the relationship between shame-proneness and dissociation in a population of 99 hospitalized women with and without histories of childhood abuse. Greater shame-proneness was associated with higher levels of dissociation, especially among women who had experienced sexual trauma early in their development.

The anticipation of and experience of shame has been linked to a desire to hide, avoid or withdraw from shame-eliciting situations and help-seeking (e.g. Gilbert, 1998), which could include seeking help from mental health professionals and the police. The desire to conceal a display of shame through non-disclosure has also been referred to, particularly in relation to the anticipation of being judged negatively, blamed or disregarded (Macdonald and Morley, 2001).

Shame can therefore play a major role in a victim's reluctance to report a rape or sexual assault. The role of shame in those who have not reported to the police is cited to be more prevalent in male victims (Weiss, 2007) and victims from non-Western cultures. Certain cultures have historically promoted a system of *'honour, dishonour and shame'*, whereby a victim of rape would be considered to have lost her honorable reputation and place in society. In early ancient Rome and ancient China, pressure was often put on the rape victim until she took her own life and this, rather shockingly, still occurs in a number of countries today.

In a study by Vidal and Petrak (2007) 88% of women reported feeling shame following sexual assault (Vidal & Petrak, 2007) and a 2007 government report in England reported *'Estimates from research suggest that between 75 and 95 per cent of rape crimes are never reported to the police.'* In addition, many asylum-seekers do not disclose pre-migration trauma in Home Office interviews, often due to feelings of shame, especially those with a history of sexual violence (Bogner, Herlihy & Brewin 2007).

What 'We' Expect

1. Reporting and Disclosure

The importance of dispelling myths surrounding rape and sexual assault has received considerable media attention over the past few years. Announcing measures aimed at addressing the low rape conviction rates in England and Wales in 2007, Solicitor General Vera Baird said that *'justice must not be defeated by myths and stereotypes'* and the CPS policy guidance (A Consultation on the CPS Policy for Prosecuting Cases of Rape, 2008) pledges it will not allow rape myths to influence its decisions and instructs prosecutors to robustly challenge such attitudes when in the courtroom.

Among the most damaging of these myths, in terms of conviction rates, are the assumptions made about victims who fail to report the incident until some time has passed; assumptions frequently made without an informed understanding of the well-researched psychological responses to trauma. During a rape or sexual assault case, delayed reporting has invariably been relied on by the defence as evidence of the complainant's untruthfulness. However, last year Appeal Court judges decreed that juries may be told that a complainant is sometimes slow to report an incident due to the psychological impact of the trauma he or she has experienced (See Attorney General's Office News Release, October 2008).

Solicitor General Vera Baird said: *'This is an important advance. It is a rape myth that a victim of sexual assault will always scream for help as soon as she is able and if she does not, she must have made the whole thing up… The court has taken the opportunity to tackle this myth, on the basis that judges are better aware from their*

court experience that many reasons, including trauma, fear and shame may make a victim unable to complain for some time.' (Court Of Appeal: Judges To Make Clear To Juries That 'Delay In Reporting Rape May Be Because Shame And Guilt Inhibit A Woman From Making A Complaint' - 'Rape Myth Busted' - Solicitor General, 24th October 2008) This advance is hoped to have a positive impact on the currently low conviction rates for cases of rape and sexual assault.

What can we do?

Often clients express the desire to report a traumatic experience, such as rape or sexual assault to the police but struggle to overcome strong, difficult feelings such as fear and shame. Helpful psychological interventions when a client is considering whether or not to report an incident to the police/disclose to the Home Office can include the following:

- Motivational Interviewing (MI) re: the client's decision to report (e.g. Miller & Rollnick, 2002). MI is based on four main principles:

    1. Express empathy: guides therapists to share with clients their understanding of the clients' perspective.
    2. Develop discrepancy: guides therapists to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be vs. how they currently are (or between their deeply-held values and their day-to-day behavior).
    3. Roll with resistance: guides therapists to accept client reluctance to change as natural rather than pathological.
    4. Support self-efficacy, guides therapists to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence.

- Psychoeducation and Normalising Psychological Reactions: For example, providing clients with information about *'normal'* psychological reactions following trauma, talking them through the Dual Representation Theory *'Brain Model'* (Brewin et al., 1996) to improve their understanding of the impact of trauma on memory and to normalise symptoms such as flashbacks, nightmares and enhanced physiological arousal.

- Challenging and Reconstructing Negative Attributions: Victims sometimes deny victimisation by holding themselves partially responsible for what happened or by indicating that they somehow deserved what they got, especially if they had been drinking alcohol. Ironically, self-blame also tends to empower victims by giving them a sense that they had some form of control over what happened, and therefore could prevent something similar happening again in the future by changing their behaviour. Sometimes it seems to be easier for people to believe that they were somehow responsible for the rape (because they were drunk, out late, because they trusted someone they shouldn't have) than to accept that we live in a world where bad things happen, often unpredictably. Anticipation that others will either question their veracity or blame them tends to exacerbate feelings of shame and embarrassment among many victims (Weiss, 2007). Some of the victims' embarrassment seems to originate from the anticipated humiliation or stigma

of being labelled a "victim", a label with the implication of being seen as someone powerless and vulnerable, especially if they have made negative attributions about their inability to fight back or prevent the rape or sexual assault from occurring. Clients tend to benefit from being presented with facts and statistics (such as the lack of physical injury in rape victims and the known impact of the fight, flight, freeze response on behaviour) in order to begin challenging and re-evaluating their negative attributions.

- Involvement of other Agencies – liaison with SOIT officers, case workers from victim support, third sector organisations: multi-agency discussion about the client's safety and need for additional support.

- Training and Service Development: For example, teaching SOIT officers and CPS lawyers about the psychological impact of rape and sexual assault and the impact of trauma on memory. Also, stimulating discussions about the timing of police ABE interviews, possible inconsistencies in accounts given over time and what to expect when a client is asked to give evidence in court (on a case-by-case basis).

2. Waiting for Court

Inconsistencies over time

Clients are often expected to wait for up to a year after reporting rape or sexual assault to the police before being asked to give evidence in court. During this time, there is great emphasis placed on the importance of *'consistency'* in their account given over time. Clients are expected to provide a detailed account, often in the immediate aftermath of the traumatic event (within a day or two) during the police ABE interview. There is an expectation that any account of the traumatic event subsequently given (to medical professionals, psychologists and ultimately when giving evidence in court) is consistent in detail, with neither gaps nor additional information provided. *'Inconsistencies'* in a client's therapy notes are potentially disclosable to the defence and are frequently used by barristers in court as an indication of the client's untruthfulness. It is important to consider this in light of what we know about memory and the impact of trauma on memory.

In a sample of 27 asylum seekers, Bogner, Herlihy & Brewin (2007) found that psychological symptoms (such as dissociation, flashbacks and avoidance behaviours) had a detrimental impact on their ability to disclose and provide a coherent account of trauma during Home Office interviews. In addition, in a recent study by Hardy, Young & Holmes (2009), increased memory fragmentation was associated with participants viewing themselves to have provided more incoherent accounts of sexual assault to the police and increased account incoherence was associated with victims perceiving themselves to be *less* likely to proceed with legal cases.

Clinical Implications and Issues when working with clients going to court

The 2001 CPS practice guidance for the *'Provision of Therapy for Vulnerable or Intimidated Adult Witnesses Prior to a Criminal Trial'* states that

- *"…the witness should not discuss or be encouraged to discuss the evidence which s/he is to give in the criminal proceedings but may receive general support to help them through the process of appearing in court."*

- *"…any detailed recounting or re-enactment of the offending behaviour may be perceived as coaching…and the criminal case is almost certain to fail as a consequence of this type of therapeutic work"*

- *Preparation for court and carefully planned preventive work which does not focus upon past abuse presents less of a problem than interpretative psychotherapy"*

- *"The least problematic aspect of therapy will focus on improving self-esteem and self-confidence, often using cognitive/behavioural techniques"*

- *"Other issues which may be addressed include: reduction of distress about impending legal proceedings; and treatment of associated emotional and behavioural disturbance that does not require rehearsal of abusive events"*

The 2005 National Institute of Clinical Excellence (NICE) Guidelines recommend that:

- Practical, social and emotional support be offered in the immediate post-incident care and 'watchful waiting' should be implemented for 1 month

- Trauma-focused cognitive behaviour therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) should be offered for severe PTSD present after 1 month

- Non-trauma focused interventions (such as relaxation or non-directive therapy) that do not address traumatic memories should not be routinely offered

NICE guidelines for PTSD recommend *'trauma-focused CBT or EMDR',* both of which involve a reliving component. There is therefore a clear discrepancy between our clinical guidelines and the guidelines provided by the CPS for pre-trial psychological therapy, which advise against *'any detailed recounting or re-enactment of the offending behaviour'* as this *'may be perceived as coaching…'* And furthermore, *'the criminal case is almost certain to fail as a consequence of this type of therapeutic work'.* This creates a very difficult and worrying dilemma for both the clinician and the client: do you follow professional clinical guidelines and offer the client evidence-based trauma-focused therapy to treat their symptoms of PTSD even if the criminal case *'is almost certain to fail as a consequence?'*

When exploring further the perception of psychological therapy in the legal world and the implications of *'any detailed recounting or re-enactment of the offending behaviour',* it becomes clear that many of the assumptions made are in relation to the modification or distortion of memory by the therapist. According to Bronitt & McSherry (1997) *'The counselling of the complainant provides a novel ground for*

repackaging defence claims of fabricated allegations. Rather than suggest fantasy or spiteful mendacity on the part of the complainant, the defence attempts to impugn her credibility as a witness on the ground that her memory has been distorted or falsified by the type of counselling employed'.

Thus, there is the suggestion that therapists, when discussing a traumatic event in detail, can distort or falsify a client's memory. The false or recovered memory debate is perhaps of the most controversial issues to have been discussed and explored at length both in the field of psychology/psychiatry and in the court room. It has been suggested that therapists are guilty of "implanting" false memories, or that individuals are legitimately "recovering" repressed memories of abuse. To quote Scheflin (1999) *'Because the squeakiest wheel gets the most grease, the courts, legislators, public and professionals have heard, and acted upon, more diatribe than dialogue. To quiet this cacophony, we must make one fundamental observation: there is a crucial difference between opinion and belief on the one hand and science on the other.'* He goes on to suggest *'Perhaps we can find common ground with the understanding that the debate is most fundamentally about science, not belief. The important questions are all questions of science: whether repressed memories exist, whether they are accurate, whether false memories can be implanted, and how far suggestion can influence memory, thoughts and conduct.'*

So, what do we know about recovered and false memories? In a recent review of the literature, Wright, Ost & French (2006) identified different types of case studies that have been used to illustrate the different processes of recovered and false memories. From biologically impossible events (Wagenaar, 1996) to alien abduction claims (e.g. French, 2003), people clearly come to believe in events that never occurred. Some well-documented case histories exist, like retractor cases against therapists (e.g. Bennett Braun, Roberta Sachs – see Bikel & Dretzin, 1995). Case studies show that it *is* possible to create memories for truly traumatic and abusive events that did not occur.

According to Wright, Ost & French (2006) we now know events *can* be implanted into a person's autobiography, that some people are more suggestible than others, that particular techniques increase the likelihood memories can be implanted, but also that most people will *not* believe bizarre memories, at least after the amount of persuasion applied in typical laboratory studies. What appear to be newly remembered (i.e. recovered) memories of past trauma are sometimes accurate, sometimes inaccurate, and sometimes a mixture of accuracy and inaccuracy. Much of what is recalled cannot be confirmed or disconfirmed. Which, although we might emphasise the use of open questions and a socratic dialogue, it is incredibly difficult for us to state with any certainty (especially in a court room) that a memory could not have been *'distorted or falsified'*..

What we do and what we don't do..

We don't: Ask clients to recount the traumatic event in detail (unless they decide they would like to engage in trauma-focused therapy, despite the potential detriment to the criminal trial); Rehearse, practice or *'coach'* witnesses in giving evidence; Suggest/implant false memories (at least not intentionally..)

We do: Routinely adhere to CPS Guidance (despite NICE guidelines); Use *Socratic* (as opposed to leading) questions; Make the boundaries of confidentiality clear (in terms of potential disclosability to the CPS of copies of *all* therapy notes); Offer regular sessions for practical and emotional support and symptom management such as grounding techniques, improving self-esteem and decreasing distress and anxiety; Find it difficult at times to withhold PTSD treatment until after the trial.

What *can* we do?

When considering pre-trial psychological therapy, after a full assessment and formulation of a client's presenting difficulties, it is useful to have an open discussion about the recommended therapy according to the National Institute of Clinical Excellence (NICE) and whether the proposed therapy adheres to CPS guidelines or could be potentially detrimental to the court case if the client's notes are requested.

The CPS guidelines (2001) state the following:

4.4 The best interests of the vulnerable or intimidated witness are the paramount consideration in decisions about the provision of therapy before the criminal trial. In determining what is in the best interests of the vulnerable or intimidated witness, it will be essential to consider the wishes and feelings of the witness and, where appropriate, of those who are emotionally significant to the witness. The witness will need to be given information on the nature of the therapy proposed in a form which is accessible. Account should be taken of issues associated with gender, race, culture, religion, language, disability and any communication difficulties both in initial discussions about the proposed therapy and in the provision of the therapy itself.

4.5 While some forms of therapy may undermine the evidence given by the witness, this will not automatically be the case. The Crown Prosecution Service will offer advice, as requested in individual cases, on the likely impact on the evidence of the vulnerable or intimidated witness receiving therapy.

4.6 If there is a demonstrable need for the provision of therapy and it is possible that the therapy will prejudice the criminal proceedings, consideration may need to be given to abandoning those proceedings in the interests of the wellbeing of the vulnerable or intimidated witness. In order that such consideration can be given, it is essential that information regarding therapy is communicated to the prosecutor.

In light of this, a collaborative decision needs to be made regarding what type of therapy is offered. If a client is presenting with PTSD, do you offer trauma-focused CBT whilst the client is waiting for the court case or do you work within the parameters of the CPS guidelines by focusing on *'improving self-esteem and self-confidence'* and *'reduction of distress about impending legal proceedings and treatment of emotional and behavioural disturbance that does not require rehearsal of abusive events'*?

It is interesting to note that the CPS consider the *'best interests'* of the client to be *'the paramount consideration in decisions about the provision of therapy',* although there is no clarity on how these interests are determined. Additionally, the guidelines state that if there is *'demonstrable need for the provision of therapy'* then court proceedings may be abandoned *'in the interests of the wellbeing of the vulnerable or*

intimidated witness'. However, there is no clarity on what constitutes a *'demonstrable need'* for therapy or how this is determined. Arguably, as clinicians, we may consider anyone presenting with PTSD as having a *'demonstrable need'* for trauma-focused therapy. Are professionals working within the CPS qualified to make a decision about whether or not psychological therapy is in a client's best interests and if so, what type of therapy they should be offered? Surely it's for the clinician to make a recommendation based on NICE clinical guidelines and the decision to be made by the client? However, experience tells us that clients are rarely keen to engage in *anything* that may be detrimental to the criminal trial, even when they present with severe PTSD, which is having a profound impact on their functioning. Clients tend to be aware of the low conviction rates, especially in rape and sexual assault trials, and want to do whatever they can to maximise their chances of a successful outcome. Thus, waiting for court often involves tolerating extremely distressing and debilitating symptoms and a general sense of life being *'put on hold'* until after the trial.

During the pre-trial period, it if often helpful for clinicians to liaise with the police and CPS lawyers. In some cases, they might benefit from further information about a client's presenting difficulties, related research articles or guidelines (the BPS memory and the law guidelines for example). In some cases, a professional statement might be requested or recommendations might be sought for a credible expert witness (though this is uncommon in rape and sexual assault cases). Difficulties arise with the inadmissibility of psychological evidence in court and CPS lawyers often report finding it difficult to know how to find a way to integrate psychological explanations as to why clients present(ed) or behave(d) in a particular way. In some cases, during the ABE interview, SOIT officers ask specific questions about a client's demeanour, thoughts and feelings during the assault and rationale for particular behaviours and a video of this interview is usually shown in court.

In our experience, at times, SOIT officers and CPS lawyers have a limited understanding about the psychological impact of trauma. At times, they are unaware of the known (and well researched) characteristics of the human memory and the impact of trauma on memory, psychological and physiological reactions that seek to explain the range of different presentations/demeanours post-assault and the fight, flight, freeze response, which answers the repeatedly asked question as to why victims *'don't fight back'.* In court, defence barristers often draw open the known *myths and stereotypes* during cross-examination, which tend to be at odds with what we *know*. Therefore, setting up teaching sessions and workshops with the police and CPS has been beneficial but this is slow progress and perhaps a longer-term solution.

Sexual assault specialists working for the CPS have expressed the desire to make changes to the current system by introducing *psychological* explanations in individual cases, where appropriate. However, it's not clear at present how this can be done. There have been suggestions that what is needed is a *'good example'*: a case where this can be tried and tested, to get the ball rolling. In addition, it would undoubtedly be useful for more psychological research to be integrated into the legal literature.

3. The Court Case

When working psychologically up until the court case, work often involves exploring and helping a client to manage their anxieties about giving evidence in court. We

know that cross-examination (even when not traumatised) can be an extremely difficult and distressing experience. How honest are you about what the client should expect from cross examination? It can be a difficult balance between honest preparation and anxiety management. It is important to discuss the *process* of giving evidence but not the *content:* be careful not to be seen to be *'coaching'* the witness. On occasion, the question is asked as to whether this part of our role as clinicians. If not, should we involve other agencies (such as victim support) to provide the relevant information about criminal proceedings?

All medical and therapy/process notes are potentially disclosable to the court and the CPS make it very clear that if requests for notes are refused, a court order will be issued. Obviously, this raises dilemmas and conflicts for therapists due to therapist/patient confidentiality. It is therefore important to clearly define the limitations to confidentiality at the outset of therapy. As clinicians, we have no *formally* recognised way of keeping clinical notes: If you use your notes as a 'clinical tool' as part of a CBT intervention (including, for example, negative automatic thoughts relating to self-blame), could they be detrimental to criminal proceedings?

According to Temkin (2002), the disclosure of confidential records such as those of doctors, teachers, counsellors, and therapists may be sought by the defence as a means of *'undermining the credibility'* of complainants in rape and sexual assault trials. The procedure is under section 2 of the Criminal Procedure (Attendance of Witnesses) Act 1965, under which disclosure of the records of third parties may be sought. However, progress is being made: in the area of sexual assault, for example, in Australia, Canada, the UK and the US, the rules of evidence and procedure have been modified over recent years to restrict the way in which defence can seek to undermine the credibility of women who allege rape. *"Rape shield"* laws in many common law jurisdictions now restrict the admission of evidence of sexual reputation and history in an effort to protect women from further victimisation by the legal process. (Temkin, 1993). Empirical studies suggest, however, that rape shield laws are routinely ignored by counsel (both defence and prosecution) and by trial judges.

4. The Verdict and Aftermath

Regardless of the decision made regarding psychological therapy, often life is *'put on hold'* by clients prior to the criminal trial. This can mean that although they have goals and aspirations for change, they feel unable to take steps towards these goals until the court case has ended. This has obvious implications for therapy, especially therapy, such as CBT, with a behavioural component. Another implication can be that psychological wellbeing becomes conditional on a conviction and the sense that *'justice has been served'.* The verdict can challenge or reinforce positive and negative thoughts and beliefs. For example, if the assailant is found not guilty, clients often interpret this as not having been believed by the members of the jury (as opposed to the assault not having been proven beyond reasonable doubt). An assailant being acquitted can, at times, lead to a strengthening of negative attributions related to responsibility and blame.

Feelings of shame and self-blame are highly prevalent in victims of crime and often more so in clients who have been raped or sexually assaulted. When being cross-examined in court, the defence barrister can bear an uncanny resonance to the client's own *'critical voice'.* And it is important not to underestimate the impact of this voice

challenging, questioning, and at times, tormenting clients across a court room full of people, many of whom are feeling incredibly anxious about giving evidence. Weeks or months of pre-trial therapy that has involved challenging and evaluating the evidence for and against these negative attributions relating to responsibility and blame is not always enough to withstand the psychological impact of cross-examination, especially when one considers the relatively high prevalence rates of pre-existing mental health difficulties and vulnerabilities in victims of rape and sexual assault (for example).

A non-guilty verdict can also result in a pervasive sense of a *'lack of justice'*, within the legal system but also more generally. Clients often report having significant difficulty in coping with the assumption that they are suffering and continue to suffer when the assailant remains unaccountable, unpunished and allowed to *'walk free without consequence'*. Whether or not this is the case is another matter but without further information about the assailant's state of mind, it is a difficult assumption to challenge. When assailants are acquitted, clients also report fears of repercussion (especially when the assailant was an acquaintance or ex-partner), doubts about their own safety and a possible increase in PTSD symptoms as a consequence.

The experience of giving evidence and being cross-examined in court can activate delayed onset PTSD (e.g. Brewin et al, 2010). DSM-IV diagnostic criteria requires a six month period to elapse if PTSD is to qualify as delayed-onset PTSD. On average, this occurs in 15.3% civilian cases of PTSD and 38.2% cases of combat-related PTSD, with initial PTSD symptoms gradually increasing in number and intensity (Andrews et al., 2007). Delayed-onset PTSD has been associated with gradually increasing levels of arousal and is often preceded by episodes of depression (Andrews et al., 2009), both of which can be common reactions to the experience of going to court.

However, it is important to remember that regardless of the verdict, the impact of a court case *can* be positive. Some clients report feeling better due to having had the opportunity to *'make the assailant accountable for what they did'* and some clients benefit from what they see as having *'had a voice'.* The court experience can result in clients feeling more empowered, especially when their strength and courage is recognised and commented upon.

Where does this leave us?

Regardless of how supportive and how skilled we are as clinicians, a client's experience of the criminal justice system can be distressing and difficult: they can feel judged and disadvantaged in the process due to psychological reactions and behaviours we, as clinicians, understand to be *'normal'*. It seems important that myths and stereotypes are challenged, in part by greater dissemination of psychological research in the area of trauma and memory into the legal arena. However, this is easier said than done. We can assume that decisions made by members of the jury are influenced by preconceived notions about demeanour and behaviour; perhaps a belief in myths and stereotypes that becomes strengthened or confirmed by the defence barrister. However, we do not have access to the transcripts of jury discussions and the research in this area is sparse.

However, case examples and research studies do exist and give further weight to what is needed. It was reported in the Times in November 2008 in response to the Regina vs. Doody case, that a defence barrister had raised the issue of delayed reporting in order to undermine the credibility of the witness (who had alleged rape) and the judge had consequently decided that *'an appropriate warning to the jury was considered necessary to ensure fairness to the complainant.'* By way of explanation, the judge stated the following:

'Very often, women who are raped within relationships feel ashamed of what's happened. They themselves feel the shame. Although they have nothing to be ashamed about, because they are the victim, that's the reaction. They feel ashamed of what's happened. They are often too traumatised or embarrassed to tell anyone what's going on, and a very serious aspect of the offence in those circumstances is that a woman feels trapped. She is, after all, in her own home, very often simply too ashamed and embarrassed to tell anyone that the person that she has brought into her home to share her life, be with her children, is now raping her. She won't tell her neighbours, friends… even very close friends…children, still less the police, because of those factors which bring to bear.'

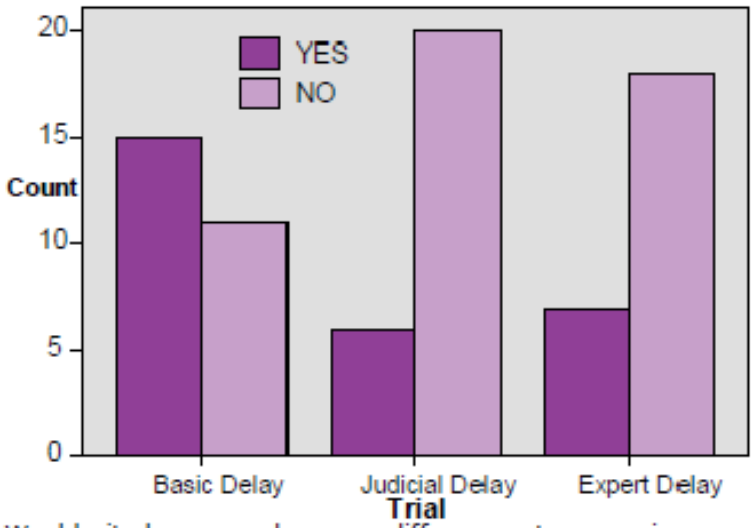
'You say to yourselves: why didn't she complain? Well, what she said to you was that when the police were in her house there were quite a lot of them. They were joking and wandering about, and she just didn't feel that she could speak to them. But when P.C. Stephenson came along; you may think what she was saying there was something of a kindred spirit. There was a sympathetic ear here. A young policeman, on his own, and she felt she had to say something. And why? You may conclude it was as a result of the ferocity of that final attack. If what she has told you is true, it was a ferocious rape. She said at one stage she was being smothered and thought that she might not survive. That's how bad she thought it was. The prosecution say that's why she looked like she did when she saw Adam in the house, and that's what made her tell the police what was going on, because in spite of her feelings for Mr D, and all that happened in the past, she was thinking that enough was enough.'

Lord Justice Latham said that the judge was entitled to make comment as to the way evidence was to be approached, particularly in areas where there was *'a danger of a jury coming to an unjustified conclusion without an appropriate warning'*. It was stated: *'The fact that the trauma of rape could cause feelings of shame and guilt which might inhibit a woman from making a complaint about rape was sufficiently well known to justify a comment to that effect.'* However, this case is seen as an exception, a good example and psychological evidence remains inadmissible…

In a recent study by Ellison & Munroe (2009), volunteers who had agreed to act as a *'mock juror'* observed one of nine rape trial reconstructions, and were asked to deliberate as a group towards a verdict. Aforementioned assumptions regarding the limits of current public understanding as to what constitutes a *'normal'* reaction to sexual victimisation appeared to be merited. Many jurors were influenced by expectations regarding why victims did not fight back (leading to questions regarding the validity of the complaint and the issue of consent), why they did not report the assault immediately to the police and emotional control (a calm demeanour, for example, leading to appraisals such as: the victim was *'cold and calculating'*). Many jurors additionally harboured unrealistic expectations regarding the likelihood of

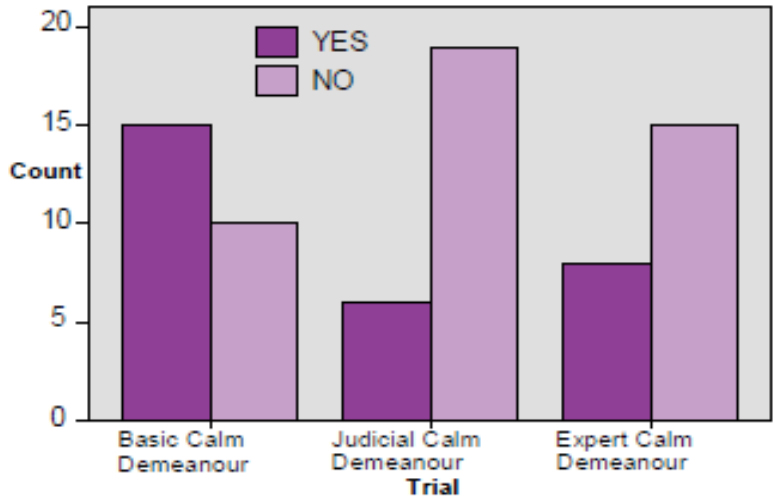
physical injury (which we know to be fairly uncommon). Jurors who received educational guidance (by either an expert or the judge) were less likely to consider a three day delay in reporting, or a calm demeanour, as necessarily problematic. Expectations regarding complainant injury/resistance were harder to shift. Educating the jurors with psychological explanations *did* seem to increase their understanding of the victims' behaviour and result in them being less likely to acquit the assailant.

a) Delayed Reporting



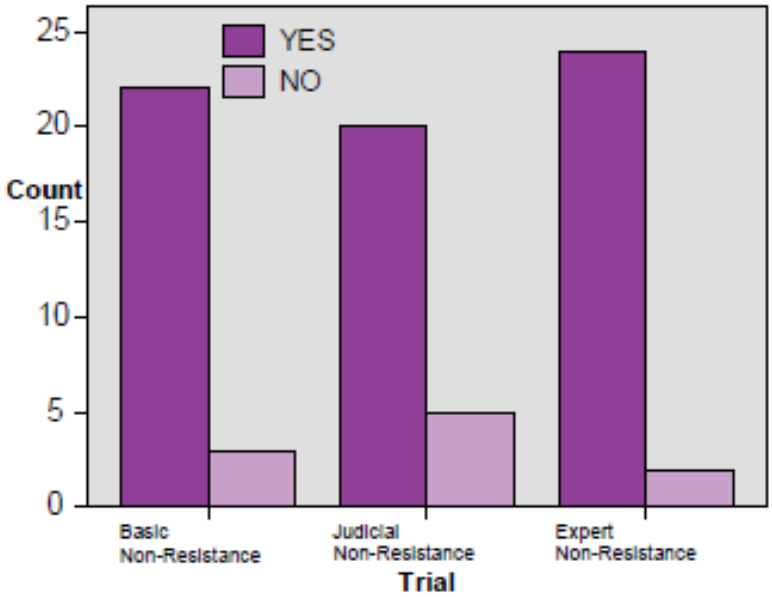
Would it have made any difference to you in your deliberations if Jane had reported the alleged assault to the police sooner?

b) Demeanour



Would it have made any difference to you in your deliberations if Jane had been more distressed/upset when giving her testimony?

c) Physical Injury



Would it have made any difference to you in your deliberations if Jane had shown signs of physical injury after the alleged assault?

However, in the UK, psychological evidence is still inadmissible in rape trials (yet widely used in asylum and family court proceedings). Teaching and service development seems to be a start in the right direction but the integration of psychological evidence and understanding into the current system is a slow process. Discussion across the psychological and legal disciplines tends to result in more questions than answers and it often seems that we are at an impasse. If a victim of a road traffic accident had a broken leg, when giving evidence in court, we would give them a chair. Yet it seems, at least for the time being, we are sending our traumatised clients in without one.

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