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## **METHODOLOGY & PROCEDURES**

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The Child Witness Project Longitudinal Study is a prospective, follow-up study of children whose sexual victimizations were prosecuted in criminal or youth court after the proclamation of the Bill C-15 amendments. The target subjects were the 126 child victims who participated in the project evaluation in 1988 and 1989. Their last contact with the Child Witness Project had been an average of two years and eight months previous. We were able to locate all but nine (seven percent) of the target sample and we contacted the parents by mail to request their participation in this study. We asked the children and their parents to come back for an interview, the purposes of which were to:

- 1) gauge the impact the court experience has had on their family, schooling and social lives;
- 2) ask their opinions on the court process as they experienced it; and,
- 3) measure the current emotional adjustment of the children.

To compensate for their time, we offered an honorarium of \$50.00. We were able to interview the child, a parent, or both in the majority of cases (61 percent).

### **RESEARCH QUESTIONS**

The research design permitted the study of these general research questions:

- 1) what is the long-term psychological and social impact on children of their experiences in court and court outcome;
- 2) how were their lives affected by the prosecution; and,
- 3) what variables best predicted emotional adjustment after four years?

We were particularly interested in how abuse characteristics interacted with other factors to influence each child's emotional outcome, three years after the verdict.

### **SOURCES OF EXISTING DATA**

There was a pre-existing data set of information on each prospective subject. At the time of court, an enormous amount of demographic and psychometric information had been collected about each child. In addition, through monitoring of the court process, information was collected on abuse characteristics and the court experience of each child. The following sources of information were available:

- ! an intake session with parent/guardian;
  - ! parent/guardian completion of Child Behavior Checklist;
  - ! requested information from involved social-service and mental-health agencies;
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- ! clinical interview with each child;
  - ! psychometric testing of each child;
  - ! review of court files; and,
  - ! court observation.

### **FOLLOW-UP INTERVIEW PROTOCOL**

Information for the follow-up was obtained primarily from interviews with the child and/or parent and through the re-administration of psychological tests. Where appropriate, some information was verified with outside agencies.

#### **INTERVIEW FORMAT**

Several interview formats were considered before it was decided that a semi-structured format would be the most appropriate. A key issue that had to be taken into account was the difference in comprehension levels of the children, who now ranged in age from eight to 20. We also had to devise questions which were relevant to a wide range of abuse situations and court experiences. Attention span was another factor to be considered. Most importantly, flexibility was necessary in order to capture the full range of facts and opinions.

The interview with the child was conducted by one of the project therapists while a parallel interview was conducted with a parent by the project researcher. Having a clinician conduct the child interview was necessary because of the sensitive nature of the material, the need to tailor the interview to the intellectual level of the child, and the need to make a clinical judgment about terminating the interview if the level of distress manifested by the child were to so indicate.

Both parent and child interviews were in a semi-structured format, interviewer-administered, with open-ended questions. Participants had been advised, in writing and verbally, that they could decline to answer any question. The children completed up to five psychological tests, three of which they had done four years ago. Parents of children under 19 years of age completed the Child Behavior Checklist and all parents filled out an attitude survey on the criminal justice system. These interviews, together with the administration of the testing, took between two and four hours, depending upon the circumstances of the case and the needs of the child. Contrary to what might have been expected, most children were very open and willing to discuss their experiences. They provided mature, frank and thoughtful responses to the questions.

#### **AREAS ADDRESSED IN THE INTERVIEW**

Prior to the commencement of the interviews, five children were interviewed with a draft version of the interview schedule. On the basis of this pilot testing, the interview was shortened significantly. The topics addressed in the final version of the interview were:

##### **1. Demographic Data**

- Current family structure and changes since disclosure
- Current residential situation and changes
- Schooling
- Employment and financial support
- Children's Aid Society involvement
- Therapy/counselling received since disclosure

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Significant life stressors and experiences since disclosure

2. The Disclosure Process

Disclosure sequence  
 Rationale for disclosing/delaying disclosure/not disclosing  
 Perceptions of parental reaction  
 Aftermath of disclosure (decision to call police, etc.)

3. Recollection and Opinions of the Criminal Justice Process

Support system waiting for court  
 Support system at the courthouse  
 Qualification and testifying (if applicable)  
 Suggestions for improvements to the procedures for child witnesses  
 Outcome/verdict  
 Sentencing (if applicable)  
 Current contact with the defendant/offender  
 Overall perceptions of court experience  
 Previous and subsequent contact with the justice system  
 Victim compensation

4. Self-report of Current Emotional Adjustment

Self-report of emotional adjustment  
 Revictimization and response  
 Future plans and debriefing

At no time during the interview was the sexual abuse itself directly asked about, although the child was not discouraged from discussing the topic.

## PSYCHOLOGICAL TESTING

To measure current emotional adjustment and facilitate pre/post comparisons, the following tests were chosen. Four of the instruments were used in the evaluation study, so the children would have completed them from one to four times previously. For purposes of before and after comparison, the pre-court administration of the test was used to compare with follow-up scores. While typically self-administered, where necessary, narrative administration was used.

*Child Depression Inventory:* The CDI<sup>37</sup> consists of 27 items, each of which allows the child to select among alternatives on a three-point scale, reflecting the degree of particular symptoms. It may well be the most thoroughly researched and widely employed self-report measure of depression in children.<sup>38</sup> Adequate reliability and validity have been reported<sup>39</sup> and the CDI has been found to be negatively correlated with several indices of social competence and functioning. The CDI is normed for children 16 years of age and under.

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<sup>37</sup> M. Kovacs (1983). *A Self-Rated Depression Scale for School-aged Youngsters*. Unpublished, University of Pittsburgh School of Medicine; and, M. Kovacs (1985). The Children's Depression Inventory, *Psychopharmacology Bulletin*, 21: 995-8.

<sup>38</sup> A.J. Finch, C.F. Saylor & G.L. Edwards (1985). Children's Depression Inventory: Sex and Grade Norms for Normal Children. *Journal of Consulting & Clinical Psychology*, 53, 424-5; and, Kazdin, A.E. (1981). Assessment Techniques for Childhood Depression. *Journal of the American (con't) Academy of Child Psychiatry*, 20: 358-75.

<sup>39</sup> R. Fauber, R. Forehand, N. Long, M. Burke & J. Faust (1987). The Relationship of Young Adolescent Child Depression Inventory (CDI) Scores to their Social and Cognitive Functioning. *Journal of Testing & Behavioral Assessment*, 9: 161-72.

*Fear Survey Schedule, Revised:* This self-report measure<sup>40</sup> has been used in a number of studies examining children. Psychometric properties of this scale are positive, and the FSSC-R possesses high internal consistency ( $\alpha=.94$ ) and test-retest reliability ( $\alpha=.82$ ). The addition of the SAFE (Sexual Abuse Fear Evaluation) scale<sup>41</sup> of 27 items embedded in the FSSC-R has made the measure particularly sensitive to the specific fears of sexually abused children, through its measurement of abuse, disclosure and revictimization fears. Because of on-going test development, normative information was not available for the SAFE.

*Children's Impact of Traumatic Events Scales, Revised:* Developed at the Children's Hospital of Western Ontario,<sup>42</sup> the CITES-R is designed for administration to children who have experienced sexual abuse. Children are asked to respond to 78 items which measure the four dimensions of post-traumatic stress disorder (intrusive thoughts, avoidance, hyperarousal and sexual anxiety), negative reaction by others, social support, self-blame/guilt, personal vulnerability, dangerous world, empowerment, and eroticism. An earlier version of this test was administered to a portion of the children at the time of court; but, pre/post comparisons were possible only for some of the scales because of the addition of many new items in the revised version. As with the SAFE, normative information was not available.

*Child Behavior Checklist:* For children 18 or under, the parents were asked to complete the Child Behavior Checklist.<sup>43</sup> It requires a parent to respond to 118 behaviour problem items and 20 social competence items. It is designed so as to obtain parents' descriptions of their children's behaviour in a standardized form. The CBCL is a popular measure which is extensively used in clinical research. It possesses good inter-parent agreement on item scores ( $\alpha=.985$ ,  $p<.001$ ), and test-retest reliability at one week intervals is high for both social competency and behaviour problem scales. As well, scores on the various scales of the CBCL have been found to correspond highly with similar scales on other checklists, such as the Quay Peterson checklist.

The CBCL provides a general measure of the child's overall social and adaptive functioning and competence as well as internalizing behaviour symptomatology. In 25 cases where we re-administered the CBCL, pre-court scores for this measure were available. As the test was re-normed in 1991, all the pre-court testing was re-scored to be comparable. This instrument could not be used for subjects who were over 18 years of age at follow-up, who were not accompanied to the interview by parents, or who had not been in contact with their parents over the previous six months.

*Youth Self-Report:* This is a self-report version of the Child Behavior Checklist.<sup>44</sup> It measures social competence and behaviour problems in youths between the ages of 11 and 19. The YSR was administered only at the point of follow-up so no pre/post comparison was possible. It was not given to children under 11 or over 18.

*Brief Symptom Inventory:* The BSI<sup>45</sup> is a self-report symptom inventory, a short version of the 90-item Symptom Checklist (SCL-90). Subjects are asked to respond to 53 items on a five-point scale of "not at all" to "extremely." It was used for subjects age 13 and older and scored according to adolescent norms for those

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<sup>40</sup> T.H. Ollendick (1983). Reliability and Validity of the Revised Fear Survey Schedule for Children (FSSC-R). *Behavior Research & Therapy*, 21: 685-92.

<sup>41</sup> V.V. Wolfe & D.A. Wolfe (1988). The Sexual Abuse Fear Evaluation Scale. Unpublished.

<sup>42</sup> See V.V. Wolfe, C. Gentile, T. Michienzi, L. Sas. & D. Wolfe (1991). The Children's Impact of Traumatic Events Scale: A Measure of Post-Sexual Abuse PTSD Symptoms. *Behavioral Assessment*, 13: 359-83.

<sup>43</sup> T.M. Achenbach (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. Burlington, VT: University of Vermont, Department of Psychiatry.

<sup>44</sup> T.M. Achenbach (1991). *Manual for Youth Self-report and 1991 Profile*. Burlington, VT: University of Vermont, Department of Psychiatry.

<sup>45</sup> L.R. Derogatis & P.M. Spencer (1982). *The Brief Symptom Inventory: Administration and Procedures Manual*. Johns Hopkins University School of Medicine.

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under 20 years of age and adult norms for the 20 year olds. It produces scores for nine primary symptom dimensions and three global indices. The authors report a high correlation of scale scores with the SCL-90 and moderate convergent validity with the scales of the MMPI.

### LIMITATIONS OF THE TESTING

In selecting tests, we were restricted to those which were normed on children and adolescents and those which could be understood by younger subjects. This presented two problems. First, some tests that we had used during the original study could not be used for those subjects who had matured beyond the ages where these inventories are valid. In addition, some items make reference to the experiences of children — such as schooling, babysitters and play grounds — and are not applicable for young adults. Second, the comprehension level or attention span of some subjects precluded their use and, for a few children, no testing was administered. Limitations of the testing data are discussed further in Chapter Ten.

### CLINICAL JUDGMENT RATING SCALE

Because of the above noted problems, there was no one psychological measure that could be used for all returning subjects. Therefore, we needed to devise a summary statistic for purposes of data analysis. To draw together the wealth of information collected about each child and to create an indicator of global functioning, we decided to use clinical judgments. At the end of each interview session, the therapist recorded anecdotal clinical impressions which included an assessment of the need for a therapy referral. She also completed a seven-point rating of ten dimensions of current life circumstances and emotional adjustment: family relationships; peer relationships; community connectedness; school/employment/career goals; life circumstances; self-esteem; mood/state of mind; coping strategies; significant life events; and, finally, future outlook. When summed, this Clinical Rating Judgment Scale provided an overall score of global functioning at the time of follow-up. The future outlook rating represented the therapist's clinical prognosis. At weekly project meetings, each therapist presented her cases, the associated clinical judgment ratings, and the rationale for her choices. Based upon a comparison of cases and a general discussion, the scores could be amended.

### STRESS INDEX

If children presented at the follow-up as being emotionally fragile or disturbed, to what could this be attributed? Abuse? Court? Or other life experiences? A specific concern was that adolescence is a period during which a certain amount of confusion, upheaval and strife is the norm. Using psychological measures normed on our target age group was one solution to this problem. Another was to devise a measure of the contextual and background issues with which the children were struggling at the time of the follow-up interview.

From a clinical understanding of the stressors experienced by children,<sup>46</sup> we created a list of 18 stressful events and circumstances. Some were stressors which can be experienced by any child and some were specifically associated with the aftermath of sexual abuse and court involvement. They were: death of a close family member; death of a peer; separation/divorce of parents; being sexually revictimized; being the victim of another type of traumatic crime; being in an abusive relationship; parental rejection or having no parents; serious accident/injury/medical problem; abortion/miscarriage; having a baby or currently being pregnant; breaking up from a serious, long-term relationship; appearing in youth/criminal court; going to jail/being institutionalized; on-going contact with or harassment by the abuser; financial hardship; on-going stress related to the court case in which they testified; and, significant parental physical/mental illness. There was also an "other" category in which we coded any other traumatic events or circumstances which were described during the interview. Each factor was scored as being either present or absent in the life of the child at the point of follow-up. The items were not weighted. Therefore, a stress score ranging between zero and 18 could be calculated.

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<sup>46</sup> See, for example, L.E. Arnold, ed. (1990), *Childhood Stress*. New York: John Wiley & Sons.

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## PARENTAL REACTION TO ABUSE DISCLOSURE SCALE

The Parental Reaction to Abuse Disclosure Scale (PRADS) is a refinement of the Maternal Reaction to Incest Disclosure Scale<sup>47</sup> provided to us by the scale's authors. The PRADS allows for the five-point rating of parental reaction on four dimensions: belief in child's report of abuse; emotional support of child; action toward perpetrator; and, use of professional services. Therefore, the lowest PRADS score would be for a parent who denied that the abuse occurred, was hostile to or rejecting of the child, chose the perpetrator over the child at the child's expense and was uncooperative with services that were offered. Conversely, the highest PRADS score would be for a parent who made clear statements of belief that the abuse occurred, was strongly committed to the child and provided emotional support, clearly demonstrated disapproval of the perpetrator's behaviour, and took an active role in securing information and services for the child.

A PRADS score was calculated for each child in reference to the parental response observed at the time of court. During the follow-up interview, the children were asked to recall their perceptions of their parents' reaction after disclosure; and the parents were asked to recall their own reactions. The PRADS rating was different from these two sources in that it reflected our perceptions of the parental response and did not always correspond with how the parent viewed his or her own response. As it turned out, the PRADS score was highly correlated with how the children rated their parents' reactions at the time.

It was the original intention to calculate a PRADS score for both parents, where children lived in two-parent families or had regular contact with a non-custodial, non-offending parent. Any discrepancy between the two PRADS scores would be a measure of discordant parental reaction, a factor thought possibly to mitigate any beneficial effect of a high PRADS score for one parent. However, we were able to gain very little information about fathers. The follow-up interviews were attended almost entirely by mothers alone (97 percent), although both parents were encouraged to come. This mirrored the situation when the children were originally seen at the Child Witness Project (and, indeed, in our on-going court-preparation services). Therefore, we created a PRADS score for the parent about whom we had the most information. This was typically the parent who had brought the child to the court preparation sessions who, in turn, had been the mother.

## ETHICAL SAFEGUARDS

It was recognized that interviewing children and adolescents about a stressful experience from their past may trigger emotional distress in some cases. Therefore, the conventional safeguards to ensure voluntary participation and informed consent were strengthened. Careful, discretionary debriefing and rigorous follow-up protocols were instituted. Several therapists in the community were approached about the prospect of taking referrals, if we were to find that some of the children were in need of crisis intervention. Moreover, we arranged an ethical review by four mental health professionals external to the Clinic and by the attorney on the Clinic's advisory board. Based on their feedback, minor alterations in procedures were undertaken.

## ASSESSMENT OF THE RISK OF THE INTERVIEW

We could identify no risk of physical harm, nor were we aware of any long-term psychological damage that could be caused by children discussing past victimization experiences. However, the risk of temporary emotional distress was a distinct possibility. It was considered to be unlikely that the interview itself would be a risk, but it might trigger unresolved emotional distress. Several precautions were instituted (discussed below). Moreover, certain benefits were envisioned.

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<sup>47</sup> Everson *et al.* (1989), *supra*. note 30.

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## BENEFITS FOR THE PARTICIPANTS

The most immediately-perceivable benefit was the \$50.00 compensation. In addition, the children could gain a sense of satisfaction in indirectly helping other children who are or will be witnesses. A third benefit was that feedback was given about their current emotional adjustment. If a problem was identified, the participants were offered a referral to an appropriate therapist or agency. The greatest benefit that we envisioned was the cathartic effect of talking about their feelings and recollections. This was done in a therapeutic way, with kindness and in a supportive environment. Extensive background information was available to the therapists who conducted the interviews so they were aware of potentially-sensitive topics. The children learned that we regarded what happened to them as serious and that we valued their opinions.

## INFORMED CONSENT

There was nothing in the research procedure which prevented fully-informed consent, as no deception was necessary in this study. The procedures were outlined in a Letter for Participants which was read by each participant prior to signing a consent form. Great care was taken in drafting the letter to use simple and clear language rather than technical jargon. The risk of emotional distress was clearly emphasized. Participants knew the approximate length of the interview, the topics addressed, and the fact that questionnaires and tests were involved. To accommodate the possibility that some people might have literacy difficulties, the letter describing the study was explained verbally after the participants had been given an opportunity to read it. This also permitted participants to ask questions and we could verify that each point was understood. Consent forms were signed by all parents and all children 12 years of age and over.

## VOLUNTARY PARTICIPATION

Participation was entirely voluntary. Because the potential research participants were contacted by mail, their decision to participate was made without face-to-face contact and was, therefore, less likely to be perceived as coerced than if a telephone call had been used; i.e., they were freer to decline. Each participant consented in principle to his/her participation by 1) returning a form by mail; and, 2) attending at the Clinic for an interview.

Before the interview, the voluntary nature of participation was elaborated upon. First, they were informed, verbally and in writing, that they could refuse to answer any question they found objectionable or upsetting. Second, they were informed, verbally and in writing, that they could end the interview at any time and retain the \$50.00. Third, after reading the letter of information, they were given the option of declining to participate. It was made clear that they could retain the \$50.00. No one exercised that option.

The provision of \$50.00 could be seen as potentially reducing the voluntary nature of the interview session. It might have been the case that people in dire financial straits would agree to participate when in the absence of that inducement they would not have. It was hoped that presenting the option of leaving with the \$50.00 would overcome this problem. In the end, we found that people who were judged at the time of initial intake to be financially challenged were no more likely than others to respond to our request for participation.

The researchers were not in a position of power over the participants and so no negative consequences could ensue from a refusal to participate. Neither was there a dependency of the participants upon the researchers. However, it could be argued that because of the past relationship — when the children were prepared for court — the researchers were in a position of trust vis-à-vis these children and their families. While we took every effort to explain the risk associated with the interview and let the parent/guardian judge the impact on the child, the potential for demand characteristics to enter into their decision must be recognized.

Because of these factors — the \$50.00 and demand characteristics — we could not assume that the above-noted cautions about voluntary participation were sufficient to safeguard *all* child participants. For that reason, we instituted the following policies:

- 1) we identified certain children who would not be interviewed. In some cases, the parent or social worker indicated that the discussion of the court process was unwise, but in others the decision was made unilaterally;
- 2) we declined to interview any child who attended for an interview but who appeared to be in a state of agitation or emotional distress; and,
- 3) the onus was not put upon the child to terminate the interview. The project therapist monitored the effect of the interview on the child and would end the interview if emotional distress was manifested.

This last step was taken in one case.

### CONFIDENTIALITY AND PRIVACY

Subjects were advised that they would not be identified in any report or article in which these data were presented and that we would take the standard precautions to safeguard the confidentiality of the information they provided. We assured participants that information about them would not be shared with anyone outside the Child Witness Project. On occasion, to aid in referral, third parties were contacted. In such cases, releases were signed by the child and/or parent. As a matter of policy, when a child was currently undergoing therapy, we asked him/her to sign a release so we could inform the therapist of the fact that we had interviewed the child. Participants were advised that there was one limitation to the confidentiality guarantee: a disclosure that a child was currently in need of protection had to be reported by us to child welfare officials. This limitation was spelled out in straight-forward language in the Letter of Information for Participants and reiterated verbally.

### DEBRIEFING AND REFERRAL

At the conclusion of the interview, the project therapist provided feedback to the child based upon the information provided during the interview and a review of the test responses. The extent of this discussion and the type of information relayed varied according to the age and maturity of the child. If clinically indicated, the issue of referral to an appropriate therapist or agency was discussed. In all cases, the clinician gave the child her card and encouraged the child to telephone if he or she felt the need, independent of the parent. For younger children, this discussion took place with the parent. In all cases where a parent had accompanied the child, the project therapist made herself available to the parent to answer questions.

### FOLLOW-UP

Each participant was advised that, because of the potentially upsetting effect of the interview, two follow-up mechanisms had been instituted. First, the child and/or parent were advised to telephone any Project member if delayed effects were manifested after they left the Clinic. Second, the project therapist made a follow-up telephone call. If indicated by the level of distress manifested by the child during the interview, a follow-up telephone call was made that evening or the next day. Children who indicated they had no social support network or who manifested feelings of social isolation were also contacted the next day. In the absence of any of such concerns, each child and/or parent was contacted within two weeks.

The purpose of the follow-up telephone call was two-fold. First, the child and/or parent was asked about any repercussions of the interview. If some concern were to be expressed, the offer to facilitate therapeutic involvement would again be made. The follow-up telephone call also permitted the project therapist to relay, if necessary, any concerns that emerged from the scoring of the psychological tests. The offer to facilitate therapeutic involvement was again made.

The final contact that we initiated was a letter to all participants. In addition to relaying our appreciation

for their assistance, we offered an invitation to call with any questions, concerns or comments. In several cases, the families have kept in touch or contacted us with questions about other issues.

### **CODING AND RELIABILITY**

The coding scheme was designed to reflect both the research questions and the full range of situations and responses we were encountering. For the latter reason, it was not finalized until the interviews were well under way. The coding of what was almost entirely open-ended material was an immense task and a great deal of effort was expended toward the development of a scheme that was workable and meaningful.

A comprehensive coding manual was developed, with precise operationalizations of each variable. Each case was coded independently by two researchers, who then compared their work. Coding errors were eliminated in this way. More importantly, however, differences of opinion which were discovered were discussed and resolved. Where no consensus could be reached between the two, a third party was consulted. In this way, 100 percent inter-coder reliability was achieved.