November 8, 2021 WebEx with Dr. Rocchio
TFO [redacted]

- In order to apply for internship at Yale, needed 450 hours of practice
- In order to get licensed, need 2 years of full time practice, 1 needs to be pre-doctoral, each year has to be 1500 hours
- Licensure: national exam, in certain states have a state exam on laws or ethics, etc.
- Reviewed draft *Daubert* motion for Dietz and Loftus:
    - LR thinks it's not necessarily right that it's hard to assess whether grooming has occurred, but it's right that it's difficult to predict whether grooming will occur (prospectively)
    - Hindsight bias: many grooming articles point out that they operate in hindsight
    - Halo effect may be an argument about how offenders compartmentalize/hide from others. That's well-known offender behavior, they hold themselves out as pillars of community.
    - LR won't argue that false allegations are impossible, but they are rare
    - LR agrees that normal memory fades over time, can be fragmented, peripheral details can be distorted – central foundational principles of memory.
    - Loftus has introduced traumatic memories (e.g. dog attack) in a lab. Usually involves a trusted person, repetition, motivation. LR is not an expert on deceiving people in labs to get them to believe things that didn't happen
    - Some of what Loftus says about conditions that induce false memory may also not be present in this case
- There is both scientific and clinical literature (clinical is "how to do treatment," etc.)
- In forensic practice, LR pays attention to ways prior vulnerabilities (1) may be a cause of later injuries, (2) make someone more vulnerable to grooming/coercion, or (3) exacerbated negative consequences
- Third parties: mostly clinical literature, but grooming literature shows perpetrators try to use third parties to normalize situation
- Duron article lays foundation for a discussion of coercive control
- Delayed disclosure:
    - Betrayal trauma literature: abuse by a close other. Established there that victims have motivations to avoid fully acknowledging/appreciating abuse
    - For young children, abuse usually found out, not kid coming forward.
        - Majority of young young kids disclose, but a significant number happen much later
    - For adolescents, among the least likely to disclose
        - Adolescents keep things among peer group, also group most likely to self-blame or feel shame
        - In general, afraid of consequences of telling – from others, or as threats from perpetrator
        - May be made to feel are in love with perpetrator/think it's a positive relationship/get benefits from relationship
    - These crimes are underreported

- The closer the perpetrator-child relationship and the older the child, the less likely to disclose (until adulthood, when adults more likely than kids to disclose)
- Disclosure is not a single event; it's a process
- In general, sexual assault survivors of all types can have experiences like forcible penetration they don't label as rape. Research has moved toward behavioral descriptors rather than labels

- Memory:
  - Purposeful efforts not to think about an event could make it more difficult to recall
  - Can be gaps if it's unsafe for individual to know what they are experiencing (e.g., lack of memory detail about traumatic event is a symptom of PTSD)
  - When similar events happen over time, details can run together, inconsistencies occur
  - Education/training: had to take classes on cognitive processes, etc. Covered memory. Continuing education on trauma/IPV -> understanding memory affects how information is relayed
  - Clinical practice: has treated delayed disclosure patients. LR has been the first person some people have ever told (adult patients). Has treated patients who suffered CSA but don't label it as abuse at first
    - Delayed disclosure is common enough that one of LR's first questions when told about CSA by a patient is "did you tell anybody? When? What did they say?"
    - Lots of patients haven't told before, told one person, waited a decade to tell, etc. Variety of types of delays. Sometimes people tell right away.
    - Majority of patients are not talking about it for the first time
    - Majority of people did not disclose at the time
    - When they did disclose at the time, majority of times it was discovered by someone else
    - Majority of patients are victims of IPV and abuse occurs in context of the kind of relationship -> vulnerable to delayed disclosure
    - Other clinicians encounter the same phenomenon – see in literature, trainings, peer consultations…
    - Incremental disclosure in a forensic context: common in sexual harassment cases, but literature in this area is more about delayed disclosure
    - Does forensic evals sometimes b/c allegation is old, so thinking about delayed/incremental disclosure
    - Responses to disclosure can significantly affect person's distress (e.g., if report and are not believed or protected)
    - Delayed disclosure comes up all the time in forensic practice
- Civil Forensic practice: e.g., adult may file a CSA civil suit beyond SOL, LR might be asked to evaluate when person reasonably became aware of abuse and consequences. Looks for consistencies, malingering, looks at court records, does collateral interviews, evaluates adult, etc. Works for both sides.
- Criminal forensic practice: e.g., does a lot of battered women homicide cases. Did woman have a reasonable fear/perception of imminent bodily harm. Does other IPV cases, sentencing issues, etc. DV cases too.
- Sees overlapping delayed disclosure issues in clinical and forensic practices

- Not sure when the term "delayed disclosure" appeared in the literature, but she was taught about issues like secrecy/shame/related issues 30 years ago in school
- Scientific Literature:
    - Widescale surveys of all kind of crime and whether the ppl surveyed also reported: ppl often say they didn't report sex crimes
    - Surveys about prevalence v. crime reporting data, and see underreporting
    - Research w/ victims tell you when they disclosed
    - Can interview adults and asked retrospectively about CSA and whether it's been reported/disclosed
- Clinical literature talks about treatment and assessment strategies. Have case studies and reports.
- Quality of literature:
    - What kind of study
    - Where is it published
    - Caliber of study itself (e.g. how applicable is it to a particular population)
- Reviewed conclusions of Alaggia article
- Incorrect to say delayed disclosure is untestable
- As indicated in the Alaggia article, there's a lot of research on why people maintain their science. Betrayal trauma literature, scientific literature on attachment/coercion. Can do things to see if concepts are established/testable
- Finding on delayed disclosure is well established and exists across populations
- Carretta study: 74% of people disclose, 24% never tell anybody. Huge problem, significant research into this to deal with the treatment. Need to encourage people to disclose.
- It is a mischaracterization of LR point to say that ppl delay disclosure because of grooming. There are a lot of reasons, one is the trust/relationship. People don't report in lots of contexts without grooming too.
- Here, LR makes a point that DD is common, not making a specific claim about the relationship between DD and veracity
- Rocchio and Loftus have another high-profile civil CSA case where they are opposing experts
- Literature are examples that would be helpful, not intended to be articles where she agrees with every sentence.
- Grooming has different definitions, but that's true of lots of terms in social science, e.g. CSA. Though there are consistencies.
- Dworkin article provides a nice summary that PTSD is more closely associated with sexual abuse than any other trauma. IPV generally inflicts trauma.
    - Reputable author, good article. Prevalence rates of PTSD following sexual abuse are much higher.
    - Average lifetime prevalence is 35%, and but this study's 12 months follow up still had 41%. They had 2 explanations: they followed people over time, so higher incidence than relying on people's memory. Also, looked at PTSD among help-seekers.
    - Doesn't agree with Dietz's interpretation. E.g., one risk of PTSD is risky sexual behavior. Clinical literature: sexual acting out is very common, and she sees it in her practice.

    - The conclusion that CSA is linked with PTSD – enduring finding in the literature. There are other consequences too, like substance abuse.
- Literature on adverse childhood experiences shows that more adversity -> more adverse outcomes, and subsection, specifically CSA is among the more traumatic -> more risk