THE NEED FOR EFFECTIVE COMMUNICATION SKILLS IN THE MEDICO - LEGAL MANAGEMENT OF CHILD SEXUAL ASSAULT VICTIMS: OBSERVATIONS FROM THE SRI LANKAN CONTEXT

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INTRODUCTION

The medico-legal management of child sexual assault victims consists of a detailed history taking, physical examination, photography, obtaining forensic samples, proper documentation, explaining the findings to the victim and guardians, and further referral, if needed. Forensic Medical Examiners (FME) who carry out the above functions greatly benefit by having effective communication skills. In fact, these communication skills are and should be an essential component in the skill repertoire of FMEs. Lack of such effective communication skills can lead to repercussions not only to the child but for the doctor himself.

Why effective communication skills?

Obtaining a history from children, especially child sexual assault victims, requires special skills. For instance, in addition to obtaining valid consent from the guardian, history taking should be initiated by asking the child permission to proceed with the interview – a practice that is not commonly seen in the Sri Lankan context. Instead, there are instances where FMEs appear to assume that the child will comply and hence proceed straight onto asking information about the incident. This is not in keeping with effective communication techniques. Obtaining permission from child victims, before history taking/examination, would be a positive experience for the child. In fact, by explaining to the child each of the steps of the medico-legal management, the FME may win the confidence and compliance of the child. Further, there may be some examination findings and management plans that could be discussed with the child, whilst taking into consideration his developmental age. By doing so, it will give him a sense of control over his body and indeed life - a control which he may perceive as lost due to the assault. Indeed, this whole process may assist the child's psychological healing process. Hence, though the doctor may use effective communication skills to facilitate his medico-legal interview, it could have a psychological therapeutic effect on the child too. This is particularly relevant in the Sri Lankan context where mental health service providers such as psychologists and psychiatrists are few in number and many victims may not receive psychological care. Hence, the FME, albeit partially, could fulfil some of these dimensions.

Questioning the child without empathy and communicating with the child without considering the developmental stage may lead to incomplete gathering of data, and worse, may even lead to secondary victimisation. Further, possible psychological complications like depression and suicidality[1] can worsen. In countries with a better developed medico-legal system, only those professionals especially trained in forensic interviewing skills obtain the history from the victim[1]. In fact, some jurisdictions recognize the ability to communicate comfortably and effectively with children and their caregivers about sensitive issues as a pre requisite to become FMEs. These standards, seen mostly in settings where clinical forensic medicine services have greatly progressed, show that the ability to effectively communicate is deemed an essential aspect of a well-rounded FME. However, these requisites are not considered in the Sri Lankan context, and in fact the MD curriculum in Forensic Medicine does not even have a dedicated teaching module or designated teaching hours on communication skills. The authors propose such an inclusion in the curriculum.

The Sri Lankan FME fulfilling duties that may not be traditionally within the purview of his job description

In many parts of the world, child sexual assault victims are routinely referred to a psychologist for psychotherapy and/or to a pediatrician for a general medical examination. However, in Sri Lanka this does not happen habitually, possibly because there is a dearth of such professionals, particularly psychologists. Therefore, the FME could be the only health care professional the

child comes into contact with, and so, the FME may need to, even if cursorily, fulfill some of the tasks that fall within the job description of these other professionals. This imposes an enormous burden on the FME whereby he has to not only complete his forensic investigation but also lessen the physical, if any, and psychological pain of the child.

Within the purview of the practice of Forensic Medicine, effective communication skills are necessary to ensure that the whole truth is divulged. Previous research has shown that those doctors who practice effective communication skills are better able to gather relevant information leading thereby to a superior ability to diagnose and consequently manage the victim. However, beyond the purview of this forensic medicine practice, such skills also help elicit victim's concerns such as fear of further assault and fear of pregnancy. The exploration of and eliciting of such information is not an easy task and requires the existence of many desirable personal qualities within the FME (towards the child victim) – qualities such as empathy, positive regard and non-judementality. Effective communication skills 'grow' within these personal qualities.

False guilt, where the victim thinks he/she is to blame for the assault, is commonly seen among children. Eliciting and addressing these psychological dynamics generally fall within the task of a psychologist. However, due to the few numbers of such professionals in Sri Lanka, FME's may also need to elicit and address these psychological dynamics in the victim. These sensitive and often unacknowledged concerns in the victim may not be easy to penetrate nor to address. However, effective communication skills could come to the 'rescue' of the FME who forges ahead to address these victims' concerns. When these concerns are shared by the victim, the FME can respond appropriately and to some extent allay these fears of the victim thereby contributing to his healing process. However, while emphasising the need for effective communication, with all the necessary skills delineated in this article, the authors acknowledge and reiterate the onus on the FME to maintain impartiality when interacting with victims of child sexual abuse.

The essential communication skills in a FMEs' practice

During the history taking and other aspects of the investigation, three core skills are needed to communicate effectively: appropriate questioning style, active listening and facilitation[2]. These three core skills could be practiced by verbal and/or non-verbal communication ways.

Verbal communication skills

Verbal communication, as the term implies, is related to the effective use of voice and words when communicating. When speaking to victims, whether child or adult, the quality of the voice itself has an impact. Doctors should maintain an appropriate volume, pronounce words distinctly, use a pleasing pitch, vary the intonation appropriately, and keep-up a steady rate of words. It is good practice to use emphasis in the right places[3]. Other than these qualities of the voice, the manner of using word too is important. For instance, rewording is an important verbal communication skill – rewording involves stating back to the victim what he had just reported, but in the FMEs' words. This conveys the message to the victim that the FME listened intently and understood what the victim said. It also gives an opportunity to re-clarify if the FME had understood incorrectly what the victim reported. The verbal communication skill of rewording is best used in instances where the victim reports many facts in one go or/and when he/she reports important information. It is the authors' observation that FMEs' in Sri Lanka may benefit by improving their verbal communication skills.

Non verbal communication skills

Non verbal skills are also called "body language". There are many dimensions of effective body language. For instance, the doctors' seating position should be adjusted to make the victim's gaze comfortable. Sitting at a higher elevation to the victim may convey a sense of superiority and power which may make the victim withhold key information. Maintaining eye contact is another key non-verbal communication and is of paramount importance[1,2,3]. Good use of gaze (looking at an area between the eyes) shows the victim that the FME is interested in the interview process. Further, a relaxed body posture and a slight forward lean would be encouraging and helpful in establishing rapport. Appropriate facial expressions that display concern towards the victim indicate that the doctor is responsive whilst gestures like nodding could be viewed as rewarding to the victim[3].

Questioning, active listening and facilitation

It is in the context of the above mentioned verbal and non verbal communication that appropriate questioning, active listening and facilitation should be endeavored. The interview should not begin with closed questions (i.e. those questions that imply an answer) but with open questions whereby the child has to describe the incident in his own words. Sometimes rewording or rephrasing what the child had told would clarify statements given by him[3] whilst also implying to the child that the FME is being attentive. Closed questions, could be used at the latter stage of the interview in order to obtain specific information. These are especially useful in the withdrawn victim[2]. Only when all open questions have been exhausted, and there appears no other manner of getting further information, can the doctor move on to closed questions. However, leading questions (which imply an answer) should be avoided at all costs as it could lead to misreporting. It is the authors' observation that in some instances, FME's tend not to use open ended questions. This is however understandable as indeed it is a skill to use these questions. Hence, training programs for FME should necessarily involve training in such questioning styles.

Listening actively is a core communication skill essential for history taking. It is a skill not easy to acquire. Active listening entails not only listening per se but also linking the information obtained to the theoretical/experiential information the FME already has. Hence, it is an active and involved process, requiring mental energy. An active listener allows victims to talk without interruption. Many doctors have the habit of disturbing their patients – studies reports that it could be even within 18 seconds of commencing the history[4] This will break the trend in the story the victim is narrating. One reason given for some interruptions may be the time pressure imposed on the doctor or else the attitude that what the victim is saying is of no significance. It is important to acknowledge to oneself if one has these tendencies and to rectify them. Doctors also display certain "blocking behaviors" which may make the victim withhold key information. Two examples of these behaviors are offering advice/reassurance before the main problems have been identified and switching the topic[5]. Doctors may display blocking behavior because of many reasons – for instance, when they feel uncomfortable by seeing a patients' sadness or psychological pain. It is important to prevent these behaviors happening and instead to actively listen to what the patient says – a process easier said than done, however.

Facilitation is where the doctor helps the victim to talk as fully as possible about the incident. Phrases like "Yes, I understand, please go on" and non-verbal communication such as nodding, facilitates the interview. In fact, facilitation involves putting into action all aspects of effective verbal and non-verbal communication.

Training in effective communication skills for FMEs in the Sri Lankan context

The above communication skills are innate in some doctors. The good news for others is that they can be learnt, as long as one has the motivation to do so. In most medical schools, it is now a component of the undergraduate curriculum that students are taught generic effective communication skills. Skills geared towards child sexual assault victim examinations per se can be imparted during the undergraduate forensic medicine attachment. However, since communication skills do not reliably improve from mere one-time experience[4], training has to be repeated at regular intervals even after graduation. Hence, the curriculum for the specialization in Forensic Medicine should introduce mandatory communication skills training, as in some parts of the world[4,6]. This should mostly be with the use of videotape/audiotape reviews, role plays and standardized patients which have been proved as effective tools[4], rather than through mere lectures. Another important factor that appears to contribute to students learning effective communication skills is the existence of role models within the clinical set-up. Hence, it is not only training but also the existence of senior clinicians, embodying these skills that lead to the effective internalization of these skills.

Further, studies indicate that doctors who felt insufficiently trained in communication skills are more likely to suffer from burnout[7], indicating that communication skills training will be of benefit to the doctor too.

The above positive interactions between the FME and the child victim will facilitate gathering of forensic evidence, considerably reduce child morbidity, result in better victim compliance and healing and prevent burnout for the doctor. Therefore FMEs should view communication skills training as a lifelong training for their benefit and for the child victims' benefit.

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