THIRTEEN

Children Who Do Not Want to Disclose

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Although there is a fair amount of research that indicates many children do not disclose when they are sexually abused, there is little guidance either from research or from practice about how to address this problem. Further, as noted in chapter 7, which describes interview structures, protocols, and guidelines, most interview techniques are based upon the premise that interviewers must avoid strategies that might produce false allegations. Thus, these protocols require interviewers to rely heavily on open-ended questions and avoid direct and suggestive questions. These are the expectations for professionals, who are usually strangers to the children they interview, in a context where children may have very close relationships with offenders, who may have engaged in a range of strategies to prevent children from disclosing sexual abuse. Protocols that are structured to guard against false positives may foster false negatives.

This chapter covers research that can inform

professionals about the extent of disclosure failures, correlates of failure to report sexual abuse, research findings suggesting disclosure is a process that may involve initial denial and recantation, and interview strategies to be employed with children who are reluctant to disclose.

RESEARCH ON DISCLOSURE FAILURES

How might professionals determine whether false negatives or nondisclosure of sexual abuse is serious problems? There are several bodies of research that address this question. These include studies of adults reporting sexual abuse as children, studies of children in high-certainty cases, and analogue studies.

Studies of Adults Reporting Sexual Abuse as Children

Studies of adults who describe a history of sexual abuse as children include large general population surveys and smaller samples, but all ask respondents whether they told about their sexual abuse during childhood. Nondisclosure rates for women reporting sexual abuse during childhood range from 33% to 92% (Bagley & Ramsey, 1986; Finkelhor, Hotaling, Lewis, & Smith, 1990; Lyon, 2002c; Palmer, Brown, Rae-Grant, & Loughlin, 1999; Russell, 1986; Russell & Bolen, 2000; Smith et al., 2000; Ullman, 2003). Similarly, for men, the

nondisclosure rates range from 42% to 88% (Finkelhor, 1979; Finkelhor et al., 1990; Johnson & Shrier, 1985; Lyon, 2002c). More recently, London, Bruck, Ceci, and Schuman (2005) reviewed 11 surveys of adults that used a range of methodologies. These researchers determined that the majority of adult victims did not report their sexual abuse during childhood. When they exclude one study of 18-year-olds, which uses a very broad definition of sexual abuse (Fergusson, Horwood, & Woodward, 2000), the disclosure rate is 31%. Four of the studies in London et al.'s (2005) review reported the rates of official report (to law enforcement or child protective services), which averaged 13%.

These findings suggest that nondisclosure of sexual abuse is a very serious problem, characteristic of more than half of victims. Moreover, only a small minority of cases appear to come to the attention of professionals. These studies reflect victims' recollections and behavior at least a generation ago; both professional and public knowledge about child sexual abuse has advanced in the meantime. However, there is no evidence that the capacity of offenders to control their victims' responses has changed. Moreover, penalties for sexual abuse may be greater, which would argue for more offender pressure not to tell.

Disclosure of Sexual Abuse in High-Certainty Cases

Although London et al. (2005) conclude that, in the past, disclosure failures were prevalent, they argue that

times have changed; professionals are now asking children about sexual abuse and children are telling. They argue that, in current samples, most children who do not disclose have not been sexually abused. A useful strategy for testing their argument is reviewing studies of high-certainty cases (high certainty because there was an offender confession, compelling medical evidence, a criminal conviction, or audiovisual evidence).

There is a modest but growing number of studies that fall into the high-certainty category. These studies reveal disclosure failures, partial disclosures, and disclosure as a process, at least for some children (e.g., Bidrose & Goodman, 2000; Faller, 1988b; Lawson & Chaffin, 1992; Lyon, in press; T. Sorenson & Snow, 1991; Terry, 1991). In addition, there are studies of children's disclosures and disclosure failures, which include a subset of high-certainty cases (clear medical evidence, offender confession, and/or audiovisual evidence) (Dubowitz, Black, & Harrington, 1992; Elliott & Briere, 1994; S. Gordon & Jaudes, 1996). Both of these bodies of research document that a substantial number of sexually abused children do not disclose sexual abuse, even when interviewed by professionals.

Medical Evidence Studies

Studies relying on medical evidence include a pioneering study by Lawson and Chaffin (1992). They reviewed 800 cases of children coming to an outpatient

sexually transmitted disease (STD) clinic. Lawson and Chaffin selected a sample (28 children) who were not suspected of having been sexually abused but were discovered to be positive for STDs. Children who tested positive for STDs were brought back to the clinic for an interview by a professional skilled in child sexual abuse assessment. Fewer than half (43%) of the children revealed sexual abuse in this interview, the predictor of disclosure being having a supportive parent.

Muram and colleagues (Muram, 1989; Muram, Speck, & Gold, 1991) report results similar to those of Lawson and Chaffin (1992) from a sample of children with medical findings consistent with sexual abuse. Almost half failed to disclose sexual abuse.

More recently, Lyon (in press) reviewed 21 studies involving children with gonorrhea, which span a time frame of 1965–1993, altogether 579 children. Of these children, 250 (43%) provided some sort of disclosure. When cases involving children younger that 3 (and therefore unlikely to provide a verbal account) and studies where the child's age could not be determined were excluded, the disclosure rate from the remaining 16 studies is 42% (185 of 437). Lyon's landmark review of the literature on children with gonorrhea provides compelling support for professional concerns about nondisclosing children.

Audiovisual Evidence Research

There are beginning to be studies of disclosure patterns

in cases involving pictures, audiotapes, and/or videotapes. Bidrose and Goodman (2000) relied on audiotapes and photographs from a case involving four female victims and eight male offenders. The review of the tapes and photographs supported 318 sexual and related acts involving these girls, 194 (61%) of which had been alleged by one or more of the victims. There were also an additional 52 (21%) acts described by the victims for which no audiotaped or photographic evidence was found. Most of these were coercive, not sexual acts. That there were some acts not captured on audiotape or in photographs does not mean they did not occur.

Sjoberg and Lindblad (2002) compared videotapes made by a single offender of his sexual abuse to videotapes of police interviews with 10 victims, nine boys and one girl. This abuse occurred over an 8-year period. No child disclosed sexual abuse before the police interview, and five denied the abuse when interviewed by the police. No child disclosed a sexually abusive act that was not on videotape. Altogether, the children who did report sexual abuse to the police revealed 102 incidents of sexual abuse, but there was a marked pattern of minimization of the victimization.

These two studies suggest that many children fail to disclose or do not disclose all of their sexual abuse when questioned by professionals.

Offender Confession Studies

Offender confession is not entirely independent of the child's disclosure but, nevertheless, is a useful index of high certainty of abuse. Faller (1988b) studied the interviews of 103 children whose offenders confessed. Only about 80% of children made disclosures of sexual abuse, younger children and boys being significantly less likely to tell. Terry (1991) interviewed 18 children of a single offender who sexually abused them in a daycare center. The offender confessed, but the children disclosed only 80% of the activities he described.

T. Sorenson and Snow (1991) supplemented offender confession (80%) with conviction in a criminal case (14%) and compelling medical evidence (6%) in their study of 116 cases of children referred to mental health services because of possible sexual abuse. These cases were chosen from a sample 630 cases, 80% of which were seen at public mental health clinics and 20% in the authors' private practices. The authors do not report how many of the 116 cases were from their private practices. They report that 72% of the children initially did not disclose sexual abuse, but that, over time, 96% of children did.

Their study has been the subject of challenge. Its critics raise questions about whether these children actually were sexually abused, the implication being that leading questions were employed with nonabused children that eventually led to a false allegation (London et al., 2005; Poole & Lamb, 1998). It is certainly true that T. Sorenson and Snow (1991) do not

document the methods for eliciting information from children, but the criteria for inclusion in the study (confession, compelling medical evidence, or criminal conviction) would suggest that most of the children were abused. In addition, London et al. (2005) question how the 116 cases were selected from the 630, but the selection criteria are included in Sorenson and Snow's article. Moreover, London and colleagues opine that some of the children were not abused because they assume that some cases involved allegations of ritual abuse and believe that ritual abuse reports, by definition, are false.[1] London and colleagues base this assumption that there were ritual abuse cases in the sample on the fact that Sorenson and Snow had written an earlier article on ritual abuse (Snow & Sorenson, 1990). T. Sorenson and Snow (1991) do not indicate whether or not any ritual abuse cases are included in the 116 high-certainty cases.

The findings on cases corroborated by offender confession indicate higher child disclosure rates than those found in medical evidence and audiovisual corroboration studies. These differences may relate to greater interdependence between disclosure and confession than between disclosure and medical evidence or audiovisual evidence. Thus, when children disclose, offenders may be more likely to confess than when they do not, and law enforcement may interrogate suspects more vigorously. When offenders confess, children may feel freer to disclose, and child interviewers may persist in trying to obtain a

disclosure. Alternatively, the interview processes (more than a single interview) in these three studies may have increased the probability of disclosure. Nevertheless, in the offender confession studies, nondisclosure constitutes a notable problem.

Analogue Studies

The final body of research that indicates nondisclosures should be a concern for sexual abuse interviewers consists of analogue studies. As noted in chapter 9 on media, some analogue research indicates that children may avoid admitting to private parts touch. In addition, analogue research suggests that children can be persuaded by "perpetrators" not to tell about bad acts.

Private Parts Touch Studies

Analogue studies that document children's reluctance to describe private parts touch involve medical exams. Saywitz, Goodman, Nicholas, and Moan (1991) questioned 72 girls, ages 5 and 7 years, half of whom had received a private parts exam as part of a well child checkup, and half of whom had received a scoliosis exam. In the free recall questioning condition, all of the children who received the scoliosis exam mentioned it, but of those who received the private parts exam, 78% of children failed to mention genital touch and 89% failed to mention anal touch. The children in the private parts condition required direct questions ("Did the doctor touch you here?") using

anatomical dolls to disclose these touches. When this direct questioning method was employed, 89% mentioned genital touch and 69% anal touch. The same questions were asked of children in the scoliosis condition, resulting in three false positives, that is, children falsely affirming private parts touch to the direct questions while the interviewer pointed to the doll's private parts. Only one child, however, provided any detail.

Comparable findings are reported by Steward et al. (1996). Their study involved 130 children, ages 3–6, both boys and girls, who received on average almost 14 types of body touch during an outpatient medical visit. About a quarter of the children were seen in the child protection team clinic. The reports of the 130 children during free recall were quite accurate, 90–97% (the latter number being the accuracy rate for 3-year-olds). However the children reported only a small proportion of the touches they experienced, 17% (3-year-olds) to 37% (6-year-olds). Similar findings were reported for private parts touch during the medical exam. For example, only a quarter of the children who received genital touch reported it. No child who did not experience genital touch reported it, when asked a yes/no question. Only 6% of children who received anal touch reported it when asked a direct question, and there were no false positives.

As noted in chapter 9, Steward et al. (1996) employed "enhanced" interviews (asking with anatomical dolls, anatomical drawings, or a computer program). With the

enhancements, about two-thirds of the children reported genital touch and about a third anal and buttocks touch. As with the study by Saywitz et al. (1991), enhanced interviews produced a small number of false positives.

Steward et al.'s (1996) study is one of the few to assess children's memories over time. They reinterviewed children 1 month and 6 months after the visit to the outpatient clinic. In the meantime, many children experienced other medical visits, both outpatient and inpatient. Children's memory of the outpatient visit being studied diminished over time.

Bruck and colleagues (Bruck, Ceci, & Francoeur, 2000; Bruck, Ceci, Francoeur, & Renick, 1995) emphasized the false positives they elicited using misleading questions in their studies involving 3- and 4-year-olds who experienced medical exams (discussed in greater detail in chapter 8). These researchers also elicited a high proportion of false negatives to commands to demonstrate with anatomical dolls or on children's bodies, direct questions, and leading questions (about 50% in all three questioning conditions—doll demonstrations, own body demonstrations, and questions).

Secret-Keeping Analogue Findings

Analogue studies demonstrate that children who were admonished not to tell about wrong-doing by an adult often protected the adult. These admonitions were

effective when the adult was a stranger or a parent (Bottoms, Goodman, Schwartz-Kennedy, Sachsenmeier, & Thomas, 1990; Clarke-Stuart, Thompson, & Lepore, 1989; Dunkerley & Dalenberg, 2000; Goodman & Clarke-Stewart, 1991; Peters, 1991; Tye, Amato, Honts, Devitt, & Peters, 1999; Wilson & Pipe, 1994, 1998).

Illustrative is a study of interrogation of 5- and 6-year-olds by Clarke-Stewart et al. (1989). Individual children observed Chester, the janitor, who was supposed to be cleaning toys in a classroom. Chester's behavior with the toys was ambiguous, but his statements indicated he was either cleaning the toys or playing with them. In one of the conditions, his statements indicated he was playing, he asked the child not to tell about his playing, and he gave the child a piece of candy. More than 60% of children in this condition were either noncommittal or said Chester was cleaning the toys, not playing with them, when interrogated later by "Chester's boss."

Dunkerley and Dalenberg's (2000) analogue study is discussed, in part, in chapter 12. These researchers studied the impact of race on children's disclosure of adult good (giving a box of candy) and bad (taking a purse) behavior, when admonished not to tell. They found children were less forthcoming when the interviewer, who asked about the source of the box of candy or the whereabouts of the purse, was of a different race from the child. These findings were more marked for African-American children and for children who were scored at high risk for sexual abuse.

Wilson and Pipe (1994, 1998) had 6- and 10-year-old children participate in or observe interactions with a magician. During one of the magic tricks, the magician "accidentally" spilled black ink on the child's white magic gloves. The magician quickly took the gloves off and hid them, warning the child not to tell, that this was their secret. Children were interviewed twice. In their first interview, only 25% of the 6-year-olds reported the "accident" during free recall questioning about the interaction with the magician, and 60% acknowledged the "accident" when asked a direct question. Ten-year-olds were more likely to report the "accident" in both free recall (66%) and when asked directly (84%). Although older age predicted less obedience to the magician, substantial proportions of both older and younger children kept the magician's secret.

Since children not only usually know their abusers but often are groomed and manipulated by them, it is reasonable to anticipate that their abusers' admonitions not to tell will be much more effective than those in analogue studies involving someone the child has never met before. Some analogue studies support this conclusion.

In a series of experiments, Tye et al. (1999) compared disclosure rates of 6- to 10-year-old children of a book theft by a stranger (research assistant) versus a significant other. Eighty-one percent of the children who had witnessed the stranger take the book truthfully disclosed the theft when asked. In contrast,

56% of children who had witnessed their significant other stealing a book wrongfully implicated the stranger when asked.

Similarly, Bottoms et al. (1990; also cited in Lyon, 2002c) reported on an analogue study conducted with 49 children 3–6 years old and their mothers. In one condition, mothers and their children were specifically told not to play with the toys. But they did, and, during the play, the mother "accidentally" broke the head off a Barbie Doll. Mothers asked their children to keep this breakage a secret. When specifically asked, only one child betrayed her mother and told. All of the 5-year-olds refused to implicate their mothers, even when asked a leading question.

These studies with significant others and mothers demonstrate children's willingness to protect people close to them. Neither of these studies, however, involves protracted manipulations to secure a promise of secrecy or any negative consequences for the children, should they tell on the transgressor. Nevertheless, they offer further support for the proposition that many children, sexually victimized by individuals close to them, will fail to report their abuse when asked.

PREDICTORS OF REPORTING AND NOT REPORTING

The literature suggests that certain case characteristics

predict reporting sexual abuse or failure to report. Severity of the sexual abuse (Arata, 1998; Paine & Hansen, 2002), closeness of the victim–offender relationship (Arata, 1998; Cantlon, Payne, & Erbaugh, 1996; Gries, Goh, & Cavanaugh, 1996; Hershkowitz, Horowitz, & Lamb, 2005; Paine & Hansen, 2002), young age of the victim (Cantlon et al., 1996; DiPietro, Runyon, & Fredrickson, 1997; Hershkowitz et al., 2005; Keary & Fitzpatrick, 1994; Lyon, 2002c; Paine & Hansen, 2002), being a male victim (Faller, 1988b; Hershkowitz et al., 2005; Paine & Hansen, 2002), and having a nonsupportive caretaker (Bolen & Lamb, 2002; Lawson & Chaffin, 1992) all may decrease the likelihood of reporting sexual abuse. The most consistent findings relate to previously having reported the victimization, having been abused by someone close, and having a supportive or nonsupportive caretaker.

Prior Disclosure Predicts Present Disclosure

Research indicates that the best predictor of telling about sexual abuse during a forensic or investigative interview is prior disclosure to someone, either a professional or someone close to the child (DeVoe & Faller, 1999; DiPietro et al., 1997; Gries et al., 1996; Keary & Fitzpatrick, 1994; Olafson & Lederman, 2006). Thus, cases in which the concern about sexual victimization does not derive from the child having told will be less likely to result in an account of sexual abuse during a formal interview.

Proximity of the Perpetrator–Child Relationship Predicts Nondisclosure

Research suggests that the closer the relationship between the child and the abuser, the less likely the child is to report (Berliner & Conte, 1995; Faller, 1990a; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Hershkowitz, Horowitz, & Lamb, 2005; Lyon, in press; Olafson & Lederman, 2006; Paine & Hansen, 2002). Especially difficult for children is reporting a caretaker. In a study using a national data set of 26,408 sexual and physical abuse cases interviewed by Israeli youth investigators, Hershkowitz et al. (2005) found that about two-thirds of reports involved parental figures. Youth investigator interviews, however, resulted in a disproportionately low number of disclosures involving parent figure offenders. With regard to sexual abuse disclosures (n = 7,812), 8% involved parent figures, whereas 92% involved nonparent figures. Hershkowitz and colleagues then examined a subset of the nondisclosing cases (n=373), in which investigators thought the child had been abused, because there was either a witness to the abuse or a prior credible disclosure by the child to a disinterested party. Parents or parent figures were the alleged offenders in 85.5% of the nondisclosing sexual abuse cases.

Caretaker Support and Disclosure of Abuse

Another important factor that predicts disclosure is

whether or not the child has a supportive caretaker. Caretakers are less supportive in situations of a close relationship between the alleged offender and the caretaker, situations of domestic violence, caretaker substance abuse, and caretaker history of child neglect (Olafson & Lederman, 2006; Paine & Hansen, 2002). As noted above, in Lawson and Chaffin's (1992) study of children with STDs, the only predictor of describing sexual abuse in the hospital-based interview was having a supportive caretaker. Of the 12 children who disclosed sexual abuse when interviewed, 10 had supportive caretakers.

Indirect support for this predictor is found in Hershkowitz et al. (2005) analysis of the Israeli youth investigator data. Children in nonparent abuser cases likely had supportive caretakers and therefore were more likely to report.

DOCUMENTATION THAT DISCLOSURE IS A PROCESS

In 1983, Roland Summit published a seminal article titled "The Child Sexual Abuse Accommodation Syndrome" that described a child's process of revealing sexual abuse—characterized by initially maintaining secrecy, feeling helpless and entrapped, delaying disclosure, providing an unconvincing account of abuse, and often subsequently retracting the allegation (see also Olafson, 2002). The process Summit described was based

upon his clinical and consulting experience. Because this clinical description was consistent with the experience of practitioners, it was widely accepted and employed in many venues to explain children's behavior. Evidence of the child sexual abuse accommodation syndrome does not prove the child has been sexually abused, however. In only explains children's reactions to sexual victimization (Conte, 2002; Lyon, 2002c; Olafson & Lederman, 2006; Summit, 1992). Nevertheless, the research on cases of suspected sexual abuse supports a number of these characteristics (e.g., Lyon, 2002c).

The most clear-cut research support for the child sexual abuse accommodation syndrome derives from the study by T. Sorenson and Snow (1991) cited above. These researchers documented the process of disclosure over several treatment sessions in a mental health clinic. Sorenson and Snow categorize children's behavior as initial denial, then tentative disclosure, followed by full disclosure, next recantation, and finally reaffirmation of sexual abuse. They note that in this population only about one-fourth of children intended to tell; for the remainder of the children, disclosure was accidental. When interviewed, almost three-fourths of children initially denied sexual abuse, but 96% made a disclosure of sexual abuse over several sessions. Of those who made a report, 22% recanted their initial disclosure, but almost all of them reaffirmed sexual abuse.

There are additional studies of actual cases that document delays in reporting sexual abuse and

recantation following a disclosure. This research draws upon current case files and follow-up inquiries.

Delay in Reporting

Several studies of cases coming to professional attention document that a substantial proportion of victims initially do not report their sexual victimization (e.g., Elliott & Briere, 1994; Olafson & Lederman, 2006; Sauzier, 1989). Elliott and Briere (1994) studied 336 children 8–15 years old who received forensic evaluations at Harbor-UCLA's Sexual Abuse Crisis Center. Among their findings were that 75% of children had failed to disclose their sexual victimization within the year after it occurred.

Similarly, Sauzier (1989), who collected data from a pioneering assessment and intervention program with sexually abused children at Tufts New England Medical Center, found that of the 156 children seen in the program, 17% delayed reporting more than a year. Thirty-nine percent told no one until they were actually evaluated at the intervention program. On the other hand, 24% of children reported within a week of the sexual abuse.

Follow-up studies of children after disclosure and litigation also support the observation that a substantial proportion of victims delay disclosure (Berliner & Conte, 1995; Goodman-Brown et al., 2003; Sas & Cunningham, 1995). Sas and Cunningham followed up more than 500 child victims who experienced criminal

court litigation regarding sexual abuse. They asked 135 children about the disclosure process and criminal litigation and found that 40% of children had no idea the behavior was wrong when they were first sexually abused, decreasing the likelihood that children would disclose. Boys and victims of intrafamilial sexual abuse were more likely to lack knowledge about the inappropriateness of the behavior. In 50% of cases, children said they were admonished by the abuser not to tell. Forty-three percent never considered telling, and 12% consciously decided not to tell. Forty-four percent of children who didn't tell were reabused by the same person. One-third of the children in Sas and Cunningham's study knew the sexual abuse was wrong and told soon after the first incident.

Berliner and Conte (1995) followed up with 82 children and their families on an average of 3.5 years after sexual abuse was reported, collecting data from both the children and their caretakers. Berliner and Conte noted that only 43% of children in the study told their parents first and quote children's statements from reabused interviews regarding the difficulty of disclosure.

Goodman-Brown et al. (2003) conducted a study of 218 cases referred for criminal prosecution in a single jurisdiction over a 2-year time frame (~60% of all such cases). In this study, 58% of children failed to disclose within 48 hours of the abuse. Predictors of delayed disclosure were being older, being a victim of incest, feeling responsibility for the abuse, and fearing the

consequences of telling.

Retraction or Recantation

Based upon current knowledge, recantation of a true allegation of sexual abuse cannot be easily differentiated from a retraction of a false one (Faller, 2003). Research, nevertheless, supports a conclusion that a substantial minority of children recant actual abuse after initially admitting (Elliott & Briere, 1994; Lyon, 2002; Malloy, Lyon, Quas, & Forman, 2005; T. Sorenson & Snow, 1991). Similarly, when children initially make a disclosure of sexual victimization to someone they know and trust, but fail to disclose when formally interviewed, often this nondisclosure is attributed to leading questions or premature conclusions of abuse by the trusted individual. An alternative interpretation of this disclosure failure is that it represents recantation as the child begins to experience the consequences of revealing the abuse (DeVoe & Faller, 1999; Keary & Fitzpatrick, 1994).

One of the earliest studies to examine the issue of recantation was that of Jones and McGraw (1987), who examined 576 cases reported to Denver County child protective services in 1983. The researchers' review of these cases resulted in a categorization of "substantiated" for 309 or 53% of the cases. Of these, 9% (n = 52) involved recantations. Since recantation often occurs after substantiation, Jones and McGraw regarded the recantation rate in their study as an underestimate.

As noted above, T. Sorenson and Snow (1991) report a recantation rate of 22%. Bradley and Wood (1996) indirectly challenge the Sorenson and Snow findings using a sample of substantiated child protection cases. Seventy-two percent of Bradley and Wood's sample had made a prior disclosure, and most were interviewed once. Bradley and Wood report that only 6% of the children in their study initially denied sexual abuse, when interviewed, and only 4% recanted. However, as Jones and McGraw (1987) point out and studies by T. Sorenson and Snow (1991) and Malloy et al. (2005) (described below) suggest, a single interview is insufficient for examining recantation, which is likely to occur over time.

Malloy et al. (2005) described the results of a case record review study of the disclosure process in 217 children (257 cases) randomly selected from substantiated sexual abuse cases from the Los Angeles Dependency Court (1999–2000). Ninety percent of the children were girls with a mean age of 10.4 years. Sexual penetration was reported in half the cases. Close to 70% of children reported sexual abuse by a parent or stepparent. On average, these children were interviewed 12 times. The researchers tracked the disclosure process over these interviews. Seventy-eight percent disclosed to someone prior to their first interview by child protective services or law enforcement. Nine percent initially denied in the mandated interview, and 73% expressed reluctance to talk about the abuse, but 98% disclosed in at least one

interview. Of these children, one-third recanted during at least one interview; 23% fully recanted, and 11% partially recanted. Predictors of full recantation were younger victim age, closer relationship with the male perpetrator, and lack of maternal support. The predictor of partial recantation (minimization of the abuse) was more severe sexual abuse. Factors not associated with recantation were medical evidence, perpetrator confession, prior offending history of the perpetrator, and a custody battle.

Gordon and Jaudes (1996) conducted a chart review of 141 children who were examined in a hospital emergency department for sexual abuse. Although 103 revealed sexual abuse in the emergency department, 17 recanted during their investigative interview, including several children with STDs.

Elliott and Briere (1994) focused on recantation in cases with external evidence of sexual abuse. Eighteen children with external evidence in their sample of 336 recanted. There were additional recanters in their sample, but these either had no external evidence or did not provide an initial credible disclosure. Recantation was associated with lack of caretaker support.

PRACTICE TECHNIQUES USED WITH CHILDREN WHO ARE RELUCTANT TO DISCLOSE

There is little direct research on facilitating disclosure by children reluctant to reveal traumatic experiences. The exceptions are the research by Carnes and colleagues on the extended assessment described in chapter 5 (Carnes & LeDuc, 1998; Carnes, Nelson-Gardell, Wilson, & Orgassa, 2001; Carnes, Wilson, & Nelson-Gardell, 1999, 2000) and a study by Hershkowitz et al. (2006). Most of the advice on practice techniques derives from practitioners.

Field Research

Carnes and colleagues' research supports conducting several interviews for children who fail to disclose in an initial interview. Based upon their three studies of children who present at children's advocacy centers, a six-session extended assessment will yield disclosures in about half of children who initially do not describe sexual abuse. In addition, about a quarter of such cases will be determined not to involve sexual abuse (Carnes & LeDuc, 1998; Carnes et al., 1999, 2000, 2001). Professionals should bear in mind, however, that most children who are interviewed at children's advocacy centers will have made a prior disclosure.

Hershkowitz et al. (2006) examined interviews conducted by Israeli youth investigators that followed the National Institute of Child Health and Human Development protocol (Sternberg, Lamb, Esplin, & Baradaran, 1999). They matched 50 interviews of

nondisclosing 4- to 13-year-old children where there was reasonable certainty that the children had been abused, with 50 disclosing children. From the very beginning of the interview, nondisclosers were somewhat uncooperative, provided fewer details, and gave more uninformative responses than did disclosers. Perhaps because of these behaviors, interviewers used fewer free recall prompts and made fewer supportive comments with the nondisclosing children in the abuse-related stages of the interview. Hershkowitz and colleagues recommend spending a longer time engaging in rapport building when children are uncooperative, and considering more than one interview. See also Olafson and Lederman (2006), who document the need to accommodate nondisclosing children.

Practice Advice

Practitioners suggest four general strategies to assist children who are reluctant to disclose: (1) preinterview strategies, (2) use of reasoning, (3) normalizing disclosure, and (4) decreasing the stress related to disclosure. All of these strategies except the first require that the interviewer have reason to believe that the child has been sexually abused. This belief can derive from something the child has said (e.g., the child saying, "I don't want to say what he did") or done (e.g., sucking a peer's penis), from physical findings, or from reports of witnesses or other victims.

Preinterview strategies that some professionals advise

include having the child's caretaker prepare the child beforehand for the interview process by explaining the purpose of the interview (Eagleson, 2002). Although interviewers may be concerned that the caretaker may influence or contaminate the child's information, it is reasonable to expect that the caretaker will say something to prepare the child. Probably it is better that the interviewer script this preparation than to rely on the caretaker.

Another preinterview strategy is to have the child's caretaker give the child permission to talk freely during the interview or to tell the interviewer specifically about what happened (Eagleson, 2002). Again, some professionals may be concerned that specific reference to the abuse may contaminate the child's account. Whether this is an advisable strategy will depend upon the particulars of the case.

During the interview, when children indicate there has been abuse but are reluctant to talk, reasoning strategies may be useful. Reasoning strategies are advised for older children, that is, children who can understand reason. Children may be afraid to disclose because they are concerned about the consequences of disclosure, and sometimes the interviewer can assuage that fear. For example, children may be afraid they will be in trouble if they tell. On the other hand, interviewers should beware of the trap of telling children that "everything will be fine" if they tell, because probably the child's life will be chaotic and stressful for a time after disclosure.

A second reasoning strategy involves motivating children to disclose in order to make something happen. Examples are getting the abuse to stop, protecting younger siblings or children, and causing the offender to be held accountable. Care should be taken not to use these reasoning strategies coercively.

Normalizing strategies are somewhat related to reasoning strategies and include normalizing the abuse ("Things like what happened to you happen to lots of kids") and normalizing the interview process. The interviewer may say, "I talk to lots of children about things like this. That's my job." Normalizing strategies are appropriate only if the interviewer has good reason to suspect the child has been sexually abused.

Related to this approach, many interviewers attempt to set expectations for disclosure during the rapport-building part of the interview, rather than waiting until they encounter resistance to disclosure (Eagleson, 2002). The interviewer might state that "This is a place where kids can talk about troubles" or employ interview rules such as "I'm going to ask you lots of questions. If you know the answer, tell me the answer, but if you don't know the answer, say, 'I don't know'" (Faller, 2003).

Finally, there are techniques that interviewers can use in the abuse-related data gathering, when children are reluctant to disclose, to reduce the child's distress while talking about the victimization. These include switching media and gathering information about the abuse context first.

With regard to the first technique, children may be allowed to switch from talking about the abuse to demonstration with dolls, showing on an anatomical drawing, drawing a picture, or writing responses to the interviewer's questions. The professional may say, "It seems to be hard to talk about what happened. Maybe you can show me with dolls." Although this technique is referred to as switching to another medium, usually the child is also saying at least a few words, resulting in a combination of verbal and some other means of communication. Children may be reluctant to talk because they take literally the offender's admonition not to tell, but they often do not apply the admonition to other means of communication. This interpretation of the admonition is more characteristic of young children. Some children benefit from being given the choice of medium in which to communicate. The interviewer can say, "Would it be easier to show me with these dolls or maybe you can draw me a picture?"

The second technique suggested, gathering information about the context first, can be helpful because describing context may be less stressful than talking directly about abusive acts. Context information includes when the abuse happened, where it happened, where other people were, what clothing the child and the offender were wearing, what clothing was taken off, whether the offender said anything to the child, and if so, what. Once these pieces of information are gathered, the interviewer can say, "Now I know (repeats the information the child has revealed). But I'm still not

sure exactly what he did" (Faller, 1988a). Interviewers sometimes combine this technique with switching to another medium, by asking the child to draw a picture of the place where the abuse occurred (see chapter 9).

None of strategies generated by practitioners for assisting nondisclosing children has been evaluated in terms of their effectiveness. And, as noted above, all strategies except for the first require the interviewer have some information that indicates the child has been sexually abused.

SUMMARY AND CONCLUSIONS

A review of the research on adults with sexual abuse histories as children, on high-certainty sexual abuse cases, and from analogue studies involving private parts touch and admonitions of secrecy supports a conclusion that there are substantial numbers of false negatives or disclosure failures in cases of actual sexual abuse. This conclusion is buttressed by research on case files and follow-up studies. Of particular concern are cases of children abused by someone close to them and cases in which children's caretakers are unsupportive; these cases seem to result in a very high number of disclosure failures. Since the studies of reports of sexual abuse involve only cases that have come to professional attention, the findings regarding disclosure failures probably represent an underidentification of the problem of children who do not tell.

In addition, there is some empirical support for the child sexual abuse accommodation syndrome (Summit, 1983). This research indicates that, for many children, disclosure is a process, which may involve initial denial of abuse and later retraction.

In contrast to the data on the problem of nondisclosure, there is a paucity of empirically based advice about what interviewers should do about nondisclosure. Carnes and colleagues' field research (Carnes & LeDuc, 1998; Carnes et al., 1999, 2000, 2001) provides support for extended assessments of children who have evidence of sexual abuse but who initially do not disclose abuse. Similarly, the interview analysis conducted by Hershkowitz et al. (2006) yields two suggestions. When children are nonresponsive during initial stages of the interview, the interviewer should extend rapport building, and in such cases, interviewers should consider more than one investigative interview.

Additional advice comes from practice experience (e.g., Eagleson, 2002; Faller, 2003). This advice includes assuring the child is prepared and has appropriate expectations for the interview and instructing the caretaker to give the child permission to talk freely. Further, when older children clearly indicate that they have been abused but decline to talk about it, interviewers may employ reasoning or try to normalize disclosure. Finally, practice-based strategies for making disclosure less stressful include gathering contextual information before asking about the specifics of the abuse and allowing the child to communicate in some

medium other than words.

NOTE

1. "Ritual abuse" is a term employed for a spectrum of very serious maltreatment cases, usually involving sexual, physical, and psychological abuse, in the context of some kind of ritual. Although ritual abuse remains a very controversial form of abuse (Faller, 2003), surveys of child maltreatment professionals indicate that about 10% of professionals have encountered ritual abuse cases (Goodman, Bottoms, Qin, & Shaver, 1994).