Why children disclose or not
Why children recant
How to respond to a disclosure

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What makes a child disclose or not?

First things first... “Disclosure of abuse is a process, not an event.” (Sorenson and Snow, 1991).

117 cases supported by medical evidence, perpetrator confession or criminal conviction:
◦ 72% of victims initially denied abuse and 78% were reluctant to discuss the abuse
◦ 74% were accidental and 22% recanted only to reaffirm later
Stages of Disclosure, Sorenson and Snow, 1991

Denial
Tentative
Active
Recanting
Reaffirming
However in another study...

Bradley and Wood found different results of 234 victims of:
- 6% contacted officials directly
- 72% disclosed to someone else (35% to family member, 16% other and 13% to a school official)
- 96% made full or partial disclosures
- 6% initially denied
- 10% displayed reluctance
- 3% recantation
Abuse disclosure is incremental over time

Child victims of intrafamilial abuse may be reluctant to disclose abuse:
  ◦ Secrecy
  ◦ Helplessness
  ◦ Entrapment and accommodation
  ◦ Delayed, conflicted and unconvincing disclosures
  ◦ Retraction
Browne, 1991

Disclosure is almost always an ongoing process. It may begin with an initial quite dramatic first step, or it may manifest itself as a series of tentative revelations, hints and explorations (p. 153)

Kelley et al., 1993,

Disclosures are often delayed and gradual (p. 82)
Prevalence of disclosure failures,
Faller and Everson, 2016

Between one-fourth and one-third of children deny sexual abuse during forensic interviews.

Populations where there are other indicators of sexual abuse have higher rates of non-disclosure.

Research indicates that more than half of children with STI do not disclose sexual abuse when asked.

Research indicates that a half to a third of children for whom there was video evidence of sexual abuse did not disclose when interviewed.

Most victims never report or delay

Many make hesitant and unconvincing initial disclosures

Partial disclosures
Fear and/or Helplessness

Fear harm to themselves, harm to loved ones, and harm to the perpetrator (Summit, 1983)

Fear of punishment by the perpetrator and or someone else, including abandonment and rejection and a desire to protect the perpetrator, or fear of hurting someone else (Russell, 1986).

Fear of losing the affection and goodwill of the offender, fear of blame or punishment, fear of harm or retaliation against someone in their family (Sauzier, 1989 and Finkelhor, 1980).

Fear of shame and blame or not being believed (Johnson & Shrier, 1985, Palmer et al, 1999).
Familial Abuse

Familial abuse is less likely to be reported than outside of family abuse. (Hanson, Resnick, Saunders, Kilpatrick, and Best, 1999; Smith et al, 2000).

Disclosure is more likely when the perpetrator was a stranger rather than a family member.

Victim/Perpetrator Relationship Continuum

Externalized
(easier to disclose)

Stranger  Friend  Sibling  Caretaker  Lover

Internalized
(more difficult to disclose)

Adapted from Ahlquist, A. (1992) CornerHouse
Secrecy

Bribes or manipulation by the offender

Children don’t want to trouble the non-offending caregiver

Protective of other family members

Sas and Cunningham (1995), “the most common admonishments not to tell were a simple statement that it is a secret or that they should not tell, a warning that the child would be in trouble, a warning that the abuser would be in trouble, a threat of withdrawing privileges, a warning that it would hurt the mother to know, and a promise of money for not telling. (p. 122)

70% told to keep abuse secret (Berliner and Conte, 1990)
Child Development

Lack understanding of it being wrong/positive socialization
Lack words to disclose body parts or actions
Lack understanding of roles and relationships
Lack understanding of need to disclose
Lack of understanding of importance/significance
Lack of memory
Can modify meaning over time due to cognitive development
Will tell different parts to different people/aren’t organized
Variance of culture
Adolescence less likely due to trust issues and awareness of consequences
Certain cultural groups may recant more often than others due to cultural taboos regarding sexual abuse (Fonts, 1993). Loyalty to family members or fear of their reaction to abuse allegations may also contribute to some denials, recantations, and reluctance to disclose (Farrell, 1988, Lawson and Chaffin 1992, and Sauzier 1989).

Language barriers

Cultural barriers of trust
Avoidance is a key component of PTSD.

Gonzalez, Waterman, Kelly, McCord and Oliveri, 1993 speculate that recantation and denial may be a way for victims to “make it all go away”.

Koverola and Foy (1993), “children suffering from PTSD often enter an avoidance phase,” in which they deny abuse or recant because they cannot cope with the anxiety about court appearances or a change in the home environment may lead to denial or recantation.

Stigma of being labeled as “broken” or “damaged goods”

Belief that they are at least partially responsible for the abuse and ashamed to reveal (Summit, 1983).
Gender  Faller and Everson, 2016

Boys are less likely to disclose than girls.

Taboos about:
- Sexual encounter with an adult
- Same sex sexual encounter
Dependent relationship

Child learns to accept the situation and to survive

Accommodates the reality of the abuse

Reconciling increase in abuse but to an increasing consciousness of betrayal and objectification by someone who is ordinarily idealized as a protective, altruistic, loving parental figure.

Survival techniques

What is the alternative to this life? Could it be worse?
Recantation Rates from studies,
London, Bruck, Ceci and Shuman, 2005

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Age (range)</th>
<th>Disclosing</th>
<th>Recantations</th>
<th>No. SSI citations</th>
<th>Type of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonzalez et al. (1993)</td>
<td>63</td>
<td>(2-12)</td>
<td>24%</td>
<td>27.0%</td>
<td>9</td>
<td>Therapy</td>
</tr>
<tr>
<td>Sorensen &amp; Snow (1991)</td>
<td>116</td>
<td>Mode = 6-9</td>
<td>25%</td>
<td>22.0%</td>
<td>70</td>
<td>Therapy</td>
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<tr>
<td>Lawson &amp; Chaffin (1992)</td>
<td>28</td>
<td>M = 7.00</td>
<td>43%</td>
<td></td>
<td>31</td>
<td>Social worker</td>
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<tr>
<td>Carnes et al. (2001)</td>
<td>147</td>
<td>M = 6.00</td>
<td>43%</td>
<td></td>
<td>not listed</td>
<td>CSA team</td>
</tr>
<tr>
<td>B. Wood et al. (1996)</td>
<td>55</td>
<td>M = 5.70 (6-11)</td>
<td>49%</td>
<td></td>
<td>2</td>
<td>CSA team</td>
</tr>
<tr>
<td>Bybee &amp; Mowbray (1993)</td>
<td>106</td>
<td>M = 5.60 (2-11)</td>
<td>58%</td>
<td></td>
<td>11.0%</td>
<td>CPS and therapy records</td>
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<tr>
<td>Cantlon et al. (1996)</td>
<td>1,535</td>
<td>Mode = 4.00 (2-17)</td>
<td>61%</td>
<td></td>
<td>3</td>
<td>CSA team</td>
</tr>
<tr>
<td>Gries et al. (1996)</td>
<td>96</td>
<td>M = 8.30 (3-17)</td>
<td>64%</td>
<td></td>
<td>15.0%</td>
<td>CSA clinic</td>
</tr>
<tr>
<td>Stroud et al. (2000)</td>
<td>1,043</td>
<td>M = 8.40 (2-18)</td>
<td>65%</td>
<td></td>
<td>2</td>
<td>CSA clinic</td>
</tr>
<tr>
<td>Gordon &amp; Jaudes (1996)*</td>
<td>141</td>
<td>M = 6.40 (3-14)</td>
<td>74%</td>
<td></td>
<td>4</td>
<td>CSA team</td>
</tr>
<tr>
<td>DiPietro et al. (1997)</td>
<td>179</td>
<td>M = 7.50 (1.4-22)</td>
<td>76% (47%)*</td>
<td></td>
<td>4</td>
<td>CSA team</td>
</tr>
<tr>
<td>Dubowitz et al. (1992)</td>
<td>132</td>
<td>M = 6.00 (&lt; 12)</td>
<td>83% (59%)*</td>
<td></td>
<td>22</td>
<td>CSA clinic</td>
</tr>
<tr>
<td>Elliott &amp; Briere (1994)</td>
<td>399</td>
<td>M = 11.03 (8-15)</td>
<td>85% (57%)*</td>
<td></td>
<td>9.0%</td>
<td>Clinician</td>
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<tr>
<td>DeVoe &amp; Faller (1999)</td>
<td>76</td>
<td>M = 6.80 (5-10)</td>
<td>87% (62%)*</td>
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<td>31</td>
<td>Social worker</td>
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<tr>
<td>Keary &amp; Fitzpatrick (1994)</td>
<td>251</td>
<td>Mode = 6-10</td>
<td>91% (50%)*</td>
<td></td>
<td>7</td>
<td>CSA team</td>
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<tr>
<td>Bradley &amp; Wood (1996)</td>
<td>234</td>
<td>M = 10.00 (1-18)</td>
<td>96%*</td>
<td></td>
<td>16</td>
<td>CPS</td>
</tr>
<tr>
<td>Faller &amp; Henry (2000)</td>
<td>323</td>
<td>M = 11.70 (3-21)</td>
<td>6.5%</td>
<td></td>
<td>1</td>
<td>CPS/policy</td>
</tr>
</tbody>
</table>

Note. SSI = Social Sciences Citation Index; CSA = child sexual abuse; CPS = Child Protective Services.

*We do not report Gordon and Jaudes’s (1996) “recantation” rate because the child was not interviewed under the same clinical watch, but rather the first interview was a brief medical screening. Also, the authors include parents’ disclosures (i.e., as historian) in the base rate. bThis rate is the percentage of children from the total sample disclosing during the investigative interview. The authors do not report the percentage of disclosing during the investigative interview for substantiated cases. cDenotes studies based on cases classified as probable abuse cases; the first disclosure rate is that of children classified as substantiated, high probability, and so forth, the second disclosure rate is for all children examined, regardless of classification of abuse likelihood.
Variables on recantation, Malloy, Lyon, and Quas, 2007 and Burkhart, 1999

- Sense of safety
  - Younger children more likely than older
- Caregiver support
- Pressure (familial, societal, investigation, court, therapy, shame)
- PTSD avoidance
- Isolation from support
- Culture
- Sense of blame/stigma
Guidelines to Prevent Recantation

Assess for Recantation risk factors

- Is the NOC able/willing to protect?
- Proximity to the offender?
- Relationship to the offender?
- Access to the offender?

Provide Safety for the Victim

- Does the child need alternate placement?
Guidelines to Prevent Recantation

Burkhart, 1999

Provide Support for the Victim
- Child Advocates/CAC, DCFS, CASA, BACA

Provide Evidence of the Victim’s Credibility
- The interview is never enough
- MDT approach

Reduce trial stress and Trauma to the Victim
- Court prep and TF-CBT therapy
Non – offending Caregivers

Support to NOC is just as important

What support does the NOC have?

Establish rapport immediately

Assess the ability of the NOC to protect
  ◦ Incapacitation due to:
    ◦ Absence due to divorce, sickness or death
    ◦ Emotional disturbances, psychologically absent
    ◦ Fear or intimidation or abuse
    ◦ Power imbalance with perpetrator undercuts her ability to be available/protective to child
Reactions of NOC to the Sexual Abuse of Child
Elliot and Carnes, 2001

Disbelief/denial
Shock
Ambivalence
Overwhelmed
Hurt/betrayed
Anger
Helplessness
Guilt
Depression
First responder influence

Inconsistent, unreliable or contaminated statements due to:

- Number of interviews
- Quality of interviews
- Length and depth of interviews
- Interviewer technique
- Interviewer/child rapport
- Process of disclosure
- False allegations
- Recantation
How to respond as a first responder?

Minimal information/facts –
  ◦ Who, what, when and where

Ensure/assess safety-
  ◦ Of the discloser as well as other children in the home

Be open minded, neutral, ensure privacy/respect and be non-judgmental

Be objective to the occurrence

Validate the disclosure and the limits of your abilities/responsibilities

Call the hotline
What not to do...

DO NOT interview the child
DO NOT ask yes/no/did/why questions
DO NOT make promises you can’t keep or have the authority to make
DO NOT ask leading questions
DO NOT make assumptions/jump to conclusions/fill in the blanks.
Important resources and details

Child abuse hotline 1-800-482-5964

It is against the law for anyone to refuse to let you report suspected child abuse

You can report anonymously

You can ask to speak to a supervisor if the report isn’t accepted

CAC interviews must be called into the hotline first
Questions?