

Considerations for the Multidisciplinary Team and Children's Advocacy Center Approach to Recantation

A Research-to-Practice Summary

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Introduction: The investigation of cases of child sexual abuse can be particularly challenging due to the weight of children’s disclosures and, in most cases, the lack of evidence to support their statements. Coupled with delayed disclosure, the dynamics of child sexual abuse and the child’s relationship with the alleged perpetrator, who oftentimes is a family member, or someone close to the family, children can be reluctant to share details of the abuse during the investigative process, and in many cases, may recant their statement after the fact (London, Bruck, Ceci, & Shuman, 2005). Multidisciplinary teams (MDTs) are responsible for providing a trauma-informed, victim-centered response to allegations of child sexual abuse, and most teams, especially those affiliated with an accredited Children’s Advocacy Center (CAC), do so as part of their investigative protocol. Evidence-based practices are required in the provision of therapeutic and medical services. It is critical that MDT investigative team members utilize evidence-informed practices based on research in their response to child sexual abuse as well. By becoming aware of the research related to children’s disclosure of sexual abuse and risk factors for recantation, MDTs should be able to bridge the gap between research and their investigative process, provide a more supportive response, and hopefully prevent recantation from occurring in the aftermath of their intervention.

Significant research has occurred over the past three decades regarding children’s disclosure of abuse and the dynamics of these cases. In their review of the literature, Olafson and Lederman (2006), identified variables that influence disclosure patterns, which include: victim’s age, maternal/parental support, fear of consequences, relationship/love of perpetrator, gender, culture, stigmatization, dissociation, and post-traumatic stress. The purpose of their article was to educate the judicial system in an effort to gain better outcomes for child abuse victims in court proceedings. The overview of the research as it relates to these issues and recantation is helpful for child abuse professionals as well. It is critical for multidisciplinary teams to have a clear understanding of these dynamics, so they can accommodate children’s disclosure and support children’s caregivers during the investigative process. This requires educating professionals regarding the dynamics of abuse, process of disclosure, and risk factors for recantation.

According to most recent studies regarding recantation, rates range from 23.1 to 27% (Malloy, Lyon, & Quas, 2007; Malloy & Mugno, 2016; Malloy, Mugno, Rivard, Lyon, & Quas, 2006). In 2007, Malloy, Lyon, and Quas conducted a study examining the prevalence and predictors for recantation by reviewing 257 substantiated CSA cases with dependency court filings. Of those cases, 58 (23.1%) of the children recanted. They define recantation as “denial of abuse post-disclosure.” Predictors for recantation identified in the study include: unsupportive caregiver; children’s vulnerability to adult familial influences; younger children; perpetrator in the household; and child placement after disclosure. Subsequent publications by Malloy and colleagues based on this study produced additional findings which stand to be useful to child abuse professionals in their practice. Malloy and Lyon (2006) looked at caregiver support in the cases from the 2005 study. They found that the reaction (or anticipated reaction) of the involved caregiver directly impacts the child’s willingness to disclose, timing of disclosure, and concerns of recantation. It was also evident that caregivers were less likely to support the child when the alleged perpetrator was a family member or romantic partner. Although the Olafson and Lederman (2006) study stresses that the existence of domestic violence in

the home is a variable that impacts disclosure patterns, especially when the alleged perpetrator of child sexual abuse is the batterer, Malloy and Lyon found that this may be a motivator for the mother to sever her relationship with the abuser. They emphasize that battered mothers as a group are not necessarily less supportive, but rather they may need support and resources to end their dependency on the batterer. In this study, they also found that parental support and belief are not static. It changes over time. Supportive mothers are the best predictor for the child's adjustment after abuse occurs. Professionals must understand that it is common for caregivers to vacillate between believing and not believing their child throughout the investigation and intervention. Therefore, immediate support through advocacy and therapeutic intervention is necessary to empower the involved caregiver to protect their child throughout the process.

According to research, decisions made by child protective services can impact children's disclosure and concerns of recantation, as well as the response of involved caregivers. Malloy et al. (2016) explored familial influences on recantation in the 58 cases from the 2005 study and found children are less likely to recant when removed from their home and separated from siblings post-disclosure. They also found that children were more likely to recant when family members other than the involved caregiver expressed disbelief in the allegation and when visitations with the alleged perpetrator were recommended at the first dependency meeting. This implies that protecting children from others who may influence their disclosure is key.

“Maternal responses that convey protection and support have been found to be associated with victims' improved mental health and social functioning. Non-abusive caregivers are often marginalized by the child welfare system in its attempt to secure physical safety for the child” (Lovett, 2004, p. 355). In Lovett's article, which reviewed multiple studies related to maternal response to child sexual abuse disclosures, it was determined that the majority of mothers do believe their children, but may need professional assistance and time to effectively plan for protection. It was found that mothers often feel marginalized by child protection workers when making protection decisions. Thus, it is recommended that early intervention, immediate mental health support, and inclusion in protection decision making is paramount in empowering involved caregivers to protect and support their child.

Maternal encouragement of the child to tell the truth proved to influence the outcomes in an experimental investigation conducted by Malloy and Mugno (2016) regarding children's recantation of adult wrongdoing. The study involved 73 children ranging from 6 to 9 years of age. The children were engaged in a scripted dialogue with highly trained research assistants, who asked the children not to tell they had used the puppets and that the research assistant broke one. The children were then each interviewed about their experience by a highly trained research assistant using a modified version of the NICHD forensic interview protocol. After the first interview, the children met briefly with their mothers, who were instructed by random selection to be unsupportive or supportive to their child. The children were then interviewed by a second research assistant regarding the broken puppet. The findings showed that in the first interview, more than 40% of the children did not disclose adult wrongdoing until asked suggestive questions. One fifth of the children disclosed in response to free-

recall questions, and one third of the children minimized adult wrongdoing. In the second interview, 23.3% of the children recanted the allegation. 0% of the children with supportive mothers (who encouraged them to tell the truth) recanted. 46% of the children with unsupportive mothers (who told them not to tell) did recant. The study also found that the children with supportive mothers were more forthcoming in the second interview compared to the children with unsupportive mothers. This suggests that children of supportive caregivers who encourage their children to tell the truth are more likely to report, and less likely to recant.

In a study conducted by Carmit Katz in 2014, the researcher sought to characterize how children recant previously reported abuse during forensic interviews. Katz analyzed 12 forensic investigations of child abuse, each with external evidence suggesting the abuse occurred (i.e., suspect admission or medical evidence). Other criteria for this study included: the children had no reported developmental delays; the children disclosed in the initial forensic interview; and the children recanted in the second forensic interview. Key categories of the researcher's findings included: children's disclosure patterns; their first testimonies; their recantations; familial and cultural contexts of recantation; and quality of the 24 forensic interviews.

The disclosure patterns in each of the 12 investigations revealed that each child initially reported the abuse to a school professional, and the abuse was immediately reported to authorities. Investigations began soon (the same day to 5 days from the outcry being made). In the initial interview, all 12 children demonstrated an understanding of rules and were cooperative in neutral narrative practice. All children disclosed in response to the first open-ended prompt in transition to the substantive phase, "Tell me why you came here to talk to me." All 12 initial interviews were considered to be of high quality—60% open-ended questions, 25% directive questions, 12.8% option-posing prompts, and 3% suggestive (yes/no) questions. Forensic interviewers assessed these disclosures to be reliable (especially since external evidence existed).

The recantations of the 12 children occurred between 5 days to 6 months from the initial forensic interview. 10 of the 12 children had the same forensic interviewer in the second interview. The causes for recantations were due to external pressure (family, cultural, trauma after the investigation). All were straightforward about the recantation, and used "stock" phrases, with no elaboration. The children were reluctant to respond to open-ended questions, which forced the forensic interviewers to increase use of directive questions. Forensic interviewers assessed these disclosures to be unreliable.

This study implies that if a second interview is to be conducted, a comparison of the disclosures and types of questions used by the interviewer will be helpful in assessing the reliability of the child's statements. Both interviews should be conducted by the same forensic interviewer if possible, and recorded in the same manner for analysis. Protocol guidelines for recantation should be in place for the investigation and conducting of forensic interviews.

Implications for Practice

By taking research into consideration during the intervention of child sexual abuse, MDTs can implement strategies to diminish the risk of recantation, such as recommending no contact with alleged perpetrator and unsupportive family members until the investigation is concluded. It is important to assess for recantation risk factors at the beginning of the investigation to ensure that immediate provision of advocacy and therapy for the involved caregiver and child are in place in an effort to increase support and education. Teams should also consider creating criteria for emergency forensic interviews in their investigative protocol to include cases in which the child is younger, the alleged perpetrator is a family member or romantic partner of the involved caregiver; the child is in an unsupportive environment; and where there is a history of domestic violence.

In the event recantation does occur, several outcomes may happen. Recantation can result in the case being unsubstantiated and dismissed; the offender not being held accountable; the offender being allowed contact with the child and family; the possibility of re-victimization; and the child's inability to heal. The best-case scenario would be for the prosecuting attorney to delay prosecution; for investigators to reassess the case; and for the team to put supports in place to encourage reaffirmation of the original allegations. Some jurisdictions engage in routine practice of automatically scheduling a "recantation interview" of the child. This decision should be made with great care and input from the entire investigative team with consideration of the purpose of the recantation interview. If the purpose is to re-interview the child about the original allegations or to challenge the child's recantation, this contradicts the goal of child forensic interviewing, which is to collect accurate, factual elements of the child's experience in a manner that is sensitive to the child's needs. In an effort to avoid re-traumatizing children who recant, MDTs should consider developing guidelines within their existing investigative protocol to outline steps for addressing recantation:

- Provide training for all MDT professionals regarding dynamics of abuse, process of disclosure, and recantation
- Provide immediate therapeutic intervention for children post disclosure, with involved caregiver participation
- Provide involved caregivers increased support and education regarding how to support their child post disclosure
- Assess existing support systems and offer support services as needed (i.e., basic needs, childcare, transportation)
- Assess involved caregiver for current and/or past trauma and refer for trauma focused therapy if needed
- Develop guidelines within MDT protocol to outline immediate response to cases that have a high risk for recantation
- Develop guidelines within MDT protocol to outline steps team should make to respond to recantation when it occurs

In conclusion, further research is needed in the field with regard to recantation. The studies cited have limitations. For instance, the 58 children who recanted in the Malloy research each had cases that were previously substantiated. The study does not include cases in which children recant during the investigation or in unsubstantiated cases. Existing research does identify the many variables that impact children's disclosure patterns. Hopefully, with an understanding of these dynamics, child abuse professionals can work to provide interventions that will prevent further harm to children and provide families the opportunity to heal.

Sample MDT/CAC Protocol Guidelines for Recantation

Initial Investigation

- Initial contact with child and family
 - Once the MDT determines a need for a forensic interview (FI), immediately contact the CAC to schedule the FI
 - Prioritize scheduling of forensic interviews considering the highest priority, cases that are at risk for recantation: younger child victim; alleged perpetrator is family member or romantic partner of parent; unsupportive caregiver; domestic violence in home
 - Explain the purpose of the forensic interview to child and involved caregiver
 - As a team, assess for recantation risk factors by researching family and alleged perpetrator child protection and criminal history
 - Assess protective capacities of the involved caregiver – whether the caregiver believes the child and is capable of supporting and protecting the child
 - When making contact with caregiver, team member should provide support and instruction on how to handle discussion of the allegation with their child
 - When scheduling the FI, advocate and/or team member should instruct caregiver to tell their child to tell the truth in the forensic interview
 - Assess whether siblings or close family members believe the allegations
 - Remove alleged perpetrator from the home until the investigation is concluded (regardless of disclosure during FI)
- MDT pre-interview discussion
 - Meet as a team to discuss family and alleged perpetrator priors and case history
 - Identify risk factors for recantation
 - Discuss circumstances of child's disclosure (outcry)
 - Briefly interview involved caregiver before forensic interview to gather information related to the child
 - developmental concerns
 - school performance/social skills
 - behavioral changes/concerns
 - medical diagnosis
 - mental health diagnosis
 - what the child knows about being at the CAC

- what the caregiver knows about the allegations
 - circumstances of the outcry statement
 - Assess with caregiver, risk factors for recantation (i.e., discuss caregiver's willingness to protect and support child; whether caregiver and family believe the allegations; caregiver and child's relationship with alleged perpetrator)
- During forensic interview
 - Record interview
 - Ask child to promise they will tell the truth
 - Engage in practice-narrative – neutral topic
 - Use narrative inviting questions
 - Use minimal yes/no questions
 - Explore alternative hypothesis
 - Explore whether the child has disclosed to others
 - If concerned about influence, explore whether someone talked to the child about what to say
 - Ask child about feelings, concerns, thoughts
 - Ask child if they feel safe, supported, believed (by caregiver and family members)
 - Have or help child identify trusted adults they can turn to if they need help
- Advocacy with caregiver during interview
 - Assess caregiver's protective capacities and whether they believe their child
 - Remember, disbelief is common early on and it is fluid; caregiver's can vacillate
 - Explore how they feel about the allegations/investigative process
 - Assess past/current trauma
 - Provide crisis intervention if needed
 - Offer support/services if needed
 - Make referral for services before family leaves
 - Obtain signed release for communication with MH provider
- MDT post-interview discussion
 - Discuss child's disclosure (i.e., details, corroborative facts, child's emotions and behaviors)
 - Discuss child protection
 - Discuss need for therapy / make referral
 - Discuss need for medical exam / make referral
 - Team meeting with involved caregiver
 - Share as much information as possible without injuring the case
 - Share assigned MDT contact information for caregiver to call when needed
 - Discuss protection plan
 - Educate caregiver on how to support and what to say if child continues to disclose

- Advocacy after the CAC visit
 - Continue daily or weekly follow up for high risk families
 - Keep involved caregiver informed of the status of the investigation (with MDT support)
 - Obtain signed release from MH provider to inquire whether family is participating in therapy
 - Follow up with therapist for status updates
 - Share therapy status with MDT as needed and at case review

If the Child Recants

- Immediately schedule case staffing with MDT members assigned to original investigation—including therapist and prosecutor if assigned
 - Discuss reassessing safety/protection of child (consider placement/protective custody)
 - Discuss how to proceed with respect to child’s needs (i.e., therapy vs. forensic interview)
- Shift the focus of the investigation to determine the cause of recantation
 - Identify the circumstances of recantation by interviewing the person to whom the child recanted
 - Determine whether contact has occurred between the alleged perpetrator and child and/or family
 - Determine whether involved caregiver and family believe child
 - Determine whether circumstances after initial disclosure influenced recantation
 - Determine whether child was influenced by other people
 - Explore victim/witness tampering by alleged perpetrator
 - Explore victim/witness tampering by others
 - Explore whether original statement was false
- If the team decides to re-interview the child, this should be after the investigation/interviews of collateral witnesses regarding the cause of the recantation—proceed with caution
 - Team should first consider the reason for another forensic interview
 - To document the circumstances of the recantation from the child’s perspective
 - To provide possible evidence of victim/witness tampering
 - To explore false allegations/alternative explanations for original disclosure
 - NOT to challenge the child’s current or original statements
 - If it is determined that a forensic interview will take place:
 - It should be conducted in the same manner, same location, by the same interviewer
 - MDT investigators assigned to the original case should be present to observe the interview and participate in pre- and post-interview discussion
 - The same advocate should be present to engage and support the involved caregiver

- The forensic interviewer and team should review the original forensic interview and case notes before the second interview
- The interview
 - During introductory phase review the same “interview guidelines” discussed in the first interview
 - Remind child that interview is being recorded and MDT is observing just as occurred in the original interview
 - Spend time building rapport inviting narrative regarding safe, neutral topics, or events
 - If the child doesn’t reference the allegation or recantation on their own, transition by acknowledging initial forensic interview disclosure and ask what happened afterward in the least leading manner possible
 - Use narrative inviting—open-ended questions
 - Increased cued-recall may be necessary if child is reluctant
 - Remain neutral, respectful, and offer reassurance
 - Use minimal yes/no or multiple choice (only for clarification when necessary)
 - Do not ask the child to repeat the original disclosure or challenge what is being said now compared to what was previously disclosed
 - Keep focus on what has happened since the original interview
 - Explore the circumstances of recantation (who was present, what was said)
 - Determine whether contact has occurred between the alleged perpetrator and child and/or family
 - Ask whether involved caregiver and family believed the child originally
 - Ask how the involved caregiver and family reacted to the child’s original disclosure
 - Explore whether circumstances after initial disclosure influenced recantation
 - Explore whether the child has recanted to others
 - Explore whether someone talked to the child about what to say
 - Determine whether child was influenced by other people
 - Explore victim/witness tampering by alleged perpetrator
 - Explore victim/witness tampering by others
 - Explore whether original statement was false
 - Close the interview according to FI protocol
 - Ask child about feelings, concerns, thoughts
 - Ask child if they feel safe, supported, believed (by involved caregiver and family members)
 - Have or help child identify trusted adults they can turn to if they need help

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