University of Southern California Law

From the SelectedWorks of Thomas D. Lyon

May 2007

14. Malloy, L.C., Lyon, T.D., & Quas, J.A. (2007). Filial dependency and recantation of child sexual abuse allegations. Journal of the American Academy of Child and Adolescent Psychiatry, 46, 162-170.

Contact Author

Start Your Own SelectedWorks

Notify Me of New Work

Available at: http://works.bepress.com/thomaslyon/20

Filial Dependency and Recantation of Child Sexual Abuse Allegations

LINDSAY C. MALLOY, M.A., THOMAS D. LYON, J.D., PH.D., AND JODI A. QUAS, PH.D.

ABSTRACT

Objective: Controversy abounds regarding the process by which child sexual abuse victims disclose their experiences, particularly the extent to which and the reasons why some children, once having disclosed abuse, later recant their allegations. This study examined the prevalence and predictors of recantation among 2- to 17-year-old child sexual abuse victims. **Method:** Case files ($n = 257$) were randomly selected from all substantiated cases resulting in a dependency court filing in a large urban county between 1999 and 2000. Recantation (i.e., denial of abuse postdisclosure) was scored across formal and informal interviews. Cases were also coded for characteristics of the child, family, and abuse. **Results:** A 23.1% recantation rate was observed. Multivariate analyses supported a filial dependency model of recantation, whereby abuse victims who were more vulnerable to familial adult influences (i.e., younger children, those abused by a parent figure and who lacked support from the nonoffending caregiver) were more likely to recant. An alternative hypothesis, that recantations resulted from potential inclusion of cases involving false allegations, was not supported. **Conclusion:** Results provide new insight into the process by which children reveal interpersonal trauma and have implications for debates concerning the credibility of child sexual abuse allegations and treatment in dependency samples. *J. Am. Acad. Child Adolesc. Psychiatry*, 2007;46(2):162–170. **Key Words:** recantation, child sexual abuse, disclosure.

During the past 2 decades, an impressive body of research has emerged concerning the effects of socio-contextual influences on children's memory and suggestibility (see Bruck and Ceci, 2004; Poole and Lamb, 1998), particularly regarding stressful events. This research has largely emphasized how legal, medical, and mental health professionals can distort children's event reports via interview context and interviewer biases. Much less attention has focused on the influence of other individuals, most notably those implicated by children's statements, on children's disclosure of traumatic experiences. For example, little is known about the process by which children disclose child sexual abuse (CSA) against known and trusted perpetrators, including the phenomenon of recantation, in which children disclose but then retract CSA allegations. Research on recantation has emphasized prevalence rates, which vary considerably across studies, and has rarely examined the processes underlying recantation. In this study, we investigated recantation of CSA in a large sample of substantiated victims (i.e., children whose CSA was deemed true by social services investigators) and tested a theoretical model in which recantation was predicted by pressures related to filial dependency.

Early research concerning CSA disclosure suggested that social and familial factors influence children's willingness to disclose CSA, consistent with widespread recognition of the significance of family context for children's social and emotional development generally (Bronfenbrenner, 1977; Parke and Buriel, 1998) and

Accepted August 29, 2006.

Ms. Malloy and Dr. Quas are with the University of California, Irvine; and Dr. Lyon is with the University of Southern California School of Law.

The authors thank Michael Nash, Presiding Judge of the Los Angeles Juvenile Court and the Los Angeles County Counsel's office, for his support. Thanks also to Julian Forman and other University of Southern California students for their assistance. Finally, thanks to Gail Goodman and JoAnn Prause for their helpful comments. This research was supported by National Institute of Child and Human Development Grant HD047290-01A2 and National Science Foundation Grant BCS-0241586.

Correspondence to Dr. Thomas Lyon, University of Southern California; University Park; Los Angeles, CA 90089-0071 or Dr. Jodi Quas, 3340 Social Ecology II; Department of Psychology; University of California; Irvine, CA 92697; e-mail: tlyon@law.usc.edu or jquas@uci.edu.

0890-8567/07/4602-0162©2007 by the American Academy of Child and Adolescent Psychiatry.

DOI: 10.1097/01.chi.0000246067.77953.f7

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

emerging ability to cope with trauma, including CSA, specifically (see Elliott and Carnes, 2001, for a review). For instance, a close relationship between a victim and a perpetrator may lead to delayed disclosure, given the child's loyalty to and dependence on the perpetrator. Similarly, a child's fears about reactions from caregivers (who are themselves close to the perpetrator) may reduce the child's willingness to disclose promptly (De Francis, 1969; Landis, 1956). More recent research reveals that children often delay reporting abuse and that disclosure is related to caregiver support, but mixed support has emerged concerning the proposition that being closely related to a perpetrator is associated with delayed reporting (see London et al., 2005; Lyon, 2002; Paine and Hansen, 2002).

Recantation following disclosure of CSA is much less understood and more controversial. Although its existence was noted in early research, it was not systematically quantified nor were its correlates examined (Goodwin et al., 1982; Sgroi, 1982). According to the most widely cited theory of CSA disclosure, Child Sexual Abuse Accommodation Syndrome (CSAAS), recantations are common and are attributable to the same influences that lead to delayed reporting (Summit, 1983). However, CSAAS has been criticized for insufficient empirical support (Bradley and Wood, 1996; Bruck and Ceci, 2004; Kovera and Borgida, 1997; London et al., 2005). More recent research has sought to quantify recantation (e.g., Elliott and Briere, 1994) without systematically examining its predictors.

Filial Dependency Model of Recantation

We propose a filial dependency model of recantation in which the likelihood of recantation is affected by the child–perpetrator relationship, supportiveness of the nonoffending caregiver postdisclosure, child's age, and child's placement postdisclosure. With regard to child-perpetrator relationship, multivariate analyses have found that children delay reporting longer when they are abused by a close relative (but see Goodman-Brown et al., 2003; Sas et al., 1995; Sjöberg and Lindblad, 2002; Wyatt and Newcomb, 1990; DiPietro et al., 1997), although univariate analyses have not consistently revealed such an association (see London et al., 2005). Longer delays to disclosing intrafamilial abuse may result from the child's desire to protect the perpetrator or other family members (Goodman-Brown et al., 2003). Moreover, the typically nonviolent and progressive nature of intrafamilial abuse may lead some children to acquiesce initially and subsequently feel implicated or responsible, thereby delaying disclosure (De Francis, 1969). Although the association between the child–perpetrator relationship and recantation has not been directly examined, it seems likely that recantation and delay will exhibit similar dynamics.

Univariate analyses have found that maternal support is negatively related to both delayed disclosure (Lawson and Chaffin, 1992) and recantation (Elliott and Briere, 1994) and that younger children are more likely than older children to recant (Gordon and Jaudes, 1996; Gries et al., 1996; Keary and Fitzpatrick, 1994). Younger children also are more deferential to adult authority (Laupa, 1994) and more willing to lie to protect a parent (Tye et al., 1999), both of which likely influence their tendency to recant CSA allegations. Of importance, both maternal support and children's age are related to the child-perpetrator relationship: Mothers are less supportive when children are abused by a family member (Pintello and Zuravin, 2001), and younger children are at greater risk of intrafamilial abuse (Quas et al., 2002). Hence, although it is reasonable to hypothesize that both caregiver supportiveness and child age affect recantation, a multivariate approach is necessary to identify the independent role of each factor.

To date, research has not examined the relationship between foster-care placement postdisclosure and recantation. Although removing a child from an environment in which pressures to recant exist could reduce the likelihood of recantation, foster-care placement may be an incentive to recant if a child wishes to return home. In light of these possibilities, it is important to examine the relationship between placement and recantation in a large sample of CSA victims.

Finally, abuse severity and gender, although not directly related to filial pressures, may predict recantation because of their associations with other factors in the proposed model and their links to children's reluctance to disclose abuse. For instance, girls are more likely than boys to be abused by a family member (Finkelhor, 1984; Quas et al., 2002). Also, more severe abuse has been linked to longer delays to disclosure (see London et al., 2005), although this relationship may reflect increases in severity over time because of nondisclosure. Finally, a few studies have found that males are more likely to delay disclosure than females

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

(see London et al., 2005). Accordingly, abuse severity and gender should be considered when studying CSA recantation.

False Allegations and Recantation

In a recent review of the CSA disclosure literature, London et al. (2005) argued that recantation rates are related to the certainty with which CSA is "diagnosed" or substantiated, and recantation of true allegations is rare. The authors posit that differences in the proportion of false reports across studies' samples explain the variability in reported recantation rates. The authors note that the study reporting the lowest recantation rate (4%; Bradley and Wood, 1996) included only CSA cases substantiated by social services, thus reducing the likelihood that the allegations were false.

Despite the parsimony of the London et al. (2005) explanation, it is hazardous to compare prevalence rates across studies employing different recruitment procedures, sample characteristics, inclusion criteria, and methods for coding interviews and recantations. For example, Bradley and Wood (1996), who reported the particularly low recantation rate, excluded open cases and recantations to professionals other than social workers and police. Moreover, the authors did not report the extent to which children were interviewed repeatedly over long periods of time, which appears to be the norm in CSA legal cases (Goodman et al., 1992). Nevertheless, a fair criticism highlighted by London et al. is that research has not considered the possible contribution of false allegations to recantation rates. To minimize the inclusion of false reports, we considered only CSA cases substantiated by social services and for which sufficient evidence warranted a dependency court filing. We further investigated associations between recantation and two factors believed to reflect on CSA allegation falsity: lack of corroborative evidence (i.e., evidence that implicates the accused of the crime) and custody-related conflict, thus enabling us to address empirically several of the main concerns raised by London et al.

METHOD

Sample

Our sample consisted of 257 cases selected from 465 substantiated cases of CSA that resulted in a dependency court filing during a 1-year period in a large urban county. The 465 cases involved 433 children (some children had more than one case). For the present study, 50% of the children (n = 217), representing 257 cases, were randomly selected for inclusion. Children in the final sample (89.9% female) ranged from 2 to 17 years (mean = 10.35) at the time of arraignment (i.e., the initial hearing after filing of the dependency petition). They were ethnically diverse: 65.6% Latino, 11.6% white, 11.2% African American, 2.3% Asian, and 9.4% other (e.g., biracial). This ethnic distribution approximated the child demographics in the county where data were collected (Children Now, 2005).

Procedure

Following approval from relevant university institutional review boards and the presiding judge of the Juvenile Court, case files were collected. These files included all social services, police, medical, and psychological reports detailing the abuse, children's reports, and events following the abuse's discovery. A detailed coding scheme was developed, based in part on schemes employed in previous studies assessing CSA disclosure (Bradley and Wood, 1996; Elliott and Briere, 1994) to score abuse characteristics, reactions of family members to the abuse, consequences of abuse discovery on the child and family, and the timing and content of each disclosure. Two raters independently coded 22 case files. Kappa values for variables coded per case ranged from 0.72 to 1.0 (percentage of agreement ranged from 86% to 100%), and kappa values for the key variables in the present analyses ranged from 0.80 to 1.0. Weighted kappa values for variables that differed in frequency across cases (e.g., details per interview when number of interviews varied) ranged from 0.70 to 0.82. Discrepancies were discussed and resolved. One rater coded the remaining files.

Perpetrators were parent figures (i.e., biological parent, stepparent, legal guardian, or nonoffending caregiver's intimate partner) in 70.9% of the cases. Nonparental figures included relatives (16.4%), neighbors/friends (6.8%), or others (6.0%). For six cases (2.3%), the perpetrator's identity was unknown. In two cases, the perpetrator was female, and in 6.3% of the cases, the perpetrator was a minor. In 77.0% of the cases, the perpetrator and child lived in the same household when the abuse occurred. Abuse severity was scored on a 13-point scale. The lowest scores reflected noncontact offenses (e.g., exhibitionism), and the highest scores reflected vaginal or anal penetration. Children's mean severity score was 6.80, roughly corresponding to digital penetration (32.7% of the cases involved penile penetration of the mouth or genitalia; 1.6% involved solely noncontact offenses). Abuse duration ranged from an isolated incident to multiple incidents over a 12-year period (72.8% involved multiple incidents). In 65.8% of the cases, CSA was accompanied by another form of substantiated maltreatment (46.5%, 32.4%, and 28.9% involved physical abuse, exposure to domestic violence, and caregiver substance abuse, respectively).

Nonoffending caregivers (90.9% biological mothers) were classified as unsupportive in 58.8% of the cases. To be considered unsupportive, documentation of at least one of the following was required of the caregiver: initially expressed disbelief or skepticism about the allegation(s), exerted direct verbal pressure on the child to recant, blamed the child, remained romantically or interpersonally involved with the perpetrator after CSA discovery (e.g., the perpetrator continued to live with the caregiver), or behaved in an unsupportive manner (e.g., forced the child to leave home). In 58.4% of the cases, the child was placed in foster care immediately on substantiation of abuse.

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

Three forms of corroborative evidence were scored. Medical evidence was indicated if the medical evaluation reported physical findings probative of abuse (19.6%). Perpetrator admission was noted if the perpetrator at least partially admitted the CSA (19.1%). The presence of other victims was scored if the file contained details about previous allegations of CSA levied at the perpetrator or if the perpetrator had a concurrent case involving another child (37.0%). Files were also examined for evidence of custody-related conflict. This included documentation of the nonoffending caregiver and perpetrator having previously litigated a case in family court or of an involved party asserting that the allegations were the result of disputes over child custody (22.2%).

Finally, interviews were coded for details relevant to disclosure and recantation, including the date of each interview, the interviewer's identity, whether the interview was formal, and the content of the child's disclosure (e.g., abuse type, frequency). Interviews (mean = 6.00; range, 1–28) were defined as any interaction between the victim and another individual in which there was an attempt made by at least one party to discuss the CSA. Formal interviews (mean = 4.26; range, 1–25) included those conducted by law enforcement, Department of Child and Family Services/social workers, medical or mental health professionals, or school personnel. Informal interviews (mean = 1.65; range, 0–7) included those conducted by a parent/guardian or an adult or child relative/friend.

Recantations, scored per interview, were defined as a child, after having disclosed abuse, explicitly and completely denying CSA by the perpetrator. According to this definition, recantations included cases in which a child denied abuse at one point during an interview but confirmed abuse at a different point within the same interview (11 cases, 4.4%). Because some children disclosed and recanted within the same interview, recantation could occur in the first interview (three cases, 1.2%).

The results reported here were computed with all of the cases included. For children with multiple perpetrators, each case was considered separately because children's age, relationship to the perpetrator, and disclosure patterns often varied across cases. However, the same pattern of results emerged when, for children with multiple perpetrators, one case was randomly selected and analyses were reconducted. Finally, in five cases, children never disclosed abuse and thus could not recant. These cases were removed from subsequent analyses.

RESULTS

Prevalence of Recantation

Children recanted allegations of CSA in 58 cases (23.1%). When recantation among only formal interviews was considered, children recanted in 49 cases (19.5%). On average, children first recanted in their fourth interview (range, 1st–14th interview). Some cases involved recantations in multiple interviews (mean = 1.74; range, 1–5). In 48.3% (n = 28) of the cases in which recantations occurred, the children reaffirmed at least part of their CSA allegations during a subsequent interview(s). At the last interview, more than half (56.9%, n = 33) of the cases involving recantations included children who were maintaining that the abuse had not occurred. Notably, the recantation rate that we observed is among the highest in published research and is considerably greater than that found in other samples of substantiated cases, an issue to which we return in the Discussion section.

Predictors of Recantation

Unlike in previous research finding low rates of recantation among substantiated cases, the higher rate that we observed allowed us to test a filial dependency model of recantation. We conducted a logistic regression analysis predicting recantation from the following: child–perpetrator relationship (coded dichotomously: parent figure or not), nonoffending caregiver unsupportiveness (coded dichotomously: unsupportive or not), child age when the case was filed, initial placement (coded dichotomously: foster care or not), abuse severity (13-point scale), and child gender. The model was significant, $\chi^2_6 = 18.29$, $p < .01$, and correctly classified 77.7% of the cases, Nagelkerk $r^2 = 0.11$. Significant predictors included the child–perpetrator relationship, nonoffending caregiver unsupportiveness, and child age (Table 1). As predicted, children abused by a parent figure were more likely to recant, as were children whose nonoffending caregivers were unsupportive. Also, and again as hypothesized, younger children were more likely to recant than older children. Finally, a trend indicated that children initially placed in foster care (20.0%) were somewhat less likely to recant than children who remained with a family member (27.4%).

Because our sample was limited to substantiated CSA allegations, it is unlikely that the high rate of recantation was simply attributable to a high proportion of false allegations. Nevertheless, we cannot definitively conclude that all of the allegations were true. Research shows that social workers rely largely on disclosure to substantiate abuse (Everson and Boat, 1989; Haskett et al., 1995), and disclosures may be false. Therefore, we separately examined evidence that could either support or detract from the allegations' veracity. If, as London et al. (2005) argue, recantations predominate among false allegations, then recantation rates should be lower among cases with corroborative evidence of abuse and higher among cases for which a possible motive to falsify can be identified (e.g., those involving disputes over a child's custody; Ceci and

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

TABLE 1
Results of Logistic Regression Analysis Testing the Filial Dependency Model

Predictor	β	SE	Odds Ratio	Wald Statistic	95% CI
Age, y**	−.09	0.04	0.92	4.45	0.85–0.99
Gender (1 = male, 0 = female)	−.39	0.59	0.68	0.43	0.21–2.17
Child–perpetrator relationship** (1 = parent figure, 0 = nonparent figure)	.76	0.39	2.14	3.74	1.00–4.62
Abuse severity (13-point scale; 0 = noncontact offense, 13 = sodomy, offender recipient)	−.01	0.04	0.99	0.06	0.92–1.07
Nonoffending caregiver unsupportiveness** (1 = unsupportive, 0 = supportive)	.93	0.37	2.53	6.21	1.22–5.25
Foster care placement* (1 = foster care, 0 = other placement)	−.57	0.34	0.56	2.89	0.29–1.09

Note: CI = confidence interval.
* $p < .10$; ** $p \leq .05$.

Friedman, 2000). We tested this possibility via a second logistic regression analysis. Four predictors were included: three forms of corroborative evidence—medical evidence, perpetrator admissions, and multiple victims of this perpetrator—and evidence of custody-related conflict.

The regression model was not significant, $\chi^2_4 = 6.85$. Among cases with medical evidence (n = 45), the recantation rate was 20.0%. Among cases in which the perpetrator admitted CSA (n = 48), the recantation rate was 16.7%, and among cases for which there were multiple victims of this perpetrator (n = 92), the recantation rate was 17.4%. Finally, among cases in which there was evidence of custody-related conflict (n = 57), recantations occurred in 17.5% of the cases. Although the rates in cases for which corroborative evidence existed appear slightly lower than that in the overall sample (23.1%), the rate among cases including custody-related conflict was also slightly lower. Thus, no evidence emerged indicating that recantation rates are related to the proportion of dubious cases in the sample. In contrast, clear support emerged for the importance of filial dependency in predicting recantation.

DISCUSSION

In the present study, a sizable minority of children recanted claims of CSA. The percentage of recantations was clearly <50% and thus is inconsistent with claims that a majority of abused children recant abuse (Summit, 1983). However, the percentage is among the highest in the literature. Because our sample comprised only substantiated claims of CSA, our findings stand in direct contrast to the proposition that higher rates reflect a larger proportion of false allegations. Instead, multivariate analyses revealed the importance of vulnerability to familial influences in predicting children's likelihood of recanting.

Prevalence of Recantation

The rate of CSA recantation we observed (23.1%) was more than five times larger than that reported in the most often cited study on CSA substantiated by social services (Bradley and Wood, 1996 [4%]). There are several possible reasons for the apparent differences. First, children can recant to anyone, and any recantation can affect perceptions of children's credibility and the progression and outcome of a case. Bradley and Wood (1996) only tallied recantations to police and social services. Similarly, in their review, London and colleagues (2005) define recantations as "statements that are made to the same assessment team who heard the disclosure." In both circumstances, informal interviews and, for some studies considered by London et al., interviews varying in their thoroughness, were excluded. In the present study, we considered formal and informal interviews. Both are obviously critical when attempting to evaluate and understand children's CSA disclosures and recantations. Nonetheless, even when we limited our study to only formal interviews conducted by police, social workers, or school, mental health, or medical professionals, our recantation rate was 18.9%. Similarly, when we relied on the definition of formal interviews employed by Bradley and Wood (i.e., only police and social services), our recantation rate was 16.9%. Both percentages remain four times higher than that reported in Bradley and Wood. Thus, definitional differences do

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

not adequately account for variations in reported recantation rates.

Second, pressures to recant likely build over time. Several researchers have noted that recantation rates are likely understated with limited follow-up (Gries et al., 1996; Jones and McGraw, 1987). Although Bradley and Wood (1996) examined the entire history of children's social services cases, they did not report the number of interviews conducted, excluded open cases, and acknowledged that recantations may increase over time. It also appears that none of the recanting victims was interviewed more than three times. The recanting children in our study were interviewed, on average, seven times (range, 3–28), and, as mentioned, their recantations first occurred on average in the fourth interview. Moreover, recantation was significantly associated with the number of interviews to which children were exposed, $r_{(257)} = 0.19$, $p < .05$, although this finding should be interpreted with caution because repeated interviews may be as much a consequence as a cause of recantation. That is, recantation is likely to trigger further interviewing, as are inconsistent reports and/or reluctance, which themselves may ultimately result in recantation. Future research should attempt to tease apart the role that repeated interviews play in recantation, particularly because researchers have almost exclusively focused on how repeated interviews increase the risk of false allegations rather than false denials (e.g., Ceci and Friedman, 2000).

Third, our sample's nonoffending caregivers appear to have been less supportive than those in the Bradley and Wood (1996) study. In our study, 46.3% of the caregivers explicitly expressed disbelief in the child's allegation(s), compared to 24.7% in Bradley and Wood (Bradley, 1995). However, Bradley and Wood only considered explicit expressions of disbelief by the caregiver and did not code for the range of behaviors that may signal caregiver unsupportiveness, making it difficult to compare the effects of caregiver responses on recantation rates between studies.

Overall, our findings suggest that we can learn little by simply comparing the recantation rates of different studies. Instead, it is imperative to consider the range of factors that may influence recantation in any particular study. These include the coding systems employed (e.g., definitions of "interview" and "recantation"), length of study follow-up, population from which the sample is drawn (e.g., substantiated cases), and family pressures that may influence children's risk of recantation.

Filial Dependency Model of Recantation

In the present study, we went beyond former research by testing an explanatory model concerning why children recant. A filial dependency model was supported and is consistent with research on factors contributing to delayed disclosure (e.g., Goodman-Brown et al., 2003; Lawson and Chaffin, 1992). Recantation appears to reflect susceptibility to pressures from influential adults, a pattern that complements and extends decades of research on children's suggestibility. However, whereas the latter research emphasizes the dangers of false allegations of abuse that can result from external pressures, our study suggests that pressures can lead truly abused children to recant. Factors that predicted recantation included child age, child–perpetrator relationship, nonoffending caregiver unsupportiveness, and initial foster care placement.

Children who recanted appeared to be more susceptible to familial pressures to deny abuse than to pressures commonly believed to influence the accuracy of CSA claims, including those associated with repeated interviewing by professionals who presumably believed that abuse had occurred. Because the interviews were not recorded, it is impossible to determine what sort of pressures interviewers exerted to facilitate disclosure, although it remains noteworthy that repeated interviews were related to increased risk of recantation rather than increased willingness to disclose. In general, future research should consider the combined influence of multiple sources of pressure on children's disclosure.

Finally, because our sample consisted of only substantiated cases of CSA, our recantation rate is not solely attributable to the inclusion of false allegations. Nonetheless, because we cannot rule out the possibility, even among substantiated cases, that some cases involved false allegations, we examined associations between factors typically associated with truth and falsity (i.e., corroborative evidence, custody conflicts) and recantation. No significant associations emerged. We would caution, however, that relationships between recantation rates and corroboration, when they do occur, may reflect methodological biases. For example, recantation in criminal trials may be low not because the cases are more likely to be true, but because prosecutors screen out children unlikely to make persuasive

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

witnesses (London et al., 2005) and dismiss cases in which recantations occur (Goodman et al., 1992). In addition, corroborative evidence may influence recantation. Children may be confronted with corroborative evidence as a means of eliciting disclosures, and disclosures may lead to corroborative evidence (e.g., perpetrator admissions [Lyon, in press]). Thus, lower recantation rates among corroborated cases, when found, may provide spurious support for the notion that recantations are primarily the result of retracting false allegations.

Limitations

Our finding that sample characteristics, which often vary across studies, affect recantation rates highlights the need for caution when applying any single study's findings to CSA generally. First, all of the cases in our study were filed in dependency court. Thus, the state intervened on behalf of the child against the parents. This increased our confidence in the veracity of the allegations but excluded families who cooperated voluntarily with social services and may explain the relatively high rate of caregiver unsupportiveness in our sample. Nevertheless, caregiver unsupportiveness is not a prerequisite to dependency intervention. The state must intervene when the perpetrator has a custodial interest in the child and refuses to relinquish that interest voluntarily or when a caregiver is unable or unwilling to prevent further abuse (Lyon and Mechanic, 2006). Indeed, 40% of the nonoffending caregivers in our sample were supportive, allowing us to examine, systematically, how caregiver unsupportiveness related to recantation.

Second, exposure to multiple forms of maltreatment was the norm in our sample. This is not atypical because researchers have found substantial amounts of overlap between sexual abuse and family violence (e.g., Kellogg and Menard, 2003). In subsequent analyses, neither substantiated domestic violence nor physical abuse predicted recantation. Moreover, previous research has not linked family violence with delayed disclosure (Kellogg and Menard, 2003). Nevertheless, if some types of abuse or violence remain undetected, they may exert some influence on recantation.

Third, more than half of the children in our sample were placed in foster care immediately following social services substantiation. The negative relationship between foster placement and recantation is inconsistent with anecdotal observations that sexually abused children view placement as punishment for disclosing abuse (Summit, 1983) but consistent with the possibility that foster placement reduces the effects of familial pressures to recant. Of interest, considerable overlap existed between caregiver unsupportiveness and foster placement, χ^2_1 (n = 257) = 21.10, p < .001. That is, having an unsupportive caregiver may well have increased the likelihood of social services' concluding that the child should be removed. Yet, caregiver unsupportiveness increased, whereas foster placement decreased children's risk for recantation, highlighting the independent relations of these two variables.

Fourth, our sample was comprised primarily of female Latinos. Although we found no evidence of gender or ethnic differences, other research indicates that boys are often less forthcoming about abuse than girls, and Latinos may experience different familial pressures to keep abuse a secret and recant (see London et al., 2005). Yet, Bradley and Wood (1996), who reported a 4% recantation rate, also had high proportions of Latinos (76%) and females (82%). In subsequent research, recantation should be examined in larger, more diverse samples to increase statistical power to identify potential gender and ethnic differences.

Clinical Implications

Clinicians are frequently called on to testify in court regarding the dynamics of CSA disclosure. Prosecution experts will testify that recantation is common among abused children (State *v* J.Q., 1993). Defense experts will testify that recantation among true abuse is rare and that no research supports the proposition that familial pressures can lead a truly abused child to recant (United States *v* Rouse, 2004). Our results suggest that although most children who disclose abuse in dependency proceedings maintain their allegations over time, recantations are hardly "rare" and are reliably associated with filial dependency. Knowledge concerning the prevalence and predictors of recantation will aid legal professionals, judges, and jurors in assessments of child witness credibility.

In light of the potential for recantation among CSA victims, it is imperative that early disclosures are thoroughly documented (e.g., by audiotaping or videotaping). Furthermore, interviewers should inquire as to whether the child experienced pressures to keep the abuse a secret or recant. This will ensure that recantations, when

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

they occur, are given their proper weight. Careful documentation may also affect caregiver supportiveness. Caregivers may be more supportive if they observe a thorough disclosure. Intervention research indicates that caregiver supportiveness can be increased by direct instruction on appropriate responses (e.g., Jinich and Litrownik, 1999) and involving caregivers in children's therapy (e.g., Cohen et al., 2004). Whether these interventions would remain effective if implemented coercively via court order and whether they would reduce recantation remain unknown.

Finally, although previous research concerning child witnesses has primarily focused on how some interviewing techniques increase false allegations, some research has examined how true allegations can be encouraged; eliciting a promise to tell the truth and reassurance about the consequences of disclosure have some positive effects (Talwar et al., 2004). Future research should examine the use of these techniques in actual child abuse interviews and determine whether the techniques decrease recantations.

CONCLUSION

Our findings highlight the power of familial pressures in influencing some children's willingness to disclose and maintain consistent narratives about a significant personal and potentially traumatic experience—sexual abuse. Children's reports of CSA, even to law enforcement and other authorities, are affected by much more than their memory representations and potential interviewer biases. Factors related to family pressures and children's susceptibility to such pressures must also be considered. With continued research, the means by which we can reduce the effects of these pressures on disclosure, accuracy, and recantation among CSA victims can be identified.

Disclosure: The authors have no financial relationships to disclose.

REFERENCES

Bradley AR (1995), How do children tell? The disclosure process in child sexual abuse. Master's thesis. University of Texas, El Paso

Bradley AR, Wood JM (1996), How do children tell? The disclosure process in child sexual abuse. *Child Abuse Negl* 20:881–891

Bronfenbrenner U (1977), Toward an experimental ecology of human development. *Am Psychol* 32:513–531

Bruck M, Ceci S (2004), Forensic developmental psychology. *Curr Dir Psychol Sci* 13:229–232

Ceci SJ, Friedman RD (2000), The suggestibility of children: scientific research and legal implications. *Cornell Law Rev* 86:33–108

Children Now (2005), *California County Data Book 2005*. Oakland, CA: Children Now

Cohen JA, Deblinger E, Mannarino AP, Steer RA (2004), A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry* 43:393–402

De Francis V (1969), *Protecting the Child Victim of Sex Crimes Committed by Adults*. Denver: American Human Association

DiPietro EK, Runyan DK, Fredrickson DD (1997), Predictors of disclosure during medical evaluation for suspected sexual abuse. *J Child Sex Abuse* 6:133–142

Elliott DM, Briere J (1994), Forensic sexual abuse evaluations of older children disclosures and symptomatology. *Behav Sci Law* 12:261–277

Elliott AN, Carnes CN (2001), Reactions of nonoffending parents to the sexual abuse of their child: a review of the literature. *Child Maltreat* 6:314–331

Everson MD, Boat BW (1989), False allegations of sexual abuse by children and adolescents. *J Am Acad Child Adolesc Psychiatry* 28:230–235

Finkelhor D (1984), *Child Sexual Abuse: New Theory and Research*. New York: Free Press

Goodman GS, Taub EP, Jones DP, England P et al. (1992), Testifying in criminal court: emotional effects on child sexual assault victims. *Monogr Soc Res Child Dev* 57:v–142

Goodman-Brown TB, Edelstein RS, Goodman GS, Jones DPH, Gordon DS (2003), Why children tell: a model of children's disclosure of sexual abuse. *Child Abuse Negl* 27:525–540

Goodwin J, Sahd D, Rada RT (1982), False accusations and false denials of incest: Clinical myths and clinical realities. In: *Sexual Abuse: Incest Victims and Their Families*, Goodwin J, ed. Boston: John Wright

Gordon S, Jaudes PK (1996), Sexual abuse evaluations in the emergency department: is the history reliable? *Child Abuse Negl* 20:315–322

Gries LT, Goh DS, Cavanaugh J (1996), Factors associated with disclosure during child sexual abuse assessment. *J Child Sex Abus* 5:1–19

Haskett ME, Wayland K, Hutcheson JS, Tavana T (1995), Substantiation of sexual abuse allegations: factors involved in the decision-making process. *J Child Sex Abuse* 4:19–47

Jinich S, Litrownik AJ (1999), Coping with sexual abuse: development and evaluation of a videotape intervention for nonoffending parents. *Child Abuse Negl* 23:175–190

Jones DPH, McGraw JM (1987), Reliable and fictitious accounts of sexual abuse to children. *J Interpers Violence* 2:27–45

Keary K, Fitzpatrick C (1994), Children's disclosure of sexual abuse during formal investigation. *Child Abuse Negl* 18:543–548

Kellogg ND, Menard SW (2003), Violence among family members of children and adolescents evaluated for sexual abuse. *Child Abuse Negl* 27:1367–1376

Kovera MB, Borgida E (1997), Expert testimony in child sexual abuse trials: the admissibility of psychological science. *Appl Cognit Psychol* 11:S105–S129

Landis JT (1956), Experiences of 500 children with adult sexual deviation. *Psychiatr Q Suppl* 30:91–109

Laupa M (1994), "Who's in charge": preschool children's conceptions of authority. *Early Child Res Q* 9:1–17

Lawson L, Chaffin M (1992), False negatives in sexual abuse disclosure interviews: incidence and influence of caretaker's belief in abuse in cases of accidental abuse discovery by diagnosis of STD. *J Interpers Violence* 7:532–542

London KL, Bruck M, Ceci SJ, Shuman DW (2005), Disclosure of child sexual abuse: what does the research tell us about the ways that children tell? *Psychol Public Policy Law* 11:194–226

Lyon TD (2002), Expert testimony on the suggestibility of children: does it fit? In: *Children, Social Science, and the Law*, Bottoms BL, Kovera MB, eds. New York: Cambridge University Press

Lyon TD (in press), False denials: overcoming methodological biases in abuse disclosure research. In: *Disclosing Abuse: Delays, Denials, Retractions and Incomplete Accounts*, Pipe ME, Lamb ME, Orbach Y, Cederborg AC, eds. Mahwah, NJ: Lawrence Erlbaum Associates

Lyon TD, Mechanic MD (2006), Domestic violence and child protection:

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.

confronting the dilemmas in moving from family court to dependency court. In: *Handbook of Children, Culture, and Violence*, Dowd NE, Singer DG, Wilson RF, eds. Thousand Oaks, CA: Sage Publications
Paine ML, Hansen DJ (2002), Factors influencing children to self disclose sexual abuse. *Clin Psychol Rev* 22:271–295
Parke RD, Buriel R (1998), *Socialization in the Family: Ethnic and Ecological Perspectives*. Hoboken, NJ: John Wiley & Sons
Pintello D, Zuravin S (2001), Intrafamilial child sexual abuse: predictors of post-disclosure maternal belief and protective action. *Child Maltreat* 6:344–352
Poole DA, Lamb ME (1998), *Investigative Interviews of Children: A Guide for Helping Professionals*. Washington, DC: American Psychological Association
Quas JA, Bottoms BL, Nunez N (2002), Child maltreatment and delinquency: framing issues of causation and consequence. *Child Serv Social Policy Res Pract* 5:245–248
Sas LD, Cunningham AH, Hurley P, Dick T, Farnsworth A (1995), *Tipping the Balance to Tell the Secret: Public Discovery of Child Sexual Abuse*. London, Ontario: London Family Court Clinic
Sgroi SM (1982), Family treatment of child sexual abuse. *J Soc Work Hum Sex* 1:109–128
Sjöberg RL, Lindblad F (2002), Limited disclosure of sexual abuse in children whose experiences were documented by videotape. *Am J Psychiatry* 159:312–314
State *v* J.Q. (1993) 617 A.2d 1196 (N.J.)
Summit RC (1983), The child sexual abuse accommodation syndrome. *Child Abuse Negl* 7:177–193
Talwar V, Lee K, Bala N, Lindsay RCL (2004), Children's lie-telling to conceal a parent's transgression: legal implications. *Law Hum Behav* 28:411–435
Tye MC, Amato SL, Honts CR, Devitt MK, Peters D (1999), The willingness of children to lie and the assessment of credibility in an ecologically relevant laboratory setting. *Appl Dev Sci* 3:92–109
United States *v* Rouse (2004), 329 F.Supp.2d 1077 D.S.D.
Wyatt GE, Newcomb MD (1990), Internal and external mediators of women's sexual abuse in childhood. *J Consult Clin Psychol* 58: 758–767

Why Are Latinos the Most Uninsured Racial/Ethnic Group of US Children? A Community-Based Study of Risk Factors for and Consequences of Being an Uninsured Latino Child Glenn Flores, MD, Milagros Abreu, MD, Sandra C. Tomany-Korman, MS

Background: Latinos continue to be the most uninsured racial/ethnic group of US children, but not enough is known about the risk factors for and consequences of not being insured in Latino children. *Objective:* The objective of this study was to identify the risk factors for and consequences of being uninsured in Latino children. *Methods:* A cross-sectional survey was conducted of parents at urban, predominantly Latino community sites, including supermarkets, beauty salons, and laundromats. Parents were asked 76 questions on access and health insurance. *Results:* Interviews were conducted of 1100 parents, 900 of whom were Latino. Uninsured Latino children were significantly more likely than insured Latino children to be older (mean age: 9 vs 7 years) and poor (89% vs 72%) and to have parents who are limited in English proficiency (86% vs 65%), non-US citizens (87% vs 64%), and both employed (35% vs 27%). Uninsured Latinos were significantly less likely than their insured counterparts to have a regular physician (84% vs 99%) and significantly more likely not to be brought in for needed medical care because of expense, lack of insurance, difficulty making appointments, inconvenient office hours, and cultural issues. In multivariable analyses, parents who are undocumented or documented immigrants, both parents working, the child's age, and the $4000 to $9999 and $15,000 to $19,999 family income quintiles were the only factors that were significantly associated with a child's being uninsured; neither Latino ethnicity nor any other of 6 variables were associated with being uninsured. Compared with insured Latino children, uninsured Latino children had 23 times the odds of having no regular physician and were significantly more likely not to be brought in for needed medical care because of expense, lack of health insurance, difficulty making appointments, and cultural barriers. *Conclusions:* After adjustment, parental noncitizenship, having 2 parents work, low family income, and older child age are associated with being an uninsured child, but Latino ethnicity is not. The higher prevalence of other risk factors seems to account for Latino children's high risk for being uninsured. Uninsured Latino children are significantly more likely than insured Latino children to have no regular physician and not to get needed medical care because of expense, lack of health insurance, difficulty making appointments, and cultural barriers. These findings indicate specific high-risk populations that might benefit most from targeted Medicaid and State Child Health Insurance Program outreach and enrollment efforts. **Pediatrics** 2006;118:e730–e740.

Copyright © 2007 American Academy of Child and Adolescent Psychiatry. Unauthorized reproduction of this article is prohibited.