SECTION 2: SEXUAL ABUSE
Chapter 8

Interviewing the Prepubertal Child for Possible Sexual Abuse

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Introduction
In this chapter, the following topics are covered: the extent of the problem of sexual abuse, whether the health care professional should question the child when there are concerns about sexual abuse, research about the process of sexual abuse disclosure, general guidelines for questioning children, record keeping, interview structure, the use of demonstrative communication, gathering information about the extent of abuse, a rationale for following the advice about questioning, and reporting interview findings. The purpose of this chapter is to provide health care professionals with the skills they need to effectively interview a prepubertal child for possible sexual abuse.

The Extent of the Problem of Child Sexual Abuse
How common is child sexual abuse? Professionals understand the extent of the sexual abuse problem primarily from prevalence and incidence studies. Knowledge about sexual abuse prevalence (how many people experience sexual abuse during childhood) comes, for the most part, from studies involving adults who report sexual victimization as children. There are sufficient numbers of studies of general population samples (e.g., stratified samples), community-based samples, special populations (e.g., psychiatric patients), and college students to permit meta-analyses of these studies. The most recent meta-analysis was conducted by Bolen and Scannapieco. They reviewed 22 studies with random samples and concluded that sexual abuse prevalence rate for women is between 30% and 40%. Fewer researchers have examined prevalence among men, but Bolen and Scannapieco conclude at least 13% of men are sexually abused during childhood.

The other strategy for understanding the extent of sexual abuse is through reported incidences of sexual abuse. Data from the National Child Abuse and Neglect Data System are the most commonly used to estimate annual rates.
of sexual abuse.8 The number of reports varies by year, but is usually about 300,000 cases, approximately one third of which are substantiated after investigation by child protection agencies. But one study suggests these officially substantiated cases of sexual abuse represent only the tip of the iceberg. The Gallup Organization conducted a survey of a representative sample of 1,000 American parents in 1995.9 One of the questions these parents were asked was whether their child had been sexually abused over the past year. The responses to this question yielded an estimate of 1 million children having been sexually abused in 1995, not the 100,000 cases substantiated by child protection agencies, thus 10 times the number of substantiated cases. Even the Gallup survey projection is probably an underestimate. Parents are not always aware of their children's sexual abuse and, no doubt in some instances, decline to report abuse because they are the perpetrators or are close to the perpetrators.

Why should health care professionals be cognizant of prevalence and incidence rates of sexual abuse? These rates tell us sexual abuse is a common problem in our society, not a rare occurrence. Child victims regularly present in medical practices. These children may see health care professionals because they have physical sequelae of sexual abuse, although physical symptoms are not common; behavioral or emotional manifestations of sexual victimization; or for reasons unrelated to concerns about sexual abuse.10

**Whether Health Care Professionals Should Question Children About Possible Sexual Abuse**

Should health care professionals question a prepubertal child suspected of being sexually victimized? Many factors influence this decision.

First, health care professionals need to consider local policy. In many communities, multidisciplinary and multiagency teams develop policies about how mandated reporters should respond to possible sexual victimization on their caseloads, including whether reporters should question children.

Second, in many cases, there is a window of opportunity, that is, a time when the child is willing to talk to someone about abuse and/or the caretaker is willing to allow the child to be interviewed. Once this window closes, the opportunity to protect the child may vanish.

Third, the health care professional may or may not have the facilities and the skills for interviewing young children. Many specialized child interview programs are based in health care settings and receive referrals from child protective services and law enforcement for medical examinations and interviews.11-13 Professionals who staff such programs usually are well-trained and qualified to question prepubertal children about possible sexual abuse.

**Understanding the Disclosure Process**

Although some children tell immediately when they have been sexually abused.14
most children do not. Failure to report sexual victimization, even when asked, is common. For example, Lyon recently reviewed studies dating from 1965 through 1993 of 529 children with gonorrhea. He found that only 43% of children gave some indication of their sexual abuse.

Similarly, many children delay disclosure of their victimization. For instance, Elliott and Briere studied 336 children aged 8 to 15 years who received forensic evaluations at the Harbor-University of California at Los Angeles 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.

Finally, retraction of the allegation after the child begins to experience the consequences of disclosure is characteristic of the disclosure process. Illustrative is the case record review by Malloy and colleagues of 217 randomly selected substantiated sexual abuse cases from the Los Angeles County dependency court. The children in those cases were interviewed on average 12 times. Over the course of the interviews, 23% of the children fully recanted their sexual abuse allegations and 11% partially recanted. Predictors of full recantation were younger victim age, closer relationship to the offender, and lack of maternal support. The predictor of partial recantation (minimization of the abuse) was more severe sexual abuse. Thus health care professionals should not be surprised if prepubertal children are not forthcoming when asked about sexual abuse.

Conversely, the available research suggests that false allegations of sexual abuse are uncommon. Rates vary somewhat depending on the source of the report and the context in which the allegation is made, but range from 0% to 10% of reports made by children. Research suggests that of the small number of false reports, most are made by older children.

Despite the body of research indicating that it is difficult for children to tell about sexual abuse and that false allegations are rare, especially in prepubertal children, the direction of advice for health care professionals is to employ questioning techniques that guard against eliciting false allegations from children about possible sexual abuse.

### General Guidelines for Questioning Children

The following are some generally agreed on guidelines or principles for questioning children about possible sexual abuse. These guidelines take into account concerns about false allegations, but also provide professionals with strategies to use when children have difficulty disclosing.

1. Gather information from the child rather than asking the child to confirm information from the caretaker or other sources.
2. Use as many open-ended questions as possible.
3. Attempt to obtain a narrative account of what happened from the child.
4. If open-ended questions are not effective, don't give up; use a more closed-ended question.
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5. If you use a more closed-ended question, place less confidence in the information obtained.
6. A closed-ended question, which elicits a positive response, should be followed by a more open-ended one (eg, "Tell me everything about that.").
7. Explore alternative explanations for the concern about sexual abuse (eg, no sexual abuse occurred, child care behavior mistaken for sexual behavior, advanced sexual knowledge from an experience other than sexual abuse).

Record Keeping
Accurate and complete records are important when health care professionals question children about sexual abuse. Videotaping interviews may not be feasible in health care settings because facilities lack this capacity, but videotapes provide the best record. If videotaping is not possible, audiotaping is a good substitute. Taped interviews are superior to notes, which have been shown in research to be incomplete. If the professional must rely on notes, it is essential that notes include the child's verbatim statements about the sexual abuse and the questions the professional employed to gather information. Any reports should include the professional's questions and the child's verbatim responses.

Interview Structure
There is a substantial body of writing about how to structure and what to include in an interview about possible sexual abuse. Presently interview protocols advise to phases, but simplicity is probably best with the prepubertal child. Professionals should expect an interview about possible sexual abuse to have a beginning (rapport-building and child assessment), a middle (abuse-related), and an end (closure). Professionals should also follow the child's lead, which may limit the ability of the professional to impose structure.

Beginning Phase
In the beginning phase, health care professionals should develop rapport with the child and assess the child's capacity to communicate. A good practice is to use open-ended questions during the rapport-building stage, such as, “Tell me all about school,” which will inform the professional about the child's ability to respond to open-ended questions and may build the child's capacity to answer such questions. If the child cannot provide responses to open-ended questions, the professional should employ more closed-ended questions during rapport building, such as, “Who are your friends?” to learn what kinds of questions the child can understand. Children's ability to report events that happened to them in the past and their knowledge of their environment (eg, who lives at their house) are other capacities to assess during the beginning phase of the interview.

Middle or Abuse-Related Phase
The literature provides numerous strategies for transitioning to the middle or abuse-related phase of the interview, but the strategies are not designed specifically for medical settings. A useful approach for health care
professionals is to state, in as open-ended a manner as possible, why there are concerns about sexual abuse and ask the child to respond. For example, “When I looked at your privates, I saw that someone or something had hurt you. Tell me what happened,” or “Your mom said something happened to you at child care. Tell me about what happened.”

Much has also been written about the appropriate types of questions to employ when inquiring about sexual abuse. Table 8.1 provides a continuum of 10 types of questions. The table divides questions into 3 categories: preferred, less preferred, and least preferred. Writers differ in the terms they use for types of questions (hence the different terms appearing under the heading, question/probe type) and, to some extent, in their views about the most appropriate types of questions.\textsuperscript{36,37,47} Table 8.1 provides terms for the different types of questions/probes found in the literature, definitions for the question/probe types, and examples. The table lists questions from more open-ended to more closed-ended and indicates that professionals should have greater confidence in information elicited using more open-ended questions and prompts.

Although best practice is to begin with open-ended questions and probes (general questions, open abuse-related questions, and invitational probes) when questioning children, these types of questions usually will be insufficient for obtaining a complete history. Indeed, prepubertal children, if they are forthcoming with answers to these types of questions, will probably only provide a small amount of information. Sometimes facilitative cues (question type 4) such as, “Anything else?” and “Then what happened?” will be useful, but most prepubertal children are unaccustomed to being asked to provide narratives to open-ended questions. Thus usually the professional will need to ask focused questions (question type 5), such as, “Tell me what happened to your peepee?” and “wh” questions (question type 6). “Wh” questions prompt children do describe “who” abused them and “what” exactly the person did, as well as contextual information, for example, “where” the abuse happened, “who” else was there, and “when” the abuse happened. It is also helpful to gather sensorimotor details about the sexual acts, such as what the sexual act felt like.

Multiple choice (question type 7) and direct (question type 8) questions are less preferred and some writers are more opposed to them than others.\textsuperscript{36} Professionals are advised to avoid leading (question type 9) or coercive (question type 10) questions when asking children about sexual abuse.

However, the appropriateness of a question depends a great deal on its context, particularly the amount of evidence there is supporting sexual abuse (eg, medical evidence) and what the child has disclosed earlier in the interview or said to others prior to the interview. For example, if a child has already disclosed sexual victimization in the interview, and the professional is gathering details, a leading question (ie, “Now earlier you said your grandpa was in your bed, didn’t you?”) is quite appropriate.
### TABLE 8.1
A Continuum of Questions to Be Used When Interviewing Children

<table>
<thead>
<tr>
<th>Open-ended Question/Probe Type</th>
<th>Definition</th>
<th>Examples</th>
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<tbody>
<tr>
<td><strong>Preferred Questions/Probes</strong></td>
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| 1. General question | Open-ended inquiry about the child's well-being or salient issues; does not assume abuse may have occurred | 1. How are you doing today? 
2. How have you been feeling? |
| 2. Open abuse-related question | Open-ended inquiry that assumes there may be abuse or trauma | 1. Do you know why I am talking to you? 
2. I see from your medical examination that something may have happened to you. Tell me about it as best you can. |
| Directive question | Utterances that invite free recall and a narrative | 1. Can you tell me everything you can remember? 
2. Tell me all about what happened, from the beginning to the end. |
| 3. Invitation or invitational question | Interviewer gesture or utterance aimed at encouraging more narration | 1. Uh huh (affirmative). 
2. Okay. 
3. Anything else? 
4. What happened next? |
| 4. Facilitative cue | A probe that focuses the child on a particular topic, place, or person, but refrains from providing information about the subject | 1. Tell me what your mom is worried about. 
2. Can you tell me about what happened to your privates? |
| Narrative cue Facilitators | Inquiry to gather contextual and specific detail about the child's experience: who, what, when, where | 1. When did this happen? 
2. Where were you? 
3. Where was your mom? |
| 5. Focused question | A question that presents the child with a number of alternative responses from which to choose | 1. Did he do it one time or more than one time? 
2. Did the abuse happen during the day, at night, or both? |
| Focused probe | A direct inquiry about abuse or abuse-related details | 1. Did John hurt your peepkee? 
2. Did he put his finger inside you? 
3. Was he wearing his pajamas too? |
| 7. Multiple-choice question | Option-posing question Forced choice question Restricted choice question (Walker, 1999) | A question that presents the child with a number of alternative responses from which to choose |
| 8. Direct question | Specific question | A direct inquiry about abuse or abuse-related details |
| Option-posing question Yes/no question | | |
TABLE 8.1
A Continuum of Questions to Be Used When Interviewing Children, continued

<table>
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<tr>
<th>Open-ended</th>
<th>More Confidence in Child’s Response</th>
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<tbody>
<tr>
<td><strong>Question/Probe Type</strong></td>
<td><strong>Definition</strong></td>
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<tr>
<td><strong>Less Preferred Questions/Probes</strong></td>
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<tr>
<td>9. Leading question</td>
<td>A statement the child is asked to affirm</td>
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<tr>
<td>Tag question</td>
<td>2. Your stepfather is the one who hurt you, isn’t he?</td>
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<tr>
<td>10. Coercion</td>
<td>Use of inappropriate inducements to gain cooperation or to elicit information from the child</td>
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<tr>
<td>Coercive question</td>
<td>2. You can’t leave this room until we are finished talking.</td>
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</table>

**Ending or Closure Phase**

Closure is important for the professional and the child. When the professional thinks all information related to the abuse has been gathered, he or she may ask, “Is there anything else you think I should know about what happened?” Closure should include calming the child, if the child is upset, and letting the child know what will happen next. With regard to what will happen next, professionals need only describe next steps (eg, that a child protection worker will talk to the child) not long-term outcomes. Some professionals provide the child with contact information if the child is old enough to use it.

**Use of Demonstrative Communication**

Because children may lack verbal communication skills or may be reluctant or distressed when asked to respond verbally to questions about sexual abuse, health care professionals may employ demonstrative communication modes. These can include having the child draw, write responses, or use body maps—for instance, anatomical drawings, anatomical dolls, or a “gingerbread” body outline. These modes of communication are also very useful in gathering details about the sexual abuse and its context (eg, getting the child to draw a picture of the place where the abuse occurred, if the child is able) and for pacing the interview so the child does not feel pressured. When these communication modes are employed, the professional is not interpreting play or drawings, but rather asking the child to demonstrate. For example, the professional might say, “Can you mark on the drawing the part or parts that Mr Jones used to hurt you?”

**Extent of the Child’s Abuse**

Many children experience multiple acts and forms of sexual victimization, especially in intrafamilial situations.
Moreover, children may experience multiple types of maltreatment. In such circumstances, professionals must decide how much questioning the child can tolerate in an interview and structure their inquiry accordingly. Additional factors to consider include the capacity of the professional setting to conduct several interviews and community practice related to interviewing children about maltreatment.

It is useful to learn about the scope of a child's sexual abuse for assessing safety issues and trauma, but prepubertal children will have difficulty describing frequency and duration of sexual abuse. Current advice is to ask children, "Did the abuse happen one time or more than one time?" Sometimes children can recall their age when the abuse started, which will allow an estimate of duration. When there have been multiple instances of sexual abuse and details are required to determine the report's validity, professionals can ask, "Tell me about the last time the abuse happened." Another good question is, "Tell me about the time you remember the most." After disclosure about one offender, the professional may ask if anyone else has sexually abused the child.

Sometimes it is appropriate to ask about other types of maltreatment (eg, neglect and physical abuse) and parental problems (eg, substance abuse and domestic violence). Professionals should be guided by the child's level of distress, the child's willingness to continue talking, and community practice regarding child abuse investigations in determining whether to question about other types of maltreatment and endangerment.

**Why Should the Health Care Professional Adhere to This Advice?**

Health care professionals may wonder why they should follow the questioning and interview strategies that have been described. These are very different from the typical questioning strategies health care professionals use, such as taking a medical history, which ordinarily involves direct questions. There are at least 2 reasons for following the advised strategies. Children's free recall memory is the most accurate, even though with prepubertal children the information may be sparse. This recall is best tapped by open-ended questions. Consequently it is advisable to begin inquiry with open-ended questions and rely on more closed-ended ones when the child has exhausted free recall.

Second, if only closed-ended probes are employed (eg, direct, leading, and coercive questions), the child's disclosures may be doubted by professionals mandated to investigate sexual abuse and by other interested parties (eg, attorneys, the person accused of sexual abuse). If the content of the interview and the child's statements are challenged, the child may not be protected.

**Reporting by Mandated Professionals**

As with other types of child maltreatment, health care professionals must report cases where they have reasonable cause to suspect sexual abuse. When the abuser is a caretaker or a caretaker has not protected the child from sexual abuse, the case is reportable to child protective services.32
Sexual abuse differs from other types of child maltreatment in that a substantial proportion of sexual abuse is committed by unrelated offenders. These cases usually fall within the mandate of law enforcement. Although reporting statutes vary by state and reporting policies vary by locality, health care professionals generally are not required to report extrafamilial child sexual abuse.

Nevertheless, professionals should develop a policy, which probably should be written, about how to handle reporting of extrafamilial sexual abuse. Such a policy could include instructing the caretaker to report, reporting to the appropriate law enforcement agency, alerting other agencies or professionals, and contacting a court. Regardless of the policy adopted, child safety is paramount. Health care professionals should ensure that children's well-being is not jeopardized by their lack of action or policy.

**Conclusion**

Health care professionals are challenged to develop skills for interviewing prepubertal children who may have been sexually abused. Advice about interview strategies and questions envisions ideal interviews. In reality, many prepubertal children cannot provide a narrative and need to be asked focused, direct, and sometimes even leading questions. The "Memorandum of Good Practice," which provides an interview structure used by law enforcement in England, proposes the concept of a "good enough interview." This concept can also be adopted by health care professionals.

Health care professionals may be in a unique position to help children who have been sexually abused. Because of their central role in the lives and well-being of their patients, they are likely to be sought out by caretakers and trusted by children. Health care professionals can use their window of opportunity to improve the lives and futures of their patients by questioning children in a sensitive and appropriate way so that they can disclose their sexual victimization.

**References**