The Credibility of Children's Allegations of Sexual Abuse

Kathleen M. Quinn, M.D.

Sexual abuse, the fastest growing type of abuse complaint, often raises issues concerning the credibility of individual allegations. This paper discusses historical, developmental, and societal factors affecting children's credibility and recommended assessment methods that maximize a child's capacity to relate his or her experience. Clinical factors leading to false allegations are discussed.

Sexual abuse allegations have emerged as the fastest growing type of abuse complaint (Finkelhor, 1983). The credibility of a child's allegation of sexual abuse has far-reaching implications. The child who is not believed may continue to be victimized, and his or her belief in adults' ability to protect may be shattered. Allegations that are assessed to be true in the absence of abuse may destroy the alleged perpetrator's reputation and hopelessly impair family ties (Renshaw, 1985).

Current estimates of false positive allegations range from 3 to 8% of sexual abuse complaints received by social service departments or voluntary general hospital–based programs (Cantwell, 1981; Goodwin, Sahd, & Rada, 1978; Horwitz, Salt, Gomes-Schwartz, & Sauzier, 1984; Jones, 1987). These are allegations in the apparent absence of abuse. Recently, several authors have published small samples of false positive allegations arising in disputes over custody and visitation ranging from 36 to 75% of these referrals (Benedek & Schetky, 1985; Brant & Sink, 1984; Green, 1986). However, these are very small clinical samples with a selective pattern of referrals. An ongoing survey of a number of domestic relations courts estimates that 2.5% of all contested custody and visitation cases include a sexual abuse allegation and that of these allegations 22% were assessed probably not to have occurred (American Federation of Conciliation Courts, 1987). No reported

Kathleen M. Quinn, M.D., is an assistant professor of psychiatry at Case Western Reserve Medical School. *Correspondence and reprint requests should be addressed to Dr. Quinn at Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio 44109.*

Behavioral Sciences & the Law, Vol. 6, No. 2, pp. 181–199 (1988)
 CCC 0735-3936/88/020181-19$04.00

statistics exist for false negative allegations, irrespective of the setting. In such cases, allegations are dismissed as untrue that eventually are confirmed to be real. Historically, the mistaken negation of actual sexual abuse has been common (Quinn, 1986).

Care must be taken to distinguish allegations assessed to be false from complaints classified as unsubstantiated (Corwin, Berliner, Goodman, Goodwin, & White, 1987). A false positive or fictitious (Jones, 1987) complaint is one judged not to have occurred. Misperception or distortion of events as well as conscious deception by the child or an adult may result in false complaints. Unsubstantiated or unfounded complaints involve cases in which the investigator cannot be confident of the allegation due to insufficient or inconsistent evidence. Unsubstantiated complaints are not necessarily false. Presently 65% of *all* reports of child maltreatment (both physical and sexual) have been reported to be unfounded or unsubstantiated (Besharov, 1985). More specifically, a representative urban county department of human services has reported 21 to 47% of its sexual abuse complaints as unsubstantiated (Galloway, Haverick, & Hall-Ellis, 1986).

This paper discusses: (1) historical, developmental, and societal factors affecting children's credibility; (2) recommended assessment methods that maximize a child's capacity to relate his or her experience; and (3) clinical factors leading to false allegations.

Most early historical trends led to decreased reporting of incidents of sexual abuse and many false negative conclusions. Established legal and religion rules defined permitted sexual activity. For example, the Bible and the Talmud stated that a girl of 3 could be betrothed by sexual intercourse with her father's permission. However, sex with a child under 3 was not a crime but simply invalid. Legally, such a child retained her "virginity" (Rush, 1980).

Common law has a long history of excluding entire classes of witnesses by preventing them from testifying. These exclusions have included the children of an accused, thus preventing sexual abuse cases from being validated by court action (Goodman, 1984). Currently, the majority of states by statute or case law prescribe an age at or above which a child is presumed competent to testify. This age varies from 10 to 14, with 10 being used in approximately half the states. The remaining 13 states, the Federal Rules of Evidence Section 601, and the Military Rules of Evidence Rule 601 have abandoned age criteria for competency of child witnesses (Bulkley, 1982).

Professionals' bias and denial have also added to false negative as well as false positive conclusions. At the turn of the century, Baginsky reported that "children are the most dangerous witnesses" (cited in Whipple, 1911, p. 308). Disbelief is an effective way to gain distance from horrifying realities (Goodwin, 1985). In recent times the pendulum has swung to the opposite extreme with statements such as "children never lie." Both positions demonstrate a lack of neutrality or freedom from bias in workers assessing

sexual abuse complaints (White, Santelli, & Quinn, 1988). Such lack of neutrality may compromise the impartiality of an investigation and raise questions concerning the credibility of a child's statements gathered during such an evaluation.

The evolution of Sigmund Freud's theories on infant sexuality and the role of fantasy, for example, profoundly affected his assessment of his patients' credibility when they disclosed material concerning sexual molestation. In 1896 Freud wrote in *The Aetiology of Hysteria* and *Studies in Hysteria* that he believed that the origin of every case of hysteria was a childhood sexual trauma. By 1897 he rejected his seduction theory, not because of new clinical data but because of his own disbelief concerning the prevalence of sexual abuse and his increasing emphasis on the role of fantasy and the unconscious in patients' productions (Masson, 1985). Freud's repudiation of the seduction theory led him to discount patient stories that he had earlier found convincing and that had been corroborated by others. The rejection of the seduction theory also played an important role in several generations of mental health professionals' assessment of children and adult patients who described episodes of molestation, causing professionals to ascribe such episodes to incestuous fantasies.

General Issues Concerning Children's Credibility

To understand the clinical assessment of a child's account of sexual molestation, the professional must first consider the paradigm of sexual abuse as an event to be remembered. Current knowledge on the natural history of sexual abuse is that childhood sexual abuse is likely to be a repetitious event (average duration of relationship is 31 weeks for girls) by an individual well known to the child in 75 to 80% of cases (Finkelhor, 1979; Mian, Wehrspann, Klajner-Diamond, & LeBaron, 1986; Tsai & Wagner, 1978). The explicit sexual details to be remembered are often fondling in preschoolers and young school-age children (Mian et al., 1986) and attempted or actual penetration in older children (Gomes-Schwartz, Horowitz, & Sauzier, 1985) and many male victims (Ellerstein & Canavan, 1980).

The issue of age-related differences in memory is often raised in questioning a child's account of a molestation. Memory retrieval consists of free recall and recognition. Free recall is well recognized as the more age sensitive (Marin, Holmes, Guth, & Kovac, 1979). Younger children make more errors of omission than do adults (Goodman & Reed, 1986). Increased retrieval strategies and selective attention develop between the ages of 5 and 10. An additional factor that affects recall in children is that they often do not have relevant prior knowledge that would allow them to organize their experiences better. However, the repetitive nature of child abuse by a familiar perpetrator overcomes much of the younger child's developmental differences in memory (Johnson & Foley, 1984).

Different aspects of memory appear at different points in development. Episodic memory, memory for specific episodes, does not appear until the third year. Another still later-appearing aspect of memory, script memory, is often involved when children are sexually abused. In script memory, children develop knowledge of the general characteristics of regularly occurring events in their lives (Nelson, Fivush, Hudson, & Lucarello, 1983; Nelson & Gruendel, 1981). Young children find it easier to describe a script for a familiar sequence than a memory for any specific instance of that script (Fivush, 1984; King & Yuille, 1987). The repetitive nature of childhood sexual abuse aids in the development of a script memory to be elicited by the investigator.

Suggestibility of young children is often raised as an issue in the credibility of child witnesses. Witnesses at all ages provide more accurate information during their free recall than in response to direct questions about particular aspects of the event (King & Yuille, 1987; Loftus, 1977). Preschoolers are more suggestible than older children and adults (Goodman & Reed, 1986). There is debate as to the degree to which children incorporate erroneous postevent information into their recollections of events (Cohen & Harnick, 1980; Dale, Loftus, & Rathbun, 1978; Goodman & Reed, 1986; Murray, 1983). However, a substantial proportion of preschoolers are able to avoid the deleterious effects of leading questions (Ceci, Ross, & Toglia, 1987). Leading questions are less detrimental if they deal with the central or salient aspects of the event (Yuille, 1980). Children generally remember significantly more central than peripheral information. Memory for actions is better than memory for the environment (Goodman, Aman, & Hirschman, 1987). Again, the repetitive nature of the sexual acts within the context of a familiar relationship form much of the central aspect of the events and appear likely to be more resistant to leading interview techniques.

The use of anatomical dolls as tools for investigating sex abuse complaints remains controversial (Terr, in press; White, 1987; Yates, in press) and may raise additional issues of credibility in an abuse investigation. Although Boat and Everson (1987) document the growing use of the dolls, their survey shows a lack of training and lack of uniformity of interview guidelines among professionals. In addition, varying physical characteristics of the dolls in use, varying methods of doll presentation, and the lack of scientific studies may form the bases of a challenge of the use of the dolls (White, 1987) and, secondarily, the child's disclosure. Recently a California appeals court rejected the admissibility of testimony about the observations of a child's behavior with the anatomical dolls (*Amber B.*, 1987). Work by Goodman and Aman (1987) demonstrates that 3-year-olds had a significantly higher false positive rate to leading abuse questions when compared to 5-year-olds, but the presence or absence of the dolls made no difference.

The vulnerability of younger children to suggestion increases the burden on investigatory interviewers. Stern (1910) argued for specially trained in-

vestigators to interview children. He wrote that falsification of testimony was often the result of the questioning and that the questioner was responsible for a child's false report (Stern, 1939). His writings foreshadowed our current understanding of the dynamics of the interview situation. Children's interpretations of the language and perceived demands of an interviewer are powerfully affected by the interview context (King & Yuille, 1987). The most counterproductive interviewing occurs when the interviewer has a strong preconceived notion of what occurred that he or she seeks to have the child endorse. Such an agenda is the conscious or unconscious effort on the part of the interviewer to have the child describe, confirm, or verify the investigator's assumptions concerning the allegation (White & Quinn, 1987). The pursuit of an agenda is a major reason for faulty investigations that may result in false positive or false negative assessment of a complaint.

Another major issue in assessing a child's credibility is the developmental capacity to lie. Current studies indicate that children under 7 are unlikely to be successful telling a lie (Feldman, Jenkins, & Popoola, 1979; Morency & Krauss, 1982). By fourth and fifth grade, however, children become more proficient at telling lies (Allen & Atkinson, 1978). In addition, children are less likely to be successful at deceiving when their true feeling is positive than when it is negative (Morency & Krauss, 1982). Fictitious complaints of sexual abuse by children are a rare event. In Jones's (1987) review of 576 complaints, he found only 8 fictitious allegations (1.4%) made by five individual children. According to Jones, a more common but still an unusual clinical event is a false allegation made by an adult on behalf of a child, totaling 5% of all reports of suspected sexual abuse.

In summary, the characteristics of childhood sexual abuse overcome many of the developmental differences in the memory of young children. The moderate vulnerability of preschool children to suggestion raises the standard of investigatory techniques used for the very young child. False allegations of sexual abuse raised by children remain very rare events.

Other Developmental Issues in Reports of Sexual Abuse

Other developmental issues may influence the evaluation of any individual complaint. The effect of the child's cognitive state upon the report may significantly cloud the clarity of the allegation, causing the child's account to be questioned. This lack of clarity is most likely to occur in children between the ages of 2 and 7 who are in the preoperational period of development (deYoung, 1986). For example, a child may refer to ejaculation as urination since this is the child's sole perceived function for the penis. Similarly, a child may have difficulty recognizing an alleged perpetrator who has changed his appearance by growing a beard. The lack of conservation characteristic of the preoperational period prevents the child from understanding that objects and persons remain the same despite a change in physical appearance. Children of this age often communicate in a seemingly

disjointed free association style, which further compounds the assessment of their credibility. Other cognitive factors such as immaturity of language may lead to confusion concerning a child's statements. For example, a child's tendency toward concrete thought may cause him or her to answer questions too literally, compromising the perception of his or her credibility (Benedek & Schetky, 1987a).

Time and sequence are difficult concepts for the preoperational child. At this age, time is often confused with place or routine. Young children's accounts of molestation are best anchored by reference to major events such as holidays, birthdays, births, or deaths. Another strategy that is helpful is to establish the activities of important people to the child, such as who their teacher(s) was at the time of the molestation (Sgroi, 1982). Interviewers who do not take into account developmental issues concerning time often ask inappropriate questions, such as how many times the abuse took place. Inconsistent or unlikely answers may incorrectly call into question a child's credibility. Work by Terr (1981, 1983) demonstrates that psychic trauma can significantly interfere with perception of the duration and sequence of time. Children of all ages as well as adults tend to recall events in canonical order (Hudson & Nelson, 1983; Mandler, 1984). For all these reasons, details about time and sequence will be particularly difficult to determine and should not be a major determinant of credibility in the younger child.

The natural history of abuse may also complicate evaluation of a child's credibility. Some professionals may not understand the frequent late disclosures of long-term sexual abuse relationships (Summit, 1983), false retractions during the suppression phase (Sgroi, 1982), or the lack of medical evidence in the majority of these cases (Ellerstein & Canavan, 1980; Enos, Conrath, & Byer, 1986). Conte and Berliner (1981), in their study of 583 sexually abused children, found that only 16% of them told anyone about the incident within 48 hours of its occurrence.

The strongest validation criteria are based upon eliciting of explicit sexual experiences with progression of acts over time described by the child. However, the frequent vagueness of the report of fondling, the most common form of sexual abuse among younger children, may confuse the evaluator. In addition, in an attempt to maintain secrecy of the behavior, the adult offender may label the sexual contact as normal, desirable, or the fault of the child (deYoung, 1981). These value judgments may cause the child to be confused and uncertain when describing his or her experiences. Another source of confusion may be the child's description of simulated intercourse, a sexual activity in which the offender thrusts and ejaculates outside of the child in the inner thigh or buttock area. Many children describe this as penetration. The resulting lack of medical evidence of penetration may then be used to discredit a child's complaint incorrectly (Sgroi, 1986).

The question may be raised: Do children have difficulty separating fact from fantasy? Children have repeatedly been shown to be more likely to commit errors of omission than of commission (Goodman et al., 1987;

Marin et al., 1979). Children may have difficulty distinguishing what they thought from what they said but are at no disadvantage in discriminating between memories of internal and external events (Johnson & Foley, 1984).

Studies show preschoolers and early latency age children have little explicit sexual knowledge (Bernstein & Cowan, 1975; Goldman & Goldman, 1982; Kreitler & Kreitler, 1966). Children's most likely sexual knowledge concerns pregnancy and birth. Young children are rarely concerned with questions of intercourse or conception unless older children or adults raise the issues. Masturbatory fantasies of young girls are described often as including imagining themselves floating, dancing, or flying. The children may imagine themselves alone or admired or envied by onlookers (Clower, 1975). Oedipal fantasies have a diffuse, romantic quality. Fantasies of a child this age generally reflect wishful thinking and have a pleasurable tone (Freud, 1965). DeYoung (1986) offers a succinct summary of what is known regarding real as opposed to fantasized sexual experiences:

> While much research and analysis need to be done in these areas existing data imply that the more details a young child can give, the more negative in feeling the experience is being related, and the more the child describes sexual acts that exceed in maturity, sophistication and ability what would be considered normal for that child's psychosexual level of development (after the variables of class, culture, and individual differences are taken into account), the more likely is the child to be describing real as opposed to imagined events. (p. 553)

Several emotional factors may affect children's accounts of sexual abuse (Benedek & Schetky, 1987a). Emotional dependency upon and loyalty to caretakers may make it exceedingly difficult for children to challenge their parents' perception of events that may differ from their own. Thus if repeatedly told that something abusive has occurred that has not, a child may come to doubt his or her own perception. Children in the midst of family conflict may have greater dependency needs and be more susceptible to parental influence. Schuman (1984, 1987) describes divorcing parents as exhibiting regressive behavior manifested by an increased emphasis on sexuality, anger, and faulty perceptions. These emotional factors may generate a false positive accusation of abuse. Conversely, loyalty issues are a major factor in false retractions of an actual complaint.

The child's use of denial, dissociation, or secondary amnesia may compromise his or her credibility when disclosing an actual abusive experience. Even partial amnesia or mild dissociation can generate dreamlike, emotionless accounts that vary with each retelling. An extreme example of compromised credibility may occur when a sexual abuse victim has resulting multiple personality disorder. The incidence of child abuse is much greater in the families of multiple personality disorder patients than in normals. Putnam, Post, and Guroff (1983), in a survey of 100 multiple personality

patients undergoing treatment, found that more than 90 had been abused as children. In a young multiple personality disorder, the child's credibility is further impaired because of differing partial memories each personality has for a single event (Goodwin, 1983).

The effect of psychopathology on reports of sexual abuse must also be considered. The most common clinical presentation of a child who is a persistent liar is the conduct-disordered individual. Stouthamer-Loeber (1986) in reviewing the literature on chronic lying and conduct disorders found that nearly two-thirds of those with conduct disorders had lying as part of their presenting problem. Lying is a primary symptom of this disorder but may also be used secondarily to conceal antisocial or undesirable acts. A sexual abuse complaint brought forth by a child with a conduct disorder must be carefully assessed. At least 20% of sexually abused children have symptoms consistent with a conduct disorder (Maisch, 1972). The assessment of deception is often complex, since even severely conduct-disordered youth may be telling the truth concerning the allegation under investigation (Quinn, in press). In cases brought to trial the determination of the effect of any psychiatric condition on the credibility of the complaining witness remains the sole province of the jury (Goldstein, 1980).

Rarely, a child may have a psychiatric disorder that will alter reality testing to the extent of fabricating sexual behavior. Such seriously emotionally disturbed children may make statements that are not lies but rather the product of a mental disorder. Such distortions may include the psychotic adolescent who makes a sexual abuse allegation against a nurse while others witnessed the event, or a borderline child who sexualizes all interactions. Clinicians should be well informed concerning developmental norms of cognition and the individual child's history, including sexual history, in order to investigate these complaints fully (Quinn, in press).

In Jones's (1987) report of eight fictitious allegations made by five children, he reported that four of the five were female adolescents who had been sexually victimized by an adult in the past. These teenagers were noted to have symptoms consistent with an unresolved posttraumatic stress disorder. With these individuals the absence or presence of explicit sexual detail could not be relied upon as the sole validator because these children were former victims. Therefore, they were able to provide considerable detail of the current alleged incident. However, a difference was noted in their emotional expression when describing their earlier abuse in contrast to more recent fictitious incidents. When describing the first incident the accompanying emotion was pained, fearful, and sometimes angry, while the current description was delivered in a bland, wooden manner. A lack of threats or coercion was reported in the fictitious allegations despite significant violence in the original corroborated abuse incidents. Care must be taken in associating these features with fictitious reports. Children who have been subjected to multiple interviews may begin to report their experience in a rote manner (Berliner & Barbieri, 1984). Also, children who have been

severely traumatized and have symptoms of posttraumatic stress disorder may show an emotional numbness in all areas of life (American Psychiatric Association, 1987).

Validation Procedures

The foremost goal of an investigation should be to obtain uncontaminated data concerning the child's experience. The aim of the investigation is to document the chronology, consistency, and context of the complaint in order to maximize the assessment of its credibility. The evaluation phase should be short-term and investigatory in nature. It should be neither educational nor therapeutic. The impact of normal developmental issues, the natural history of abuse, and the possible influence of psychopathology must be assessed in attempting to establish the credibility of individual sexual abuse complaints. The stages of an evaluation are enumerated in Table I.

A key issue prior to beginning any evaluation of a suspected child abuse case is the evaluator's establishing independence from all sides of a dispute. There are two distinct types of independence (White, Santelli & Quinn, 1988). "External independence involves the evaluator's objective stance of not allying him or herself with any particular individual in the investigation" (p. 94). External independence is demonstrated through the structure of the evaluation, such as the interviewing of both parents in an allegation that includes a pending custody and visitation evaluation. "Internal inde-

TABLE I Stages of Evaluation

Stage	Key Issues
Intake	Decision to accept referral
	Negotiation of parameters of evaluation
	Setting of fee and method of payment
	Indication of method of feedback
History	Establishment of context and chronology of complaint
Child interviews	Documentation of child's statements
	Assessment of consistency
	Determination of child's developmental and emotional status
	Minimization of contamination
Medical triage	Referral for timely examination to clinician experienced in sexual abuse cases
Referral for treatment	Referral based on assessment of number and intensity of signs and symptoms as well as child's present level of functioning
	Referral to clinician not involved in investigation and experienced in treatment of victims and their families

pendence, or neutrality, is the evaluator's internal ability not to be biased relative to the allegation as the details are presented to him or her" (White, Santelli & Quinn, 1988, p. 95). Failure to maintain independence may result in the pursuit of an agenda. Professionals who have an agenda are more likely to utilize specific errors of interviewing such as leading and coercive techniques (White & Quinn, 1987). Any resulting distortion of the child's data as well as the incorporation of postevent suggestion by the child may compromise the ability of other professionals to assess the credibility of the child's account.

One recommended method to maximize independence is the use of a two-person team in evaluating child abuse (White, Santelli & Quinn, 1987). One professional functions as the intake person who also gathers the full psychosocial history of the child and family while the second professional is the child interviewer who remains "blind" to the content of the complaint. When a team is not available or feasible, the primary concerns are the maintenance of independence and the conscious separation of various roles by the investigator. It is imperative that the individual conducting the investigation be completely separate from the personnel providing treatment or advocacy for the child victim. A common error is the blurring of investigating and therapeutic roles, which becomes another way in which professional conduct may inadvertently confound the assessment of the child's credibility.

Proper technique may enhance the eliciting of more credible interview data. For example, immediate assessment after disclosure with initial verbatim quotes preserves the least contaminated data (Mann, 1985). A full psychosocial and psychosexual history permits the abuse to be placed in context (Benedek & Schetky, 1987b) (see Table II). A minimum of two child interviews and maximum of three will permit assessment of consistency of a complaint while attempting to minimize contamination. Inadequate evaluations often fail to investigate the history and influence of overstimulation, past abuse history, and exposure to sexually explicit materials and other possible perpetrators. Particular care must be taken to differentiate, whenever possible, hygienic from abusive touching. All these factors may be relevant to the credibility of the child's complaint.

The current validation of sexual abuse complaints is based upon the complaint being consistent with the known natural history of sexual abuse. Sexual abuse, according to Sgroi (1982), has five distinct phases: (1) the engagement phase; (2) the progression of sexual acts; (3) the secrecy phase; (4) disclosure, and (5) the suppression phase. A credible, validated complaint will have aspects of each phase. In the engagement phase the adult offender enlists the child's cooperation by either nonviolent or violent means. Nonviolent means include enticement, in which the child is given an emotional or tangible reward for participation, or entrapment, in which an adult misuses his or her position of authority and power to enlist the child. Violent means include the threat or use of force.

TABLE II Psychosocial History of Suspected Sexual Abuse Cases.

Psychosocial History	Key Issues
Chronology of allegation	Is there a history of escalating allegations?
	What is timing of disclosures with respect to status of other litigation or changes in parental access to child?
	What is utility of allegation as perceived by complainant?
Child's level of development including sexuality	What are baseline behavior and knowledge?
	Are there special needs that require modification of evaluation or referral?
Full history of behavioral disturbance in child	Do symptoms attributed to possible abuse predate time of alleged abuse?
History of child's exposure to sexually explicit materials and/or activities	Is there an alternate explanation for child's behavior or statements?
	Is there overstimulation, if not abuse?
Relevant family dynamics	To whom has the child been exposed?
	Are there custody and visitation issues pertinent to complaint?
	Are there motives to deceive consciously?
	Are there fears or alienation fueling an allegation?
	What are other concurrent events in child's life?
Family's daily living pattern	What are the current and past traditions concerning privacy and nudity?
	Have there been significant changes in practices?
	Are current practices developmentally appropriate?
	Are there any indicated interventions due to overstimulation?
Family's approach to sexuality and sex education	What are child's vocabulary and expected level of knowledge?
Mental health history of all parties	Does any family member have a major mental illness that would cause him or her to distort reality or lie?
	Is there a history in any family members of repeated sexualization of relationships?

In the second phase, a progression of sexual acts occurs, usually over multiple encounters unless the offender is a child rapist (Groth, 1979). Initial sexual behaviors usually include exposure, voyeuristic acts, and fondling, and progress to attempted or actual penetration or simulated intercourse. The interviewer should look for specific detail about such sexual behavior, a description told from the child's viewpoint, and an emotional response consistent with the nature of the abuse (Faller, 1984). Methods to maintain secrecy follow, which often include a continuation of the engagement strategies.

Disclosure may occur by accident or on purpose. Purposeful disclosures are more common, especially in older children. However, accidental disclosures may mean that many children are not yet prepared to talk about their experience (Mian, 1986). Assessment of an allegation should attempt to determine any motive to disclose a false complaint. After a disclosure a child is often subjected to considerable family pressure to retract or suppress a true complaint. The credibility of any retraction should be evaluated, since as many as one-third of children who have been sexually abused consider falsely retracting their complaints (Nakashima & Zakus, 1977).

The assessment of a sexual abuse complaint should also include possible motivations to report sexual abuse falsely on the part of either the child or, more frequently, the adult bringing the complaint. For example, all but 2 of the 26 false allegations of sexual abuse brought by an adult in Jones's (1987) study arose in the context of custody and visitation evaluations. Useful information to gather in such cases includes whether there is a history of escalating allegations, the timing of the complaint (i.e., particularly with respect to the status of litigation), prior attempts by the complaining parent to curtail the alleged perpetrator's access to the child, the method used in making the allegation (e.g., a first report to mandated investigators or only to custody or visitation evaluator), and the utility of the allegation as perceived by the disclosing parent. Standard validation criteria should be sought in all such cases. The clinical interviews may be adapted to include (to the child), "Is there anything else you were supposed to tell me?"—aimed at eliciting possible attempts at brainwashing, and (to the alleged perpetrator) "How can it be that such an allegation has arisen against you?"—seeking his or her discussion of actions or parenting behavior that should be assessed for appropriateness or distortion by the complainant.

Several clinical factors formerly used to assess the credibility of a child's complaint are no longer recommended. For example, the lack of specificity of so-called behavioral indicators of sexual abuse diminishes their usefulness in attempts at verifying abuse. Toward this point, more than 20% of sexually abused children are asymptomatic on these indicators (Conte, Berliner, & Schuerman, 1986). Seductive behavior by children has been used to discredit a child victim. However, premature sexualization is a learned behavior indicative of at least overstimulation if not overt abuse, either in the past or present.

The alleged victim's feelings toward an abuser are not specific validation criteria. As Sgroi (1986) stated, "It is the rare child victim who hates the offender." The child often has highly ambivalent feelings toward the perpetrator. Molesters who use enticement or at times entrapment engagement strategies often have a significant portion of their relationship with the child that remains positive. The child most often wants the sexual behavior controlled while a relationship is maintained. On the other hand, children may become alienated or afraid of a parent for many reasons (Gardener, 1986, 1987). For these reasons, the data from the observation of a child with an

allegedly offending parent should not be used to validate a complaint of sexual abuse. However, such an observation may appropriately be used to measure how much of a positive relationship has been preserved and the child's tolerance for and the proper format for continued access, including the need for supervision by family members or protective service workers or in the context of an ongoing treatment of the child and family.

Clinical Presentations of False Complaints

In the rare cases in which a sexual abuse allegation is false, numerous conditions may be causative (Quinn, 1986). Malingering, the intentional production of false or grossly exaggerated physical or psychological symptoms in pursuit of a recognizable goal (American Psychiatric Association, 1987), is the most uncommon etiology. An allegation of sexual abuse may be pursued to seek a goal such as alternate placement or may be a conscious pursuit of custody. Goodwin and colleagues (1978) describe adolescents who readily acknowledged that they had lied in order to leave a conflicted but nonabusive setting. Older latency-age children and adolescents are more likely to pursue a malingered sex abuse complaint. When an adult consciously seeks to deceive concerning a sexual abuse complaint, the children in such cases often give little in the way of a spontaneous allegation. MacFarlane (1986) described such complaints as having several common characteristics, such as lack of detail, use of adult language, lack of authenticity, and repetitiveness. None of these indicators or others described in the literature are validated empirically, and they may not be specific to false complaints.

The overanxious child often with an anxious parent may misperceive actions as abusive. Careful reconstruction of a child's history may reveal the diagnosis of an anxiety disorder. Anxiety disorders of childhood may be manifested as long-standing worries, intolerance of separations, nightmares involving themes of separation, and avoidant behaviors, any of which may be misinterpreted as behavioral indicators of abuse. Children with anxiety disorders as well as children who have not been previously symptomatic may present as anxious and oppositional at the time of scheduled access to a noncustodial parent. This "visitation phobia" may be an irrational response on the part of a child when approaching a visit with his or her parent similar to the fears of the school-phobic child (Chase, 1983). The custodial parent may manifest hypervigilance concerning the visitation, as well. The interplay between the child's and the custodial parent's fears may result in increasing symptoms in the child and/or the interpretation of the parent's actions as abusive. Careful history and child interviewing should detect the family dynamics and a lack of standard validators.

Psychopathology of the child and/or parent may give rise to a false complaint. Benedek and Schetky (1985) and Green (1986) describe false allegations of sexual abuse arising in cases in which there are prominent paranoid

and histrionic traits in caretakers. Posttraumatic stress disorders in either a previously abused child or a parent may be the basis for a new false complaint (Jones, 1987). Rarely, a child and caretaker will mutually share a bizarre, implausible belief concerning the alleged perpetrator consistent with a *folie à deux* (Kaplan & Kaplan, 1981). Investigation of such cases should document overt delusions, severe character pathology, oversexualization of multiple social relationships, or prominent posttraumatic symptoms to support the diagnosis.

Changing family dynamics may generate a false complaint in separating or divorcing families. Family practices concerning privacy, nudity, toileting, bathing, and sleeping arrangements formerly tolerated in a two-parent family may no longer be acceptable after a separation. For example, Rosenfeld, Bailey, Seigal, & Bailey (1986), in studying a nonclinical population, found a considerable amount of incidental sexual touching between young children and their parents, often at bath time. A child or parent may begin to experience and/or interpret a practice as overstimulating or abusive. A noncustodial parent may assume parenting tasks previously only done by the same-sex parent to the discomfort of the child. In addition, the noncustodial parent may fail to appreciate a child's growing modesty and independence concerning personal hygiene. Separated families also lack the chaperoning effect of having both parents present. A careful psychosocial history of the family's practice both before and after the separation, with verification from the child, will often establish the nature of such a case. Parental guidance interventions by mental health personnel may sufficiently address practices assessed to be overstimulating but not abusive (Summit & Kryso, 1978).

Similarly, a child's bodily curiosity and knowledge may be misinterpreted as evidence of abuse, especially in divorced or separated families. Questions such as "Where did you learn that?" may yield a face-saving reply by a child that fuels an allegation.

Large-scale investigations resulting in mass disclosures of sexual abuse are susceptible to a copycat or mass hysteria phenomenon that may yield false reports. For example, investigations of a residential school for children and developmental centers for the retarded yielded many actual cases of abuse resulting in criminal convictions. However, investigators noted a trend that late-arising complaints were more likely to be assessed as unsubstantiated or false.

Another type of false allegation was described by Katan (1973), in which several children in analysis initially attributed sexual abuse to the wrong person, that is, their fathers. A more probable clinical entity is a child's false accusation when the actual perpetrator is a father, stepfather, or a person in a parental role. Such allegations are fueled by unresolved posttraumatic stress symptoms (Jones, 1987), loyalty issues, or fear, or may result from improper or inadequate investigation of an allegation.

Leading and coercive interview techniques may result in a false positive assessment of a complaint. In one case (Humphrey, 1984), some children

were interviewed more than 30 times by up to 10 interviewers. Lack of documentation further hampered the assessment of consistency of the allegations. At times, one child was told what another had said for endorsement. Severe credibility problems develop in cases that show excessive interviewing, poor documentation, cross-germination of allegations between child witnesses, and other problematic strategies. Because of the backlash from several national cases, many agencies are now performing only one investigatory interview in an attempt to validate cases. This practice does not permit an assessment of consistency of the complaint over time. Structured interview protocols as developed by White, Strom, Santelli, and Quinn (1987) and Boat and Everson (1986) and meticulous documentation of the process of investigatory interviews aid in the minimization of contamination.

SUMMARY

The investigation of sexual abuse complaints should attempt to assess factors affecting the credibility of the allegations. Such factors may be found within the child, family, society, or investigation procedure. The characteristics of childhood sexual abuse overcome many of the developmental differences in young children's memory. Proper investigatory technique can maximize the child's ability to relate his or her own experience. False allegations by either children or adults remain rare events. The final determination of credibility rests with the trier of fact in a legal proceeding.

REFERENCES

Allen, V.L., & Atkinson, M.L. (1978). Encoding of nonverbal behavior by high-achieving and low-achieving children. *Journal of Educational Psychology, 70*, 298–305.

Amber B. & Teela B. v. Ron B. (1987, April). Court of Appeals of the State of California First Appellate District. Div. 5.

American Federation of Conciliation Courts. (1987). *The abuse allegations project: fifth quarterly progress report.* Unpublished document, Denver, CO.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders (3rd ed., rev.)* Washington, DC: Author.

Benedek, E.P., & Schetky, D. (1985). Allegations of sexual abuse in child custody and visitation disputes. In D.H. Schetky & E.P. Benedek (Eds.), *Emerging issues in child psychiatry and law.* New York: Brunner Mazel.

Benedek, E.P., & Schetky, D. (1987a). Problems in validating allegations of sexual abuse: Part I. Factors affecting perception and recall of events. *Journal of the American Academy of Child & Adolescent Psychiatry 26*, 912–915.

Benedek, E.P., & Schetky, D. (1987b). Problems in validating allegations of sexual abuse: Part II. Clinical evaluation. *Journal of the American Academy of Child & Adolescent Psychiatry 26*, 916–921.

Berliner, L., & Barbieri, M.K. (1984). The testimony of the child victim of sexual assault. *Journal of Social Issues, 40*(2), 125–138.

Bernstein, A.C., & Cowan, P.A. (1975). Children's concepts of how people get babies. *Child Development, 46*, 77–91.

Besharov, D.J. (1985). Doing something about child abuse: The need to narrow the grounds for state intervention. *Harvard Journal of Law & Public Policy, 8*(3), 539–589.

Boat, B.W., & Everson, M. (1986). *Using anatomical dolls: Guidelines for interviewing*

young children in sexual abuse investigations. Chapel Hill, NC: University of North Carolina.

Boat, B.W., & Everson, M. (1987, April). Use of anatomical dolls amongst professionals in sexual abuse evaluations. In M. Stewart (Chair), *Evaluation of suspected child abuse: Developmental, clinical, and legal perspectives on the use of anatomically correct dolls.* Symposium conducted at the Society for Research in Child Development, Baltimore.

Brant, R., & Sink, F. (1984, October). *Dilemmas in court-ordered evaluation of sexual abuse charges during custody and visitation proceedings.* Paper presented at the thirty-first annual meeting of the American Academy of Child Psychiatry, Toronto.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*(1), 66–77.

Bulkley, J. (1982). *Child sexual abuse and the law* (3rd ed.). Washington, DC: National Legal Resource Center for Advocacy and Protection.

Cantwell, H. (1981). Sexual abuse of children in Denver, 1979: Reviewed with implications for pediatric interventions and possible prevention. *Child Abuse & Neglect, 5*, 75–85.

Ceci, S.J., Ross, D.F., & Toglia, M.P. (1987). Age differences in suggestibility: Narrowing the uncertainties. In S.J. Ceci, M.P. Toglia, & D.F. Ross (Eds.), *Children's eyewitness memory.* New York: Springer-Verlag.

Chase, G.A. (1983). Previsitation anxiety, postvisitation depression, visitation phobia: Visitation conflicts: Preludes to child custody contests. *Conciliation Courts Review, 21*, 81–86.

Clower, V.L. (1975). Significance of masturbation in female sexual development and function. In I.M. Marcus & J.J. Francis (Eds.), *Masturbation: From infancy to senescence.* New York: International Universities Press.

Cohen, R., & Harnick, M.S. (1980). The susceptibility of the child witness to suggestion. *Law & Human Behavior, 4*, 201–210.

Conte, J.R., & Berliner, L. (1981). Sexual abuse of children: Implications for practice. *Social Casework, 62*(10), 601–607.

Conte, J.R., Berliner, L., & Schuerman, J. (1986). *The impact of sexual abuse in children.* Unpublished manuscript.

Corwin, D., Berliner, L., Goodman, G., Goodwin, J., & White, S. (1987). Allegations of child sexual abuse in custody disputes—No easy answers. *Journal of Interpersonal Violence, 2*, 91–105.

Dale, P.S., Loftus, E.F., & Rathbun, E. (1978). The influence of the form of the question on the eyewitness testimony of preschool children. *Journal of Psycholinguistic Research, 7*, 269–277.

deYoung, M. (1981). Promises, threats and lies: Keeping incest secret. *Journal of Humanics, 9*(1), 61–71.

deYoung, M. (1986). A conceptual model for judging the truthfulness of a young child's allegation of sexual abuse. *American Journal of Orthopsychiatry, 56*(4), 550–559.

Ellerstein, N.S., & Canavan, J.W. (1980). Sexual abuse of boys. *American Journal of Diseases of Childhood, 134*, 255–257.

Enos, W., Conrath, T., & Byer, J. (1986). Forensic evaluation of the sexually abused child. *Pediatrics, 78*(3), 385–398.

Faller, K.C. (1984). Is the child victim of sexual abuse telling the truth? *Child Abuse & Neglect, 8*, 473–481.

Feldman, R.S., Jenkins, L., & Popoola, O. (1979). Detection of deception in adults and children via facial expressions. *Child Development, 50*, 350–355.

Finkelhor, D. (1979) *Sexually victimized children.* New York: Free Press.

Finkelhor, D. (1983). Removing the child—Prosecuting the offender in cases of sexual abuse. *Child Abuse & Neglect, 7*, 195–205.

Fivush, R. (1984). Learning about school: The development of kindergartners' school scripts. *Child Development, 55*, 1697–1709.

Freud, A. (1965). *Normality and pathology in childhood.* New York: International Universities Press.

Galloway, B., Haverick, J., & Hall-Ellis, M. (1986). *Sexual abuse monitoring*. Unpublished document, Cuyahoga County (Ohio) Department of Human Services.

Gardener, R.A. (1986). *Child custody litigation: A guide for parents and mental health professionals*. Cresskill, NJ: Creative Therapeutics.

Gardener, R.A. (1987). *The parental alienation syndrome and the differentiation between fabricated and genuine child sexual abuse*. Cresskill, NJ: Creative Therapeutics.

Goldman, R., & Goldman, J. (1982). *Children's sexual thinking: A comparative study of children aged 5 to 15 in Australia, North America, Britain, and Sweden*. London: Routledge & Kegan Paul.

Goldstein, R.L. (1980). Credibility and incredibility: The psychiatric examination of the complaining witness. *American Journal of Psychiatry, 137*, 1238–1240.

Gomes-Schwartz, B., Horowitz, J.M., & Sauzier, M. (1985). Severity of emotional distress among sexually abused preschool, school age, and adolescent children. *Hospital & Community Psychiatry, 36*, 503–508.

Goodman, G.S. (1984). Children's testimony in historical perspective. *Journal of Social Issues, 40*(2), 9–32.

Goodman, G., & Aman, C. (1987, April). Children's use of anatomically correct dolls to report an event. In M. Stewart (Chair), *Evaluation of suspected child abuse: Developmental, clinical, and legal perspectives on the use of anatomically correct dolls*. Symposium conducted at the Society for Research in Child Development, Baltimore.

Goodman, G.S., Aman, C., & Hirschman, J. (1987). Child sexual and physical abuse: Children's testimony. In S.J. Ceci, M.P. Toglia, & D.F. Ross (Eds.), *Children's eyewitness memory*. New York: Springer-Verlag.

Goodman, G.S., & Reed, R.S. (1986). Age differences in eyewitness testimony. *Law & Human Behavior, 10*, 317–332.

Goodwin, J. (1985). Credibility problems in multiple personality disorder patients and abused children. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality*. Washington, DC: American Psychiatric Association.

Goodwin, J., Sahd, D., & Rada, R. (1978). Incest hoax: False accusations, false denials. *Bulletin of the American Academy of Psychiatry & the Law, 6*(3), 269–276.

Green, A.R. (1986). True and false allegations of sexual abuse in child custody disputes. *Journal of the American Academy of Child Psychiatry, 25*(4), 449–456.

Groth, N. (1979). *Men who rape*. New York: Plenum.

Horowitz, J., Salt, P., Gomes-Schwartz, Z., & Sauzier, M. (1984). *Unconfirmed cases of sexual abuse*. Unpublished document, Division of Child Psychiatry, Tufts-New England Medical Center, Boston.

Hudson, J., & Nelson, K. (1983). Effects of script structure on children's story recall. *Developmental Psychology, 19*, 625–635.

Humphrey, H.H. (1984). *Report on Scott County investigations*. Unpublished document, Office of the Attorney General of Minnesota, Minneapolis.

Johnson, M.K., & Foley, M. (1984). Differentiating fact from fantasy: The reliability of children's memory. *Journal of Social Issues, 40*(2), 9–32.

Jones, D.P.H. (1987). Reliable and fictitious accounts of sexual abuse to children. *Journal of Interpersonal Violence, 2*, 27–45.

Kaplan, S., & Kaplan, S. (1981). The child's accusation of sexual abuse during a divorce and custody struggle. *Hillside Journal of Clinical Psychiatry, 3*, 81–95.

Katan, A. (1973). Children who were raped. *The Psychoanalytic Study of the Child, 28*, 208–224.

King, M., & Yuille, J.C. (1987). Suggestibility and the child witness. In S.J. Ceci, M. P. Toglia, & D.F. Ross (Eds.), *Children's eyewitness memory*. New York: Springer-Verlag.

Kreitler, H., & Kreitler, S. (1966). Children's concepts of sexuality and birth. *Child Development, 37*, 363–378.

Loftus, E.F. (1979). The malleability of human memory. *American Scientist, 67*, 312–320.

MacFarlane, K. (1986). Child sexual abuse allegations in divorce proceedings. In K. MacFarlane & J. Waterman (Eds.), *Sexual abuse of young children*. New York: Guilford.

Maisch, H. (1972). *Incest*. New York: Stein & Day.

Mandler, J. (1984). *Stories, scripts, and schemes.* Hillsdale, NJ: Erlbaum.

Mann, E.M. (1985, February). *The assessment of credibility of sexually abused children in criminal court cases.* Paper presented at the Third Annual Symposium in Psychiatry and the Law, the American College of Forensic Psychiatry, Newport Beach, CA.

Marin, B.V., Holmes, D.L., Guth, M., & Kovac, P. (1979). The potential of children as eyewitnesses. *Law & Human Behavior, 3,* 295–306.

Masson, J.M. (1985). *The assault on truth: Freud's suppression of the seduction theory.* New York: Penguin.

Mian, M., Wehrspann, W., Klajner-Diamond, H., & LeBaron, D. (1986). Review of 125 children 6 years of age and under who were sexually abused. *Child Abuse & Neglect, 10,* 223–229.

Morency, N.L., & Krauss, R.M. (1982). The nonverbal encoding and decoding of affect in first and fifth graders. In R.S. Feldman (Ed.), *Development of nonverbal behavioral skill.* New York: Springer-Verlag.

Murray, S. (1983). *The effect of post-event information on children's memory for an illustrated story.* Unpublished manuscript.

Nakashima, I., & Zakus, G.E. (1977). Incest: Review and clinical experience. *Pediatrics, 60,* 696–701.

Nelson, K., Fivush, R., Hudson, J., & Lucarello, J. (1983). Scripts and the development of memory. In M. Chi (Ed.), *Trends in memory development research.* Basel: Karger.

Nelson, K., & Gruendel, J. (1981). Generalized event representation: Basic building blocks of cognitive development. In A. Brown & M. Lamb (Eds.), *Advances in developmental psychology* (Vol. 2). Hillsdale, NJ: Erlbaum.

Putnam, F.W., Pose, R.M., & Guroff, J.J. (1983, May). *100 cases of multiple personality disorder.* New Research Abstract #77 presented at the annual meeting of the American Psychiatric Association, New York.

Quinn, K. (in press). Children and deception. In R. Rogers (Ed.), *Clinical assessment of malingering and deception.* New York: Guilford.

Quinn, K. (1986, October). *False sexual abuse allegations: Clinical presentations.* Paper presented at the Academy of Child and Adolescent Psychiatry annual meeting, Los Angeles.

Renshaw, D. (1985). When sex abuse is falsely charged. *Medical Aspects of Human Sexuality, 19*(7), 44–52.

Rosenfeld, A., Bailey, R., Seigal, B., & Bailey, G. (1986). Determining incestuous contact between parent and child: Frequency of children touching parent's genitals in a nonclinical population. *Journal of the American Academy of Child & Adolescent Psychiatry, 25,* 481–485.

Schuman, D. (1984). False accusations of physical and sexual abuse. *Bulletin of the American Academy of Psychiatry & the Law, 14,* 5–21.

Schuman, D. (1987). Psychodynamics of accusation: Positive feedback in family systems. *Psychiatric Annals, 17,* 242–247.

Sgroi, S. (1982). *Handbook of clinical intervention in child sexual abuse.* Lexington, MA: Lexington Books.

Sgroi, S. (1986, March). *Investigation and assessment of sexual abuse.* Paper presented at the American Orthopsychiatric Association annual meeting, Chicago.

Stern, W. (1910). Abstracts of lectures on the psychology of testimony and on the study of individuality. *American Journal of Psychology, 21,* 273–282.

Stern, W. (1939). The psychology of testimony. *Journal of Abnormal and Social Psychology, 34,* 3–30.

Stouthamer-Loeber, M. (1986). Lying as problem in children: a review. *Clinical Psychology Review, 6,* 267–289.

Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child Abuse & Neglect, 7,* 177–193.

Summit, R., & Kryso, J. (1978). Sexual abuse of children: A clinical spectrum. *American Journal of Orthopsychiatry, 48,* 237–251.

Terr, L.C. (1981). Psychic trauma in children: Observations following the Chowchilla bus kidnapping. *American Journal of Psychiatry, 138*(1), 14–19.

Terr, L.C. (1983). Time sense following psychic trauma. *American Journal of Psychiatry, 53*(2), 244–261.

Terr, L.C. (in press). The anatomically correct but emotionally incorrect doll: A dilemma for our courts and our children. *Journal of the American Academy of Child & Adolescent Psychiatry.*

Tsai, M., & Wagner, N.N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behavior, 7*, 417–427.

Whipple, G.M. (1911). The psychology of testimony. *Psychological Bulletin, 8*, 307–309.

White, S. (1987). *Anatomical dolls in investigatory interviews: Should we or shouldn't we?* Unpublished manuscript, Case Western Reserve University School of Medicine, Cleveland.

White, S., & Quinn, K.M. (1987). *Problematic interview techniques in child sexual abuse investigation.* Unpublished manuscript, Case Western Reserve University School of Medicine, Cleveland.

White, S., Santelli, G., & Quinn, K.M. (1988). *Child evaluators' roles in child sexual abuse assessments.* In E.B. Nicholson (Ed.), Sexual abuse allegations in custody and visitation cases. Washington, DC: American Bar Association.

White, S., Strom, G., Santelli, G., & Quinn, K.M. (1987). *Guidelines for interviewing preschoolers with sexually anatomically detailed dolls.* Unpublished manuscript, Case Western Reserve University School of Medicine, Cleveland.

Yates, A. (in press). Genital representation has merit. *Journal of the American Academy of Child & Adolescent Psychiatry.*

Yuille, J.C. (1980). A critical examination of the psychological and practical implications of eyewitness research. *Law & Human Behavior, 4*(4), 335–345.