# PRACTICE

## Can Therapy Induce False Allegations of Sexual Abuse?

-by Kathleen Coulborn Faller

Among the concerns about the veracity of children's accounts of sexual abuse are two that relate to therapy. The first is that a therapist who incorrectly assumes that a child has been abused may persuade the child that she* has been victimized, causing the child to give a false account of abuse. The second concern is that, through the process of therapeutic intervention, the clinician may contaminate the child's account of abuse that in fact occurred, undermining the reliability of the child's disclosure.

Significant consequences occur when a charge is made that treatment influenced a child's account. When the charge is that the therapist created the allegation, therapists have been vilified by alleged offenders, their supporters, and their attorneys; therapists have been sued and had ethics charges filed against them; and therapists have been legally prohibited from continuing treatment with the child. The last outcome may occur when the accused is a parent. In such cases, the accused family member may be successful in having the therapist removed from the case and having a "neutral" therapist appointed, or in having the child seen by a therapist whose role is to "undo" the work of the believing clinician.

Because of concerns about therapist contamination, attorneys sometimes advise against treatment until the child has testified. In multiple victim cases, a variation on this practice may be found; group therapy for victims from a single site may be discouraged because of fear that the children will contaminate one another's accounts. If treatment has occurred before litigation, children's testimony may be challenged in court.

What can be said about the impact of therapy on children's memories and descriptions of sexual abuse? This question will be examined from three perspectives: (1) the psychological dynamics of adult concern about contamination; (2) research on children's memory and suggestibility; and (3) how allegations of sexual abuse present and are addressed in treatment.

### Psychological Dynamics

Concern about the impact of therapy on children's accounts of sexual abuse should be understood in the context of two phenomena: (1) the adult need to deny that children are sexually abused, and (2) adult identification with the alleged abuser. These phenomena operate at both individual and societal levels. Despite considerable progress in understanding child sexual abuse, the reaction of many people is difficulty believing that an adult would engage in such behavior. Abuse is especially difficult to believe when the alleged offender is the "type" of person with whom it is easy to relate and empathize. Thus, it is easier to believe sexual abuse of someone who is "different." Difficulty believing may be experienced when the alleged offender appears to function adequately, comes from a background similar to that of the observer, or is the same gender as the observer. Denial may lead to discounting the possibility of abuse, and focusing on alternative explanations for the child's allegations, such as undue influence during treatment. The alleged offender and defense counsel may play upon this tendency to deny, thereby fostering the notion that therapy resulted in a false, exaggerated, or distorted account.

### Relevant Research Findings on Children's Memory and Suggestibility

Research on children's memory and suggestibility sheds light on whether children's accounts can be affected by therapists. Unfortunately, there is no research that directly addresses the question. There is research, however, that is indirectly relevant. Particularly pertinent is research regarding the accuracy of children's accounts, and questioning techniques that might be similar to techniques used by therapists.

Most of the research consists of analogue studies. Generally, the studies involve exposing the child to some event and then questioning the child about it. The event may be a naturally occurring experience in the child's life (Saywitz, Goodman, Nicholas, & Moan, 1991; Steward, 1989; Yuille & Cutshall, 1986) or a manufactured experience (Goodman & Clarke-Stewart, 1991; Peters, 1991; Zaragoza, 1991). A number of studies provide the child with misleading information either before, during, or after the event to see if the child's account or memory can be altered by misleading information (Lindberg, 1991; Loftus & Loftus, 1980; Loftus & Foley, 1984; Peters, 1991; Zaragoza, 1991). Some research compares different methods of eliciting information from children, such as anatomical dolls versus questioning alone (Saywitz, Goodman, Nicholas & Moan, 1991; Steward, 1989). One study compared the effect on suggestibility of a supportive interviewer versus a non-supportive interviewer (Goodman, Bottoms, Schwartz-Kenney, & Rudy, 1991).

Research indicates that children have the ability to remember. Older children's memories are as good as those of adults (Perry & Wrightsman, 1991). Younger children have more difficulty with unaided memory; are much more likely to commit errors of omission than commission (Goodman & Aman, 1987); have better recall of central than peripheral information; and are more accurate in reporting events in which they are actively involved than events they merely observe (Goodman & Clarke-Stewart, 1991). Research related to impact of stressful situations on children's ability to recall provides mixed results, some studies finding children are less accurate if the event is traumatic (Peters, 1991) and others finding they are not (Goodman, Reed, & Hepps, 1985).

Research reveals that it is rare for children to falsely allege that they have been touched in their

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** Feminine pronouns will be used to refer to victims and masculine ones to refer to offenders; however, it is appreciated that there are both boy victims and female offenders.*

## CONTENTS

continued from page 3

private parts. In one study, a substantial proportion of children who experienced genital and anal touch during a physical examination by a doctor did not volunteer this information when asked general questions about the examination. The majority of children in the study revealed genital and anal touch only when they were asked specific questions like, "Did the doctor touch you there?" (Saywitz, Goodman, Nicholas, & Moan, 1991).

Children experience difficulty when asked to identify "perpetrators" from photo line-ups, and children make more errors when the "perpetrator" is not included in the line-up. Children do much better with a live line-up (Perry & Wrightsman, 1991). However, increased accuracy is only the case when the child is spared face-to-face contact with the "perpetrator." If faced with the "perpetrator," a substantial proportion of children fail to identify the individual, even though the child has no prior relationship with him (Peters, 1991). Similarly, when children are admonished not to tell, a considerable number remain silent, even though the offender is not present (Goodman & Clarke-Stewart, 1991).

One study involved a delay between the experience and questioning which is comparable to the delay found in many sexual abuse cases (four years), (Goodman, Wilson, Hazan & Reed, 1989). Few children could remember the experience during free recall. Children needed specific questions to trigger memory. However, an experience of sexual abuse might be more memorable than participation in an analogue study.

It is difficult to isolate questioning styles in existing research which closely resemble questions asked during therapy because there are so many therapeutic styles. Some therapists rarely or never directly discuss the sexual abuse, concentrating instead on the child's reaction to the abuse. However, most clinicians treating sexually abused children believe that it is important in therapy to talk about what happened. Such discussion not only allows the therapist to know the full extent of the victimization, but also provides a context for discerning the child's reaction to the abuse.

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Typically, therapists take their cues from their clients—for example the child's play, drawings, or affect during discussions—pursuing themes in the child's activities and making relevant observations. This approach is usually less suggestive than the questioning employed in research.

Clinicians often praise children for disclosure of difficult material and for progress in therapy. A therapist could conceivably supply a child with incorrect information, for example, material obtained from a parent or a police officer. It is also possible that a therapist might attempt to persuade a child that the therapist's interpretation of events is the correct one. It is unlikely that therapists would ask deliberately misleading questions.

Research on questioning techniques indicates that a substantial proportion of children do not disclose sensitive material in response to open-ended questions. For example, in the study by Saywitz and colleagues previously noted, 60% of children failed to mention a genital exam when asked an open-ended question about their visit to the doctor (Saywitz, Goodman, Nicholas, & Moan, 1991). When children are asked yes-no questions, they generally provide accurate information (Goodman & Clarke-Stewart, 1991). Dolls can, in some cases, facilitate children's disclosure of sensitive material (Saywitz, Goodman, Nicholas, & Moan, 1991). Research does not find dolls to be unduly suggestive (Everson & Boat, 1990).

Research regarding the use of positive reinforcement in the course of questioning indicates that younger children (3-4 years old) provide more accurate information when the interviewer is "nice" than when the interviewer is distant. Whether the interviewer was "nice" or not did not affect the performance of 5 through 7 year olds (Goodman, Bottoms, Schwartz-Kenney, & Rudy, 1991).

Research indicates that children's memory and/or accounts of events can be contaminated by misleading information (Loftus & Loftus, 1980; Loftus & Foley, 1984; Zaragoza, 1991). However, most of these studies involve situations in which children observe pictures or slides, rather than actively participate in a meaningful event.

Clarke-Stewart and her colleagues (1989) have demonstrated that children's interpretation of ambiguous events can be manipulated and altered by an authority figure who insists upon a particular interpretation (see also Lindberg, 1991). Therefore, a child who has been touched in the genitalia during the course of child care (cleaning or applying medicine), or hurt in the genital area by accident, might—under the influence of suggestive questions—misconstrue such behavior as sexual abuse. Adding to concern is the fact that some sex offenders attempt to disguise sexual abuse as child care or as other innocent touching.

In sum, the research suggests that older children are likely to provide more complete unassisted disclosure than younger children. Younger children may need more memory cues in the form of specific questions than older children. Therapists are much more likely to find false negatives than false positives. Finally, therapists should be aware of the possibility the child may identify the wrong person. When conducting therapy, clinicians should take care not to provide misleading information, should avoid assuming an authoritarian stance, and should

*continued on next page*

## Practice

-by Kathleen Coulborn Faller

continued from previous page

not insist upon a particular interpretation of ambiguous experiences. Generally, however, the research indicates that concern about the contaminating effects of therapy on children's recollections of sexual abuse is exaggerated. Of course, concern that therapy may alter children's accounts cannot be dismissed. There undoubtedly are instances in which therapists influence children's statements.

### How Allegations of Sexual Abuse Present and are Addressed in Therapy

There are four different therapeutic situations in which child sexual abuse is an issue. These situations are discussed below:

*When conducting therapy, clinicians should take care not to provide misleading information, should avoid assuming an authoritarian stance, and should not insist upon a particular interpretation of ambiguous experiences.*

***Child in Therapy for Something Else Discloses Sexual Abuse.*** Common examples of the first situation include children in therapy for running away, drug use, or suicidal behavior. During treatment, the child discloses sexual abuse. If the disclosure is made spontaneously, there is little concern about contamination. Moreover, the therapist is justified in tentatively asking about sexual abuse. However, if the child is an adolescent and has a prior history of sexual abuse, the therapist should be somewhat more circumspect because this is a circumstance in which false allegations sometimes occur.

A child whose parents are divorcing may be referred to therapy to cope with the divorce. During therapy, the child may describe sexual abuse by a parent. The therapist should exercise caution in such cases. Research indicates that the proportion of fabricated reports may be higher in the divorce scenario than in other contexts (Faller, 1990; Jones & Seig, 1988). Studies suggest most false reports are made by adults, not children (Jones & McGraw, 1987; Jones & Seig, 1988). Exaggerated skepticism is unwarranted, however, because many reports of abuse that arise in the context of a dispute over child custody or visitation are true (Faller, 1991; Jones & Seig, 1988; Thoennes & Tjaden, 1991).

Children may be removed from parental care because of physical abuse or neglect, and, during therapy for these forms of mistreatment, describe sexual abuse. When children disclose sexual abuse under these circumstances, it is usually because they finally feel safe to tell without fear of retaliation. The risk is low that such a report is false.

***Treatment for Possible Sexual Abuse.*** With increasing frequency, children who may be victims of sexual abuse are sent to therapy. The therapist is asked to determine whether abuse occurred. Referral to a therapist typically occurs when earlier interviews are inconclusive or result in a denial which is inconsistent with other evidence. Therapists are often frustrated by these cases because they do not know whether to do therapy or investigative interviewing.

Cases in which there are medical indicators of abuse or statements of other children regarding abuse are not likely to be false. Situations in which an adult is making the charge should be evaluated on the basis of all available information, including any motivation the adult might have to make a false report.

***Child in Treatment for Sexual Abuse and Additional Abuse Comes to Light.*** Discovery of sexual abuse prior to therapy is usually based upon an interview or interviews by investigators or mental health experts. Typically, the goal of interviews prior to therapy is to establish whether or not the child has been sexually abused so that steps can be taken to ensure the child's safety. Clinical research (Sorenson & Snow, 1991) and experience (Faller, 1988) indicate that for most children, revealing sexual abuse is a process which occurs over time. A typical pattern is one in which children begin with the least overwhelming experience and gradually disclose more and more as their accounts are accepted and believed. Alternatively, abuse may be repressed and become accessible to the victim during the course of therapy. Thus, the uncovering of additional information during therapy is to expected, and should rarely be a cause for suspicion of therapist contamination.

***Full Extent of Sexual Abuse is Known.*** In the fourth situation, the offender may have confessed, there may have been a successful criminal prosecution, or the victim may have given a full account before coming to therapy. In these cases, therapist contamination is seldom an issue.

### Conclusion

Those concerned about treatment affecting children's accounts of sexual abuse should be less worried when they appreciate the goals of therapy. Although therapy may result in a more complete understanding of the child's victimization, this is not its major goal. The goal of treatment is to help children deal with their feelings about their abuse and consequent behavioral problems. Child victims often feel they are "damaged goods" (Sgroi, 1982) or are somehow responsible for the sexual abuse, and for the consequences of disclosure. Children may have overwhelming anxiety and fears merely because of the experience itself, or because they were threatened during the course of the abuse. Children may experience debilitating anger. Because of their sexual abuse, children may see the world as a dangerous place, and view adults as untrustworthy. These reactions can lead to a wide range of behavioral difficulties: sleep problems; problems with elimination; phobias; self-destructive behavior such as suicidal acts, substance abuse, promiscuity, aggression; and acting out such as fire setting, assault, stealing, and other criminal acts. The major goal of therapy is to address these feelings and behaviors.

continued on next page

## Practice

-by Kathleen Coulborn Faller

continued from page 5

Consideration of the role of therapy in causing or contaminating children's accounts of sexual abuse suggests the risk is limited. However, therapists should be aware of the findings from research on children's memory and suggestibility. This research indicates that there are vulnerabilities which should be taken into account during therapy. In addition, therapists should be familiar with results from research which note situations in which there may be a higher proportion of false allegations. Finally, clinicians should appreciate that the therapeutic process in sexual abuse cases may well be scrutinized in the legal arena. This possibility argues for both carefully considered therapeutic practice and thorough documentation of interventions and their results, including disclosures and discussions by victims of sexual abuse.

**References**


Britton, H. & O'Keefe, M.A. (1991). Use of nonanatomical dolls in the sexual abuse interview. *Child Abuse and Neglect, 15,* 567-574.

Clarke-Stewart, A., Thompson, W., & Lapore, S. (1989, Apr.). Manipulating children's interpretation through interrogation. In G.S. Goodman (Chair). *Can children provide accurate eyewitness reports?* Symposium conducted at the biennial meeting of the Society for Research in Child Development. Kansas City, MO.

Everson, M., & Boat, B. (1990). Sexualized doll play among young children: Implications for the use of anatomical dolls in sexual abuse evaluations. *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 736-742.

Faller, K.C. (1988). *Child sexual abuse: An interdisciplinary manual for diagnosis, case management, and treatment.* New York: Columbia University Press.

Faller, K.C. (1991). Possible explanations for sexual abuse allegations in divorce. *American Journal of Orthopsychiatry, 61.*

Faller, K.C. (1990). *Understanding child sexual maltreatment.* Newbury Park, CA : Sage.

Goodman, G., & Aman, C. (1987, Apr.). Children's use of anatomically detailed dolls to recount an event. In M. Steward (Chair). *Anatomically detailed dolls: Developmental, clinical, and legal implications.* Symposium conducted at the meeting of the Society for Research in Child Development, Baltimore, MD.

Goodman, G., Bottoms, B., Schwartz-Kenney, B., & Rudy, L. (1991). Children's memory of a stressful event: Improving children's reports. *Journal of Narrative and Life History, 1,* 69-99.

Goodman, G., & Clarke-Stewart, A. (1991). Suggestibility in children's testimony: Implications for sexual abuse investigations. In J. Doris (Ed.) *The suggestibility of children's recollections: Implications for eyewitness testimony.* Wash., D.C.: American Psychological Association.

Goodman, G., Reed, R. & Hepps, D. (1985, August). The child victim's testimony. In M. Toglia (Chair), Current trends in evaluating children's memory for witnessed events. Symposium presented at the meeting of the American Psychological Association, Los Angeles, CA.

Goodman, G. Wilson, M., Hazan, & Reed, R. (1989, March). *Children's testimony nearly four years after an event.* Paper presented at the meeting of the Eastern Psychological Association.

Jones, D.P.H., & McGraw, E.M. (1987). Reliable and fictitious accounts of sexual abuse of children. *Journal of Interpersonal Violence, 2,* 27-45.

Jones, D.P.H., & Seig, A. (1988). Child sexual abuse allegations in custody or visitation disputes. In E.B. Nicholson & J. Bulkley (Eds.) Sexual abuse allegations in custody and visitation cases: A resource book for judges and court personnel. Wash., D.C.: American Bar Association.

Lindberg, M. (1991). An interactive approach to assessing the suggestibility and testimony of eyewitnesses. In J. Doris (Ed.) *The suggestibility of children's recollections: Implications for eyewitness testimony.* Wash., D.C.: American Psychological Association.

Loftus, E. & Foley, M. (1984). Differentiating fact from fantasy: The reliability of children's memory. *Journal of Social Issues, 40,* 33-50.

Loftus, E. & Loftus, G. (1980). On the permanence of stored information in the human brain. *American Psychologist,* 35, 409-420.

Peters, D. (1991). The influence of stress and arousal on the child witness. In J. Doris (Ed.) *The suggestibility of children's recollections: Implications for eyewitness testimony.* Wash., D.C.: American Psychological Association.

Perry, N. & Wrightsman, L. (1991). *The child witness.* Newbury Park, CA: Sage.

Saywitz, K.J., Goodman, G.S., Nicholas, E., Moan, S.F. (1991). Children's memories of a physical examination involving genital touch: Implications for reports of child sexual abuse. *J. Consulting & Clinical Psychology, 59,* 682-691.

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

Sorenson, T. & Snow, B. (1991). How children tell: The process of disclosure of sexual abuse. *Child welfare, 70,* 3-15.

Steward, M. (1989). *Final report of grant #90CA1332: The development of a model interview for young child victims of sexual abuse: Comparing the effectiveness of anatomical dolls, drawing, and video graphics.* Davis, CA: Department of Psychiatry, University of California.

Thoennes, N., & Tjaden, P. (1991). The extent, nature, and validity of sexual abuse allegations in custody/visitation disputes. *Child Abuse and Neglect, 14,* 151-153.

Yuille, J. & Cutshall, J. (1986). A case study of eyewitness memory of a crime. *Journal of Applied Psychology, 71.* 291-301.

Zaragoza, M. (1991). Preschool children's susceptibility to memory impairment. In J. Doris (Ed.) *The suggestibility of children's recollections: Implications for eyewitness testimony.* Wash., D.C.: American Psychological Association.


*Kathleen Coulborn Faller, MSW, PhD, is Professor of Social Work at the University of Michigan in Ann Arbor, and Secretary of APSAC.*

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