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# False Accusations of Sexual Abuse: Psychiatry's Latest Reign of Error

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The problem of false accusations of child sexual abuse requires explanation. Investigators uncritically accepted theories and techniques from mental health authorities because of our society's traditional faith in such "experts." The history of this development is reviewed, illustrating the confusion resulting from a blending of investigative and therapeutic roles. Similarly hasty acceptance of unsupported medical interpretations are also reviewed. Recommendatons for reform stress a separation of investigators from mental health ideology, as well as more responsible investigative techniques.

Our society's belated recognition of child sexual abuse, in the late 1970s and early 1980s, seemed initially to promise greater protection to yet another oppressed segment of society. Prisoners, mental patients, rape victims (and abused women in general), the elderly, the handicapped – each group had in turn been the focus of greater awareness of and sensitivity to traditional abuses inflicted by persons or groups with unchecked power.

The much needed focus on physical abuse of children immediately preceded our recognition of sexual abuse. Spearheaded by pediatrician Henry Kempe and his colleagues at the University of Colorado, the "battered child syndrome" became a household word (Kempe and Helfer, 1968), and laws mandating that professionals report cases of suspected abuse were quickly passed by all the states.

As sexual abuse became the next target for efforts at greater protection of children, law enforcement and child protection agencies turned for guidance to mental health professionals and medical doctors, just as they had in the case of physical abuse. *This collaboration has led to a system of investigation which has gone terribly awry.* In the following discussion I will attempt to trace the

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development of this partnership, illustrate what happens when a mental health model dictates the behavior of investigators, and I will propose alternative approaches which hold greater promise for protecting children from abuse while doing a better job of finding which allegations of abuse are true and which are false.

## The Building Blocks

From the beginning, in the early 1970s, the distinction between investigator and therapist was missed. That this was a crucial oversight should become clear as we trace the development of certain key theories and practices which to this day are hindering responsible handling of sexual abuse accusations.

The Child Sexual Abuse Treatment Program (CSATP), started in San Jose, California in 1971, is the most important single precursor to our current methods of investigating alleged sexual abuse. It began as a project of the Santa Clara County Juvenile Probation Department, and was intended "to provide immediate humanistic treatment to the child and her family" (Giaretto, 1982, p. 3).

Perhaps because no responsible person could disagree with the idea of making prompt treatment services available for families caught in the web of sexual abuse, the crucial mistake which followed was lost on all concerned. CSATP joined forces with the San Jose Police Department and their respective roles became blurred. The police saw themselves as facilitators of treatment, while the therapists were thrust into the role of investigators. That neither side recognized what was happening only worsened the muddle.

### *Investigators as Therapists*

If we consult CSATP's *Treatment and Training Manual* (Giaretto, 1982), which summarizes what has become a nationwide model for both sexual abuse therapists and investigators, we read that a major goal is to "learn how the police use CSATP as a resource to help obtain confessions and to convince the family to enter treatment. . ." (p. 109). This not only assumes that the accusation is true, but also that therapists should make the same assumption and do what they can to support the allegation.

This attitude – that allegations of sexual abuse should automatically be taken at face value – soon became an article of faith. To be both progressive and caring, professionals must "believe the child." Conversely, serious investigation which *tested* the validity of an allegation became virtually tantamount to non-support of the child. Because false allegations were not considered a serious possibility, it was assumed that those who raised doubts,

as all investigators are mandated to do, were out of touch with what the experts were teaching – "children don't lie about sexual abuse."

Why were police and child protection investigators so ready to accept such reasoning, which runs counter to the very essence of the investigator's function? Because those who promoted these ideas were mental health professionals, and their expertise was taken for granted. The reliance by social agencies on mental health ideas and techniques had, of course, a long tradition to recommend it. As I have discussed elsewhere at greater length (Coleman, 1984), the language of psychiatry and psychology has done much to make the mental health professions appear more scientific, and therefore more reliable, than they are. If, for example, the new child protection movement uncritically accepted the false idea that sexual abuse was a "diagnosis," best made by mental health professionals, this was not too different from the idea that "dangerousness" or "criminal responsibility" were also issues best determined by experts from mental health.

In fairness to the reformers, we might recall that the need for protection from sexual abuse was (and is) real enough. Once confronted, child abuse in all its forms brings a sense of urgency to those now concerned about the problem and looking for tools to shake society out of its complacency. It may be that a medical/mental health model has been so attractive to reformers for the past 150 years, and was so again with the child abuse reformers, precisely because those with the power to make changes – especially legislators and polititians – are not likely to question advice from doctors.

History teaches, however, that the quickest response may not be the best. New ideas, uncritically adopted and molded into bureaucratic routine, are not easily undone. We have been living, for example, with the absurdities of the insanity defense for well over a century despite the widespread recognition that questions of criminal responsibility cannot be "examined" or "diagnosed" by mental health experts.

It has been argued by many (myself included) that the masquerading of a social problem as a medical/psychiatric problem often serves to disguise "hidden agendas" which are less palatable than surface appearances. I argued in *The Reign of Error* (Coleman, 1984), for example, that indeterminate sentencing of prisoners was never intended as a tool of rehabilitation as much as a tool of behavior control. Involuntary treatment of mental patients was more a matter of community and family convenience than individual treatment.

In the case of the child sexual abuse reformers, however, the problem was not a hidden agenda but the central role of uncritical assumptions about the nature of the problem and the nature of the solution. The whole problem, as reformers saw it, was getting the molested child to talk. And who would know better how to do this than the child therapists? Completely unrecognized was the baggage the therapists would bring with them. Thus, when police

and social work investigators – but also legislators and judges – so easily adopted the ideas of the reformers, they may have had tradition on their side, but they nonetheless were unwittingly planting a mine field which was bound to blow up once the battle began.

Both the policy makers and the front line workers failed to realize that therapists are expected to be advocates for their clients and investigators are expected to be advocates for the truth. Put another way, the investigators failed to realize that therapists might be prone to assume victimization, that being good at "getting the child to talk" might create false information, and that in such cases child protection was furthered by finding the truth of a false accusation as much as finding the truth behind a true accusation.

Just how complete was the acceptance of the idea that investigators should act like therapists, and therapists should act like investigators, may be gleaned by returning to the program so successfully promoted by CSATP. Spokespersons for the San Jose Police Department's new Sexual Assault Investigation Unit became a standard part of CSATP's training program. Highlights of the approach include:

> We do what we have to do to get the father to admit and to protect the child.
>
> We . . . explain that there is help for the family from Parents United [CSATP].
>
> . . . [T]he mother must be supportive and agree to keep the father away.
>
> . . . [T]he officer interrogates the victim . . . we tell them we want them to know that they are victims and haven't done anything wrong . . . and that you did the right thing by telling. . . . [T]he children may deny it to us at first. Then we approach them with, "Daddy may have a sickness. . . . [I]f Daddy has something wrong with his head, with how he thinks, we would take him to a psychiatrist to get him help. You would want him to get help for any of these things that are wrong, wouldn't you?" The victim usually will concur by now. So we say, "Okay, I've been told that maybe Daddy has a little sickness in his head and we're here to try to help Daddy get better. . . ." So we finish the interview with the child, getting information about how the perpetrator approached her . . . where he touched her . . . whether he bribed her . . . etc.
>
> . . . [W]e want to get the family hooked into the CSATP as soon as possible. . . . [A]n intern or . . . volunteer will pick up the mother and victim and drive them back to the CSATP. . . . [T]here never is any question that they will make a connection one way or another with the CSATP. We let them know that this is part of the way they will cooperate with us. . . .
>
> . . . [S]ometimes a man won't come in. Then the department must use whatever means it has available to bring him in and get a confession. . . . *[T]here are generally two kinds of fathers, the ones who are so relieved to have the molestation exposed that they confess everything to the officer at once, and the others who deny or partially deny because they're too afraid to admit.* [italics added]
>
> . . . [T]he process of investigation and connecting the family to the CSATP is compressed into a few hours. We get a confession from the father, he is persuaded to stay out of the home and not have contact with this child, the connection to CSATP . . . is made, the

> police go right to the district attorney with the evidence and a complaint is filed. . . . (Giaretto, 1982, pp. 113–120)

Such an "investigation" is obviously based on the assumption of guilt, from the outset. How else could there be only "two kinds of fathers" – those who are guilty and admit, and those who are guilty and deny? Why else would a referral to a sexual abuse treatment program be considered appropriate even before any real investigation had been done? How else can we explain not a single mention of false accusations in the CSATP manual?

*Therapists as Investigators*

If obtaining a confession from the accused became the natural goal for the investigator trained to think like a therapist, it was inevitable that therapists who functioned as investigators would adopt a similar style. At workshop after workshop on the sexual abuse of children, therapists had all their attention drawn to the fact that a molested child might conceal the information – even deny it when questioned – but no attention drawn to the possibility that a child could be influenced by adults to claim falsely to be the victim of abuse.

If we look, for example, at a highly influential article by Summit (1983), a leading proponent of such thinking, we read that "It has become a maxim among child sexual abuse intervention counselors and investigators that children never fabricate the kinds of explicit sexual manipulations they divulge in complaints or interrogations" (p. 190). Such a belief never had any data to support it, but it nonetheless became codified by phrases like "children don't lie about sexual abuse," or "believe the child."

In this same article which became standard fare for all who desired to be amongst the new wave in child protection, Summit outlined his "child sexual abuse accommodation syndrome." Situations where a child might be pressured to avoid disclosure were thoroughly discussed. Totally unmentioned was the possibility that such an "accommodation" to adult power and influence was not necessarily a one-way street, that a child might be pressured *into* an accusation, as well as *out of* one (Coleman, 1985).

In addition, therapists at sexual abuse workshops were taught to equate both their concern for children and their professional competence with the ability to bring a child to the point of "disclosure." If the leaders of this fledgling specialty were correct that children never fabricate tales of explicit sexual manipulations, then leading and suggestive questioning would do no harm. The non-molested child would not respond to such questioning with false statements, while the molested child might need just such techniques to overcome fear or embarrassment.

Having studied hundreds of video and audio tapes of children interviewed by therapists or investigators armed with such thinking, I have seen the results: the frequent training of a child to believe things which mirror the interviewers' questions and assumptions instead of the child's memories. The young child, especially, is soon unable to distinguish what is *remembered* from what is drawn out by the interviewer's insistent questioning. The child may not, therefore, be "lying" but still not telling the truth, because the child no longer *knows* the truth. This has been well documented not only in literature from mental health disciplines (Wakefield and Underwager, 1988) but also from official inquiries by the Attorneys General of Minnesota (Humphrey, 1985) and California (Van de Kamp, 1986).

Perhaps the most notorious example of this process is the way that the children from the McMartin preschool of Manhattan Beach, California were interviewed. In 1983, after the mother of a 2½-year-old boy became convinced that her son had been molested at the school, police investigators were unable to obtain corroboration from the boy or from other children attending the school. Convinced that the children were too frightened to reveal anything, the District Attorney decided that a mental health professional should have a try.

Social worker Kee MacFarlane had recently come from the Department of Health, Education and Welfare where she coordinated programs focusing on child sexual abuse. She was now at Los Angeles' Children's Institute International, and had a reputation as an expert at helping children disclose sexual abuse. Dolls and puppets were her forte. Especially because MacFarlane was (and in some circles still is) considered a model for others to emulate, let us take a closer look at the techniques said to be necessary to help children "disclose."

As we come to this excerpt from an interview with an eight-year-old boy who had attended the McMartin school four years earlier (Gorney, 1988), the child is holding a Pac-man puppet in his hand.

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|---|---|
| MacFarlane: | Here's a hard question I don't know if you know the answer to. We'll see how smart you are, Pac-man. Did you ever see anything come out of Mr. Ray's wiener? Do you remember that ? |
| Child: | (no response) |
| MacFarlane: | Can you remember back that far? We'll see how . . . how good your brain is working today, Pac-man. (Child moves puppet around) |
| MacFarlane: | Is that a yes? |
| Child: | (Nods puppet yes) |

| | |
|---|---|
| MacFarlane: | Well, you're smart. Now let's see if we can figure out what it was. I wonder if you can point to something of what color it was. |
| Child: | (Tries to pick up the pointer with the Pac-man's mouth.) |
| MacFarlane: | Let me get your pen here (puts a pointer in child's Pac-man puppet mouth.) |
| Child: | It was. . . . |
| MacFarlane: | Let's see what color is that. |
| Child: | (Uses Pac-man's hand to point to the Pac-man puppet.) |
| MacFarlane: | Oh, your pointing to yourself. That must be yellow. |
| Child: | (Nods puppet yes.) |
| MacFarlane: | You're smart to point to yourself. What did it feel like? Was it like water? Or something else? |
| Child: | Um, what? |
| MacFarlane: | The stuff that came out. Let me try. I'll try a different question on you. We'll try to figure out what the stuff tastes like. We're going to try and figure out if it tastes good. |
| Child: | He never did that to [me], I don't think. |
| MacFarlane: | Oh, well, Pac-man, would you know what it tastes like? Would you think it tastes like candy, sort of trying. . . . |
| Child: | I think it would taste like yucky ants. |
| MacFarlane: | Yucky ants. Whoa. That would be kind of yucky. I don't think it would taste like . . . you don't think it would taste like strawberries or anything good? |
| Child: | No |
| MacFarlane: | Oh. Think it would sort . . . do you think that would be sticky, like sticky, yucky ants? |
| Child: | A little. (p. D1) |

Tragically, those most responsible for developing interview techniques such as this, the mental health "experts," have thus far refused to acknowledge the terrible mistake inherent in the "believe the child" approach. They have also lacked the courage to admit that "believe the child" really meant a very select kind of belief. Denials from the child were *not* to be believed, as MacFarlane's behavior so clearly illustrates, but eventual disclosures (no matter how much they reflected adult pressures) were given blanket acceptance.

Summit (1986), for example, has tried to defend MacFarlane's interviews by writing, "there was both reason and precedent for the methods used. . . ." They represent the "state of the art . . . highly evolved, intensely specific

and largely unknown outside the fledgling specialty of child abuse diagnosis" (p. 1). This new art form, Summit continues, is "an amalgam of several roles. . . . [T]he knowledge of a child development specialist to understand and translate toddler language, a therapist to guide and interpret interactive play, a police interrogator to develop evidentiary confirmation and a child abuse specialist to recognize the distinctive and pathetic patterns of sexual victimization." Police investigators need to copy such methods, Summit writes, because such techniques demonstrate "specialist understanding [that] is both unexpected and counterintuitive" (p. 2).

Using the format of workshops for police, child protection workers, district attorneys, and therapists, the style epitomized by MacFarlane's questioning of the boy from the McMartin school has become standard practice throughout the nation and even across the world. In my own experience studying tapes of children interviewed for alleged sexual abuse, I seldom encounter interview techniques which do not reflect the style started by CSATP and refined by specialists like MacFarlane. That such interviews are frequently done over and over with the same child, by therapists rather than investigators, with no tape recording to document what is happening, only adds to the impossibility in many cases of determining which statements of children are truly their own memories and which are the product of adult influence.

*Politicized Medicine*

The same motivation which spawned this blending of therapeutic and investigative roles – a sincere but badly muddled belief that concern for abused children was equal to assumption of guilt – has led a small group of medical doctors to overinterpret their findings on anal and genital examinations. Because victimized children may not voice a complaint immediately, if ever, and because non-violent forms of molestation may not leave any signs on examination, a few doctors have made claims to be able to interpret "subtle" evidence which "non-specialists" are unable to evaluate. To properly evaluate such "microtrauma," a "specialist" is needed.

Medical examinations for sexual abuse, done long after the alleged fact, are a new phenomenon. All but a handful of the articles on this subject are from the 1980s. An early but very influential discussion was that of Woodling and Kossoris (1981), a family physician and a district attorney from Ventura County, California. Their article describes variations of anal and genital anatomy, such as erythema (redness), anal muscles said to be too tight or too lax, fissures, or hymenal "irregularities." They claimed these findings were indicative of sexual abuse.

In support of such alleged indicators of prior sexual contact, Woodling offered only his "experience." This assumed, of course, that he had a way

of knowing when his opinions were correct and when they were not. No discussion of this problem was included, and no studies comparing molested with non-molested children were cited. None had been done. Nonetheless, when a growing number of physicians and nurses began to take a special interest in forensic ano/genital examinations of possible abuse victims, these new specialists eagerly absorbed the "experience" of their trainers.

Frequently, these ideas were being transmitted in workshops sponsored by District Attorneys. No one seemed to see any problem with this blending of medical education and legal advocacy. The fervent desire to protect children from abuse simply overwhelmed scientific caution. As trainees went back to their communities, and in turn became trainers, these uncorroborated claims became the conventional wisdom of the experts. This second generation wrote more articles which passed along the same alleged "indicators" of molestation, but were conspicuous in their absence of any data showing that these indicators were limited to, or more frequently found in, molested children (Coleman, 1989). Most doctors refused to perform such examinations, deferring to those few who claimed to be "specialists." Law enforcement and child protection workers quickly learned which examiners were likely to make findings supportive of an allegation of molestation. Most often these examiners were members of a "sex abuse team."

What little research exists has failed to support the idea that molestation can be detected by such things as size of vaginal opening, shape of hymen, pattern of blood vessels, alleged "scars" of a few millimeters, or anal relaxation (Emans, Woods, Flagg, and Freeman, 1987; McCann, Voris, Simon, and Wells, 1989). Findings which are being described in courts across the land as clear indicators of sexual molestation are found with high frequency in normal, unmolested children (Coleman, 1989). A good many criminal convictions are currently being appealed on the grounds that medical testimony now discredited was an important part of the trial.

To illustrate another aspect of the human cost which such politicized medicine is capable of inflicting, led us take a brief look at what happened in Cleveland, England, where two pediatricians were sure that anal relaxation meant "buggery" (sodomy). Hobbs and Wynne (1986) had reported that "Dilatation and/or reflex dilatation of the anal canal" were not seen in normal children, and indicated sodomy. They added that, "In addition to reflex dilatation, we have also seen alternative contraction and relaxation of the anal sphincter or 'twitchiness' without dilatation. In our experience this also indicates abuse" (p. 794).

Despite a total absence of controlled data to support these notions, these claims were accepted as uncritically in Britain as similar ones here. This is how the *Report of the Inquiry into Child Abuse in Cleveland 1987* (Butler-Sloss, 1988) described what then started to unfold:

> Dr. Higgs had, in the summer of 1986 . . . suspected sexual abuse and on examination saw for the first time the phenomenon of what has been termed "reflex relaxation and anal dilatation." She had recently learned from Dr. Wynne . . . that this sign is found in children subject to anal abuse. . . . (p. 14)

Higgs and a colleague (Wyatt) were soon diagnosing children right and left as victims of sodomy. So sure were they of their conclusions that when the finding disappeared and then returned – and the alleged perpetrator had no contact prior to the reappearance – they presumed a second sodomy by a different person. In one case, by the time of the fourth reappearance of anal relaxation, the grandfather, father, and finally two foster parents had all been accused of sodomizing the child! Before this farce played itself out, Higgs and Wyatt had, over a period of five months, "diagnosed" sexual abuse in 121 children from 57 families. Typically, the child was removed from the parents and then subjected to regular "disclosure work" interviews.

Eventually, outraged parents were able to arrange second examinations, and in almost all cases these second opinions differed drastically from the initial findings. And while most of the children were eventually returned home, there is no more indication in Britain than America that the medical community is ready to grapple with the problem.

## What Is To Be Done?

While a few spectacular cases, such as the McMartin preschool case in Manhattan Beach, California or the multiple allegations in Jordan, Minnesota, have alerted many people to the fact that not all sexual abuse allegations are valid, few persons are aware of the magnitude of the problem. It is, of course, impossible to scientifically determine anything like a precise figure, since there is no scientific standard by which to determine the truth in individual cases. Statistics, therefore, will obviously reflect this uncertainty.

Most influential of those pointing to the frequent occurrence of false allegationstions is attorney Douglas Besharov. As a former prosecutor and former head of the National Center on Child Abuse and Neglect, his citations to data showing a national incidence of unfounded reports of abuse being near the sixty percent figure (Besharov, 1985) have added to the increasing awareness of this problem. In my own experience, cases labeled as "founded" or "validated" by police or child protection agencies are routinely full of improper invesigative methods and discrepancies which cast much doubt on where the truth lies.

I submit that we do not need to know the exact, or even approximate incidence of false allegations of sexual abuse. All we need to know is that false allegations are not at all rare and that they are occurring primarily because

of ill-conceived assumptions and methods on the part of police, caseworkers, therapists, and doctors. I propose the following changes.

Investigators from police and child protection agencies will require a systematic re-training, focusing on neutral investigative techniques. The intimate alliance with mental health theory and practice will need to be examined and removed, freeing investigators to see themselves as seekers of truth rather than advocates for any particular person.

State legislatures should mandate tape-recording of all child interviews by professionals from law enforcement, child protection, mental health, and medicine, in which the subject of possible sexual abuse is discussed. Such tapes would, of course, be available to all parties involved in civil or criminal accusations of molestation, but otherwise protected as confidential material.

The medical community should review the current state of the art of sexual abuse examinations, widely publicize its findings, and censure those doctors who persist in offering reports and testimony which go beyond what is known.

Written records of child protection agencies and therapists interviewing children for molestation must be available to persons accused of molestation and their attorneys. This is especially important prior to the day when taping becomes mandatory. Secret interrogations of children, by adults trained to believe that false allegations are seldom if ever a problem, and trained to encourage "disclosure," are a sure recipe for injustice toward accused adults and victimization of children by a form of abuse unintended but nonetheless real.

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