Short Report

Children who fabricate sexual abuse

H Perera[1], K Wanigasinghe[2], H Jayasekara[3], H M P P Karunaweera[3], C D K Mudalige[3], V I Dharmawardena[3], K Ratnayake[3]

Sri Lanka Journal of Child Health, 2006; **35**: 20-24

(Key words: children, sexual abuse, fabrication)

Introduction

Child sexual abuse is a highly emotive issue that stirs the moral conscience of the general public, with feelings of sympathy and protection towards the victims and disgust and outrage about the perpetrators. Though similar feelings may affect the health professionals who manage these abused children, there is in addition a complex array of health, social, ethical, legal and human rights issues that demand their attention. Hence, any assessment of a child presenting to a medical setting with suspected sexual abuse should be valid enough not only to allow relevant therapeutic interventions for the benefit of the child, but also to withstand trial in a court of law, so that justice is done. Such a complex assessment relies heavily on the account given by the child about the alleged event. It is usually assumed that the child is capable of providing valid information most of the time and the story given is considered as a genuine and accurate account of the event concerned. However, obtaining a valid account of the incident of abuse from a child can be a challenge for several reasons. *Firstly*, children are less capable than adults of accurate comprehension, recall and giving verbal descriptions of their experiences. *Secondly*, children's memories are open to suggestive influences by others[1,2]. It is known that if the memory of an experience is contaminated by providing contradictory facts, the child will have difficulty in separately identifying the two sources of information[3]. Hence, the child may even seem to be lying when recalling an event. On the other hand, children are known to claim that they lied about being abused for fear of reprisal by a perpetrator[4].

Thus, some children intentionally or unintentionally lie that they were sexually abused, although the vast majority tell the truth and should be taken seriously. We present here 4 cases of alleged sexual abuse, seen in an inpatient unit over a period of 2 years that turned out to be fabricated stories. The objective of this presentation is to discuss the relevant child characteristics and the environmental factors that contributed to such behaviour by these children, and specific aspects of their management.

[1]*Senior Lecturer, Department of Psychological Medicine, Faculty of Medicine, Colombo,* [2]*Medical Officer / Psychiatry,* [3]*Registrar / Psychiatry*

(Received on May 27 2005. Accepted on 14 July 2005).

Case reports

Case 1 – D a nine year old girl claimed that a certain young man in the neighbourhood raped her. D had first informed her class teacher about the abuse and also gave a note to that effect in writing when requested to do so. When allowed to describe her ordeal, she gave an account of an incident of rape in great detail. She also reported bleeding from rectum when opening her bowels, mildly at first and profusely a day later. The alleged event, according to D, took place when she was alone in the house and therefore not witnessed by anyone else. She did not call for help as no one was expected to hear her. She was living with her step father, his mother and a younger sibling at the time. Her mother was employed in the Middle East. Her biological parents had separated few years before but the contact with her father continued irregularly.

Forensic examination did not show any evidence that vaginal or anal penetration had taken place and the child's story could not be substantiated. When confronted about it, the child admitted that she lied as she did not like living with her step father and his mother, because they made her do household chores such as washing clothes and fetching water. Her expectation was that she would be sent to live with her biological father. Her second preference was to live in a children's home. She had gained knowledge about sexual behaviour in adults by secretly watching her mother and step father. She also alleged that her older sister was once abused sexually by the same perpetrator and knew the details of that incident. This

story could not be confirmed. Another source that may have influenced D in making up her story was a serial documentary on television which she regularly watched.

D had above average intellectual ability on testing and was skilled in academic work and performing arts. She also related several episodes of stealing and lying. She had no intention of getting anyone into serious trouble by her allegations. There was no evidence of a psychiatric disorder.

Case 2 – S a 10 year old newly ordained samanera priest was admitted after an episode of screaming and running around the temple premises in a state of panic and shouting that he was scared. He had claimed that another priest, around 18 years of age, attempted to sexually molest him. S also accused this older priest of previous incidents of attempted sexual abuse on him and others as well, but did not give any details. On the claim made by S, the alleged perpetrator was arrested and remanded in custody by the police. S later admitted that the older priest only touched him on the hand when they were standing near an outdoor water tap. A sexual connotation in this incident was unclear. S justified his claim of attempted molestation on the ground that the older priest had a "bad reputation". There were no injuries on his body though he claimed to have fallen while running in panic. Few days before, the head priest of the temple had threatened to send S back to his parents or to another pirivena because of his persistent difficult behaviour. This possibility, which S did not want, may have been the most likely precipitant for the acutely disturbed behaviour and the exaggerated response to the situation.

Though his mother supported S on his abuse story, she also agreed that he had problem behaviours. He was defiant and aggressive both at home and in school. He chose to go to the pirivena as he disliked school and lessons. His mother encouraged this choice but his father disagreed, which had led to frequent arguments between them. The history given by the mother was strongly suggestive of hyperactivity, learning difficulties and conduct problems. The head priest also reported major difficulties in managing him due to frequent non-compliance with rules at the pirivena, dishonesty and stealing.

Case 3 – T an 11 year old obese girl was admitted after she ran away from home and went to the police claiming that she spent the night before in the company of several young men. However, she also stated that she did not allow any of them to engage in any sexual activity or even touch her. Several young men in the area were arrested by the police and an identification parade was held for T to point out the alleged perpetrators. The outcome of this parade is not known. T claimed that she had had sexual intercourse with several men in the past but forensic evidence did not substantiate this claim. A vaginal discharge was investigated but no evidence of sexually transmitted infections was found. According to her mother, T was usually timid and socially inhibited with an over-concern for cleanliness, method and order. However, she had lately become promiscuous, and also hostile and rebellious with mother. This change was noticed after she attained menarche. Even after admission to hospital, she had offered her address to a young man working at the hospital canteen who was later found loitering near the ward.

The possibility of a brain tumour to account for her behaviour change was considered but there were no neurological signs and a CT brain scan was normal. Her mental state examination revealed a depressed mood, irritability, suicidal wishes, self depreciating thoughts and a low self esteem. She had an average intelligence and no specific learning difficulties. She had a body mass index of 31.6 kg/m^2 but did not have evidence of a metabolic syndrome. Her mood improved with antidepressant medication and at one year follow up, remains well with no further recurrence of depression or behaviour problems.

Case 4 – P was a 12 year old girl who presented with a history of change in behaviour noticed by her mother in the previous 3 weeks. The child had complained to the mother that an adult male relative attempted to sexually molest her. When confronted by the mother, she denied such an experience. By then she had already told this story to her class teacher. On a later occasion, she told her mother that several youth dragged her into the bushes and molested her. She later denied having said so. Four days before admission to hospital, she ran away from home after stealing 4,000 rupees from her mother. She left a note to say that she would be at a friend's house, some miles away. P had visited this friend only once before with her mother. She later confessed to her mother that a woman in the neighbourhood, who is a known psychiatric patient, made her behave in this inappropriate manner by charming her. She also accused this woman of trying to break up her family. Previously, P was known to spend a lot of her time in the company of this neighbour even in defiance of her mother.

P is the eldest of 3 siblings. Her father died 3 years before, 3 months after she attained menarche. Her mother had plans to get married again and her intended partner was a man several years her junior. The mother claimed that the child accepted his presence though initially ambivalent. Her school work was reported as satisfactory and there was no evidence of developmental problems. According to the mother, P's current behaviour was uncharacteristic as she was never known to steal or behave oppositionally with her. Mental state examination showed a depressed mood with tearfulness, feeling fed up and loss of interest. She disliked home but did not want to live anywhere else. It was apparent that this child had difficulty in adjusting to the prospect of her mother getting married again. She probably sought comfort in a substitute relationship with her neighbour who may have emotionally exploited her.

Discussion

All 4 children were initially assessed in other settings before referral for inpatient care. This meant that the children sounded convincing to the referrers concerned or any doubts about the incidents could not be clarified from the available evidence at the time. Hence, an in depth assessment was needed before falsification of abuse was considered. Further assessment focused on two crucial issues. The first was to identify the factors that may have motivated these children to lie about sexual abuse. The second was to find out whether such behaviour indicated an underlying mental health problem or even a mental disorder. It was apparent from the histories that temperamental characteristics, psychiatric illness and social circumstances were all associated with the behaviour of the children. In *case 1*, social factors played a primary role. However, a sense of deprivation about the absence of mother, a sad mood, and certain antisocial traits may have contributed to deliberate manipulation of others to achieve her desired end. In *case 3*, clinical depression was a prominent feature. Depression is known to be associated with a range of maladaptive behaviours in adolescents and youth. Epidemiological studies have shown that depressed adolescents are at high risk of drug and alcohol abuse, violence and delinquency, promiscuity, teenage pregnancy and sexually transmitted disease[5,6]. In *case 4* too, depressed mood, adjustment difficulties and an attempt to draw the mother's attention to her distress may have all contributed to the child lying about abuse. A diagnosis of conduct disorder was possible in case 2. Children with conduct disorder engage in persistent antisocial behaviours and are defiant with adults. The extent to which these psychosocial variables contributed in each case towards fabrication of abuse is difficult to estimate. The more generic diagnosis of factitious disorder is used when a primary diagnosis is not identified in those who fabricate symptoms[7,8]. The diagnosis of factitious disorder by proxy, popularly known as Munchausen syndrome by proxy, is used where the falsified presentation is strongly influenced by the primary care giver[7,8].

The possible motivation for the behaviour shown by these 4 children was variable. Direct parental or any other adult involvement in initiating the behaviour was not apparent but covert coaching by a parent or another adult could not be excluded, especially in cases 2 and 4. However, children and adolescents can falsify symptoms even without known parental involvement[9]. Motivation in case 1 was to escape from an intolerable social situation. In the children who had depressed mood states (cases 3 and 4), the behaviour may have been a cry for help. An accurate assessment of primary motivation is difficult as secondary gain from parental attention, sympathy of medical staff or avoiding difficult situations also influence children's behaviour[7]. Motivation in alleged abuse is thought to be related to fantasy, innocent lying, misinterpretation, deliberate lying and confabulation[10]. There are reported cases of false allegations of sexual touching made by children against their physicians, where the motivating factor was anger for not getting the desired attention[11,12] .

Clinical and legal implications and recommendations

- Paediatricians & other child health professionals should work closely with judicial medical services in assessment of children with sexual abuse. A comprehensive account of psychosocial background of child will be enlightening as well as useful for further management.

- Medical professionals open themselves to litigation if decisions and recommendations are influenced only by feelings of sympathy for a victimized child or rigidly held attitudes about perpetrators. Such instances are on record from other countries[13].

- Initiate direct discussion with child about what your assessment has revealed. Question in a non-threatening way to find the possible cause as child may need your understanding and intervention to overcome underlying problem.

- Ensure continued protection for child who may need to be safeguarded from the wrath of persons falsely accused.

- Failure to recognize a child's fabrication can subject family to unnecessary legal action and unwittingly support the use of a similar manipulative technique by other susceptible children.

Finally, it should also be remembered that children may withdraw an allegation of abuse from fear of reprisal of a perpetrator especially in cases of incest. Failure to recognize such a situation may leave the child in danger of further sexual abuse or of physical punishment for having revealed the secret.

References

1. Hershkowitz I. A case study of child sexual false allegation. *Child Abuse and Neglect* 2001; **25**:1397-411.

2. Savvidou I, Bozikas VP, Karavatos A. False allegations of child physical abuse: a case of Munchausen by proxy-like syndrome? *International Journal of Psychiatry and Medicine* 2002; **32**: 201-8.

3. Roberts KP, Powell MB. Describing individual incidents of sexual abuse: a review of research on the effects of multiple sources of information on children's reports. *Child Abuse and Neglect* 2001; **25**: 1643-59.

4. Gushurst CA. Child abuse: behavioural aspects and other associated problems. *Pediatric Clinics of North America* 2003; **50**: 919-38.

5. Dolgan JI. Depression in children. *Pediatric Annals* 1990; **19**: 45-50.

6. Ramrakha S, Caspi A. Dickson N, Moffitt TE, Paul C. Psychological disorders and risky sex in young adulthood: a cross sectional study in a birth cohort. *British Medical Journal* 2000; **321**: 263-6.

7. Diagnostic and Statistical Manual of Mental Disorders 4th ed. Washington DC: American Psychiatric Association; 1994.

8. World Health Organization. International Classification of Diseases 10th ed. Geneva: WHO; 1992.

9. Libow JA. Child and adolescent illness falsification. *Pediatrics* 2000; **105**: 336-42.

10. Bernet W. False statements and differential diagnosis of abuse allegations. *Journal of the American Academy of child and Adolescent Psychiatry* 1993; **32**: 903-10.

11. Silber TJ. False allegation of sexual touching by physicians in the practice of paediatrics. *Pediatrics* 1994; **94**: 742-5.

12. Silber TJ. False allegations of sexual touching – in reply. *Pediatrics* 1995; **95**: 797-8.

13. Dyer C. Doctor accused of exaggerating child sexual abuse. *British Medical Journal* 2005; **330**:1044.