False Sexual-Abuse Allegations by Children and Adolescents: Contextual Factors and Clinical Subtypes

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The authors present a typology of false allegations of sexual abuse against children that is derived from the literature and their clinical experience. The specific subtypes described are false allegations (1) arising out of custody disputes, (2) stemming from accusers' psychological disturbances, (3) resulting from conscious manipulation, (4) being caused by iatrogenic elements.

INTRODUCTION

The determination of the validity of a child's or adolescent's allegation of sexual abuse is one of the most difficult clinical questions that mental health professionals are confronted with. Despite the fact that many studies now indicate that a certain percentage of these allegations are false, large numbers of clinicians respond to the enormous complexities of these cases by resorting to oversimplified generalizations such as "children never lie." This type of response renders the decision-making process uncomplicated, but can also yield numerous false positives as this logic virtually precludes the existence of false allegations. In this manuscript we will review the literature concerning false allegations and will present a typology of their clinical subtypes to aid in the detection and clinical understanding of false allegations of sexual abuse, as well as in future research in the area.

FREQUENCY OF FALSE ALLEGATIONS OF SEXUAL ABUSE BY ADOLESCENTS AND CHILDREN

A recent review of the literature concerning systematic research into the frequency of false allegations of sexual abuse[1] revealed rates ranging from

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two to eight percent of referrals to child abuse clinics,[2–4] six percent of emergency room referrals[5] and substantially higher rates of 36.4%[6] to 55.5%[7] for the special circumstance of allegations arising out of the context of custody disputes. These articles are summarized in Table I.

In a large retrospective review involving all 576 complaints of sexual abuse made to the Denver, Colorado, Department of Social Services in 1983, Jones and McGraw[8] utilized the innovative strategy of breaking away from a strict Yes/No dichotomy and put forward four categories that capture the ambiguity of many of these situations. Their four categories and the frequency of each are as follows: confirmed—53%; suspicious but not conclusive—17%; insufficient evidence to reach a conclusion—24%; and, definite false allegations—2%.

An important variable that has been analyzed in this research is the age of the child as it relates to the frequency of false allegations. This research as summarized by Everson and Boat[1] indicates that the relative frequencies for different age groups is as follows [N for each group indicated in ( )]: 1 to 2.9 years of age (N = 124)6%; 3 to 5.9 years of age (N = 301)7%; 6 to 11.9 years of age (N = 414) 4.3%; and 12 to 17.9 years of age (N = 410) 8.0%. Thus, it would appear that the risk of an allegation being false is greater with older children.

Table I REPORTED FREQUENCIES OF FALSE ALLEGATIONS OF SEXUAL ABUSE

	N	Methods	False Allegation Rate
Peters[5] 1979	64	Examined in hospital E.R. after allegation	6%
Goodwin[2] et. al. 1979	46	Referrals to child abuse agency	2%
Horowitz[3] et. al. 1984	181	Special sexual abuse program	8%
Faller[4] 1988	142	Child abuse program referrals	3%
Benedek[7] & Schetky 1984	18	Case referred in midst of custody dispute	55.5%
Green[2] 1986	11	Case referred in midst of custody dispute	36.36%

CLINICAL ASPECTS OF FALSE ALLEGATIONS

While the research cited above is of use in ascertaining anticipated rates of false allegations the studies do not provide a great deal of clinical detail other than to indicate that one's suspicion should be heightened in cases where the allegation arises out of a custody dispute and that older children have higher rates of false allegations. This lack of clinical detail is not a specific shortcoming of the studies per se, but rather is reflective of their goal to determine overall frequencies of false allegations. More clinical detail is presented in the case-report literature which provides clinical descriptions of the reported cases. While these reports do not have the statistical significance of the studies previously mentioned they do provide more detail concerning the context and circumstances which surround false allegations. A summary of reported cases of false allegations made by children and adolescents is presented in Table II.[1,6,9,10–12] We have attempted to locate and summarize as many of these reports as possible, but do not claim that this listing includes every report which has ever been published. We have also excluded those cases that did not appear to have a firm basis for concluding that the allegation was false as opposed to inconclusive.

The reported cases continue the theme elaborated in the empirical research that allegations arising out of custody disputes are more suspect. However, the case reports also extend the range of contextual factors to be considered by highlighting the importance of the psychological stability of the reporting individual be it the child or an involved adult, and manipulation on the part of the child to obtain a specific result.

A TYPOLOGY OF SUBTYPES OF FALSE ALLEGATIONS OF SEXUAL ABUSE BY CHILDREN AND ADOLESCENTS

Our own clinical research into this phenomenon coupled with the literature reviewed has led to the formulation of a typology of subtypes of false allegations that can alert the clinician to contextual factors that should at least heighten concern and which might otherwise go undetected. Our findings suggest that these factors are not usually found in pure culture (although pure forms of each do exist). We will present the major subtypes below accompanied by a brief description of each with references to similar cases in the table. Following these we will present other more complex cases that represent aspects of more than one clinical subtype. All cases described in detail or by brief vignettes have either been reported in the literature, are a matter of public record, have been approved by the individuals involved or have been altered in a minor manner that would be sufficient to avoid identification.

Table II CASE REPORTS OF FALSE ALLEGATIONS OF SEXUAL ABUSE OF CHILDREN AND ADOLESCENTS

Author Year	Case No Reporter	Alleged Victim[s] Sex/Age	Alleged Offender Offense	Domestic Situation	Comments
Schuman[9] 1986	#1 Mother	F/4, F/2	Father. Anal and vaginal penetration by hand, beating	Divorse in progress, property and visitation dispute	Mother has history of psychological instability. Child's "canned" story revealed by independent psychiatrist Mother admits to coaching children, retracts allegations.
Schuman 1986	#2 Mother	F/10	Father Husband "had slept with" daughter and "fondled a 3-yr -old named Greta," (3-yr -old later revealed to be a dog)	Divorce in progress	Mother "felt aimless and unidentified without the social mission of motherhood
Shuman 1986	#3 Herself and father	F/13	Stepfather Breast fondling, lingual kissing, vaginal intercourse	Chronic custody dispute	Daughter retracts allegation saying she wants to live with father.
Schuman 1986	#4 Mother and Stepfather	M/6	Father. Homosexual fondling	Chronic visitation dispute	Son "had never spoken" of fondling. Mother admits to being pressured by her 2nd husband to try to terminate paternal visits.
Schuman 1986	#5 Mother	F/6, F/4	Father· Beating, burning, father cross-dresses during visits.	Divorce in progress, visitation dispute.	Unsupervised visits allowed.
Schuman 1986	#6 Father	F/6	Teen-age friend of family: Fondling chest and crotch, penile vaginal penetration	Stormy remarriage for father	Father withdrew all charges
Schuman 1986	#7 Mother	F/4 or 5	Father· Erotic licking, fellatio to orgasm, vaginal intercourse, year-long course.	Mother remarried and wants to move out of state, contested visits	Medical exam showed no evidence of intercourse. Girl had never complained of any pain. Her responses were fluent, showed unexpectedly little sexual anxiety.

Table II (Cont.)

Yates[10] 1987	#1 Mother	M/5	Father: Sexual molestation	Custody dispute	Father & son's descriptions of activities are identical, but son indicates they were supposed to be sexually stimulating. Father practiced holistic health by bathing nude in spa and massaging child.
Horowitz[3] 1984	#1 Herself	F/12	Mother: Doing "sexual things" to child. Rubbing soiled tampons on child's face	Child unhappy in home, wants to live with another relative	Child evaluated as being "emotionally distrubed" and retracts allegation after several sessions
Horowitz 1984	#2 Herself	F/11	Grandparents. Sexual assault, pmography and sadistic treatment	Stepmother is suspicious of abuse	Child retracts allegations.
Horowitz 1984	#3 Herself	F/15	Stepfather: Sexual molestation.	Longstanding hostile relationship between child & stepfather; she wants him out of the house.	Continued embellishment of child's reports with absence of suport.
Horowitz 1984	#4 Anonymous	F/6 mos.	Parents and 4 other men: Sexual abuse	Mother's sister is psychiatrically ill and hostile.	Mother's sister is suspected of falsely reporting abuse
Ohmans[11] 1984	#1 Neighbor	F/2, F/4	Parents: Suspicious sexual behavior of children, excessive masturbation; father had children touch his penis, "father ejaculated on the children"	No problems evident.	Children taken into county custody while case proceeds. Parents file suit against county Community Services Department.
Green[6] 1986	#1 Mother	M/3 yrs., 10 mos.	Father: Kissing genitals and buttocks, "kissing child with tongue," and father & child mutual fondling of penises.	Marital problems	Mother's evaluation "revealed faulty perception, and paranoid delusional ideation." Joint interviews with parents and child showed evidence of prompting of child by mother.
Green 1986	#2 Mother	F/9	Father: Forcing child to perform fellatio as an infant	Parents divorced, father has visitation rights	Child retracts original allegation saying she wanting to please her mother. Mother "felt to be delusional and suffering from a circumscribed paranoid psychosis"
Green 1986	#3 Mother	M/4	Father: Rubbing of genitals, penile penetration of anus	Parents divorced	Child retracts story.

Green 1986	#4 Maternal Grandparents	F/5	Father: Sexual abuse	Mother dead. Grandmother and father "argue over the possession" of the child.	Father becomes child's primary caretaker.
Goodwin,[2] et al 1979	#1 Herself	F/13	Stepfather: Vague account of seduction.	Mother recently remarried, child ran away from home	Child had "become jealous, disobedient, and depressed after her mother's remarriage. Child retracts accusation."
Goodwin, et al 1979	#2 Mother	F/10	Stepfather. Rape. Mother associates daughter's genital rash with a dream.	Divorced mother remarried.	Mother pathologically jealous and had dreamt her husband raped her daughter. Physical exam "showed an intact hymen. In an individual interview the daughter said she had supported her mother's allegations in order to conceal the masturbation which the child though had caused the rash
Goodwin, et al. 1979	#3 Mother	F/9, + F/infant	Father: Fondling of genitals	Mother hospitalized with schizophrenic symptoms during investigation	Nine year old denied allegations
Terr[12] 1986	#1 Herself	F/3	Father: Oral sex	Parents divorced	See below.
Terr 1986	#2 Same as above	F/8		Mother commits suicide, "wills child to her sister. Father comes forward demanding the child.	On exam by a child psychiatrist child remembered nothing but that she and her mother went to the police "to get rid of Mom's boyfriend." She also said her father ". . . never really did any stuff to me, but I needed to take care of Mommy. So I told the stuff she told me."
Everson[1] and Boat 1989	#1 Stepfather	F/12	Mother's boyfriend: Sexual intercourse	Stepfather and biological mother "undergoing an acrimonious separation."	Child "denied intercourse, but reported the man had touched her inappropriately." Child retracts allegations after "realizing the seriousness of the charge," and "admitted she had been paid $5.00 by her stepfather to make the accusation."

Subtype I: False Allegation in the Context of Custody Dispute

As noted above this would appear to be the most frequent type of false allegation based both on the empirical and case-report literature. This type of allegation is a conscious manipulation on the part of one parent or caregiver to obtain custody of children from another parent or caregiver often as a countermeasure to damning allegations (e.g. physical abuse against the main caretaker). In its purest form this would entail a parent or relative seeking custody who consciously sets out and plots to coerce a child into alleging sexual abuse at the hands of the target parent or caregiver. In these instances the description of the abuse may be more sophisticated than the child would be expected to have at their developmental level.

Example: The mother of a mentally retarded eleven-year-old boy is in a comatose state as the result of an auto accident. The large monetary settlement has been placed in trust for the boy under control of the maternal grandparents. The boy's biological father maintains custody but, in fact, the boy spends much of his time with the grandparents. The father commences legal action to obtain control of the trust. In the context of this action the boy alleges having been forced to engage in reciprocal oral sex with his seventy-two-year-old grandmother. The boy's descriptions of this activity used words which are much more sophisticated than the rest of his vocabulary. For example, he uses the word ejaculate and cunnilingus, but can not explain what they mean. It emerges that the allegations are fabricated by the father who had coerced and coached the boy as he feels it will aid his efforts to gain sole control of the trust fund.

Subtype II: False Allegations Resulting from the Accuser's Psychological Disturbance

This type of false allegation is the outgrowth of psychological disturbance of the reporting individual, be it the child himself/herself, a caregiver, a relative or neighbor. When the reporter is the child the nature of the disorder is usually such that it compromises the ability to differentiate fantasy from reality, such as borderline personality disorder or a psychotic process. In cases where the reporter is an adult caregiver, the disorder usually entailed a circumscribed delusional process in an individual who in general appears to be functioning adequately.

Example 1: A woman who had been sexually abused by her fourteen-year-old brother when she was twelve has two children, an older son and a younger daughter who also are two years apart in age. When the son reaches age fourteen and the daughter twelve, the mother becomes obsessed with the thought that her son is abusing her daughter. The evidence that she

reveals is clearly delusional in nature although she does not appear to be grossly psychotic. The allegations (which the daughter denies) are ultimately seen as an outgrowth of the mother's early abuse at the hands of her brother.

Example 2: An immigrant from a civil-war-torn third-world country brings her seven-year-old son for treatment following the dismissal of charges brought against a male summer camp worker who the mother had alleged abused her child. The therapy does not focus on the alleged abuse, but rather, on the difficulty the mother and her children are having in adjusting to a strange culture without family supports. Approximately 18 months after treatment begins the therapists receive a call from a local hospital late in the evening. The mother has arrived with her son at the emergency room stating that she has found blood in her son's underwear and that upon questioning him about this he had admitted that he had been sodomized by a black male teacher at school. The physical examination revealed no signs of anal tears. Both the mother's therapist and the boy's therapist are concerned about the extremely distraught nature of the mother and the reticence of the boy, but decide it is safe for them to return home. Two days later the boy calls his therapist and leaves a message on his answering machine that no abuse had occurred and that he had been forced by the mother into disclosing the abuse. It subsequently emerges that in what would appear to have been a circumscribed delusional episode, the mother had mistaken menstrual blood on her underwear for blood stains on her son's underwear. When he denied that he had been sodomized she had beaten him until he agreed with her. The exact genesis of this delusion is never fully determined, however, the therapist who worked with the mother does elicit an unfolding history of abuse that the mother had suffered in the context of the civil war in her native country.

Subtype III: False Allegation as Conscious Manipulation by the Child or Adolescent

This type of false allegation refers to those instances where a child makes an allegation of abuse toward an adult either as a means to obtain a specific goal or out of vindictiveness, desire for revenge or rage. The most infamous example of this type of allegation involved not sexual abuse, but witchcraft. When the adolescent girls of Salem who started the witchcraft hysteria were asked (after the hysteria had passed) why they had watched their victims hanged or burned at the stake a few of them answered "for sport."[13] This type of sadistic premeditation is fortunately quite rare and most of the case examples cited in the literature involve children who want to extricate themselves from a living situation with a step parent or foster family that is

not to their liking. There are also cases involving an allegation that is the outgrowth of anger over a perceived injustice or feelings of abandonment.

Example: A seven-year-old, severely deprived boy forms a close relationship with his primary counselor at a long-term residential treatment center. Following the return from an annual camping trip, the boy alleges that the counselor molested him on a hike, despite the observation that there were almost always others around. Prior to the trip, the counselor had told the boy that he would be terminating in two months to return to college. The counselor was encouraged to continue his termination work with the boy without withdrawing from him. During the course of the subsequent investigation the boy admits that he had fabricated the allegation out of his feelings of anger and abandonment over the counselor's announced termination.

Subtype IV: Iatrogenic

Iatrogenic components can be found in many cases involving false allegations. These factors most often consist of contamination errors involved in the conduct of the evaluation. There is also an iatrogenic quality to much of the pseudo-clinical lore that has developed concerning allegations of sexual abuse by children. Taken in their totality these baseless clinical "axioms," such as "children never lie," make it logically impossible for an allegation not to be found to be true once it has been made. For example, if the child later retracts the allegation it is said to be due to the child's ambivalence and need to protect the perpetrator.

Pure iatrogenic cases are relatively rare. However, one individual can do significant social and clinical harm, such as the pediatrician in England who felt that she could detect sexual abuse based on subtle findings on physical examination which were known only to her. Based on these results charges were made against a number of parents in one village in England.[14] Although we have not been able to obtain material relating to the psychological profile of these individuals one would assume that at least circumscribed psychopathological factors are involved.[15] Less flagrant but equally difficult to comprehend cases are summarized in the following narrative provided by a colleague:

An adolescent student at a private school seeks help for an eating disorder. The therapist has read articles concerning the frequency of sexual abuse in females with eating disorders. Despite a negative history of sexual abuse and what would appear to have been a stable family background, the therapist becomes convinced that there must have been an incestuous relationship between the girl and her father. Ultimately, she resorts to

hypnotism. Under the influence of the hypnotic state and in response to distorting leading questions, the patient produces a history of sexual contact with the father that the therapist believes supports her theory. When the patient later states misgivings about the allegation she is told that it is common for victims to have ambivalent feelings about disclosure and is told that the allegations must be true.

Combination Subtype

As indicated above, most cases of false allegations do not evolve as purely as the examples cited in this article and involve elements of more than one subtype, (although it is usually possible to discern a *major* subtype). The following are three more detailed case examples involving multiple themes.

Example 1: Henry is a 32-year-old physician who met and married his wife, Helen, while in college. His wife had been married before and Henry proceeded with efforts to adopt his wife's son by her previous marriage. The couple later has two daughters ages six and four. Helen gradually deteriorates psychologically. She refuses attempts at treatment by different psychiatrists who diagnose her as having a borderline personality disorder. Ultimately Henry seeks a divorce due to Helen's condition and refusal of treatment. The couple have joint legal custody of their children and Helen is awarded physical custody. Henry is given liberal visitation with his children. Following the divorce Helen appears to deteriorate further and Henry becomes increasingly concerned about her refusal of treatment and her ability to care for the children. Reluctantly he petitions for sole legal and physical custody of the children with only visiting rights for Helen. The court-ordered evaluations of the parents are not favorable to Helen, and Henry appears to be on the verge of winning full custody. Literally hours before the final hearing, both daughters allege that Henry has sexually abused them during their visitation with him. Henry's position rapidly changes from being on the verge of winning custody of his children to facing a grand jury. Although ultimately acquitted of the sexual abuse charges, the negative publicity destroys his career and he loses both custody and visitation with his children. The court mandates that he can only resume visitation if he undergoes psychological treatment. The therapist whom he is ordered to see states that as a prerequisite for therapy he must admit to the charges. Henry maintains his innocence and consequently can have only professionally supervised visits with his children. Henry resumes his visits under these constraining and expensive conditions while undertaking legal efforts to regain custody.

Three years after the sexual abuse allegation the adopted stepson comes

forward and admits that he heard his mother coercing and coaching her daughters with the details of the allegations just before the final custody hearing. The daughters' fear of the mother was such that they acquiesced. Despite this admission, favorable reports by the visitation supervisor, the dismissal by the grand jury, the reconstruction of his career, a successful second marriage, and favorable reports by subsequent professional evaluations, Henry is granted only a decrease in the percentage of supervised visits. The stigma of the original allegation coupled with the first psychologist's report that he must be guilty because he refused to admit his guilt proves too great an influence on the judge who refuses to reverse his decision.

This case is illustrative of a combination of subtypes involving (1) aspects of those cases arising out of custody disputes, (2) psychological instability on the part of the reporter and, (3) an iatrogenic component. It also illustrates the power of the stigma of the allegation which can, on occasion, not even be undone even by first-hand witnesses to the contrary.

Example 2: Kerri is a fifteen-year-old, mildly retarded girl with Down's syndrome who attends a special school. She lives at home with her parents, two brothers, and three sisters. Teachers at her school became concerned when Kerri begins to engage in sexually provocative behavior such as lifting up her skirt in the classroom. She will also openly masturbate. One of the teachers had attended a seminar in which she had been told that sexually provocative behavior in a student could be a sign of sexual abuse. On this basis the Department of Social Services is contacted. Leading questions by the interviewer yield an ambiguous statement by Kerri that she has been sexually abused. The details as she describes them are sketchy, but primarily consist of inappropriate touching of her genital area. When asked to name the perpetrator Kerri named her brothers, her father, two male teachers at her school, and a famous rock star.

At this point the Department of Social Services refers her to a local clinic specializing in sexual abuse. After attending the clinic on a weekly basis for several months, Kerri has developed a strong attachment to her female therapist, but still has not narrowed down the list of possible "perpetrators." Out of desperation and pressure from the Department of Social Services, the therapist at the beginning of one session places Kerri in the therapy room by herself, puts a piece of paper in front of her and tells her that she will return in fifteen minutes; she further indicates that if Kerri does not write down the name of one perpetrator by the time she returns she can never come back to see her therapist again. When the therapist returns Kerri has written down the name of her father. The local authorities are contacted and the police come to remove the father from the family home. He is ordered

by the court to maintain separate living quarters and to have only supervised visits with his family. The family hires a private attorney and eventually lose the house they are building as they cannot afford both the legal fees (which ultimately exceeded $40,000) and construction costs.

The family is referred to our clinic by their attorney to assist in their re-stabilization following this trauma. In her first interview Kerri states that just the night before the visit she had had dinner in Hollywood with the rock star she had once named as abusing her. When asked how she was able to get back and forth from the West coast so quickly, she says "Like this" and snaps her fingers. After four months of individual work with Kerri, which is purposefully *not* focused on the alleged abuse, she spontaneously tells her therapist that she has not been sexually abused by her father or anyone else. She has been voluntarily engaging in sexual activity with an older retarded boy at the school. It is this activity which has led to the sexually stimulated behavior observed by the teacher.

Kerri relates that she admitted to the sexual abuse when questioned by the Department of Social Services worker, because she was embarrassed by the sexual activity and afraid that she would get into trouble at school as a result. When asked to name a perpetrator she named several men to avoid blaming any one person. When she was confronted with naming one person, she had singled out her father out of a childish concrete view that her father was so powerful, he could not be hurt. The family subsequently sues the Department of Social Services.

An interesting footnote to this case is the reaction of the therapist to whom Kerri told the correct sequence of events. Even though this version is spontaneous rather than being built upon answers to leading questions, is consistent with the events, and is consistent each time she recounts it, the therapist is still worried that perhaps the father is guilty. After all she reasons he had been initially defensive and had worn dark glasses to one early session which the therapist had thought might be to cover up eyes bloodshot from drinking. This reaction on the part of the therapist again illustrates the stigmatizing power of the allegation.

Example 3: A junior at a small college has a well-known penchant for fabricating stories to friends and comes from a severely abusive background. While in the process of developing a story line for a fictional work, he calls a rape hotline and alleges that he has been sexually assaulted by an unnamed faculty member. The call elicits more of a response than he planned on, and the student retracts the allegation, stating it was made only in the interest of obtaining information for his fictional work.

The representatives of the college do not accept his explanation and

begin to pressure the student into naming a faculty member. Under this pressure and hoping for an end to the incident, the student names faculty member A. After an informal evaluation of faculty member A, the college's investigations conclude that it could not have been done by this individual, as he was away at the time of the alleged incidents. Confronted with this information, the student names faculty member B. Again, the investigations conclude that it could not have been this individual.

The investigators have reasons of their own to suspect yet a third faculty member. Accordingly, when confronting the student with the information that it could not have been faculty member B, they also tell him (even though this is not true) that faculty member C has been accused of sexually abusing a male student in the past. The rationalization of the investigators for engaging in this rather blatant falsehood is that they are sure that faculty member C is guilty, and a campus therapist told them that victims of abuse will often try to conceal the name of the perpetrator to protect him/her. Given this false information, the student formally names faculty member C and charges are brought against him.

This case represents elements of both subtype II (psychologically disturbed reporter) and subtype IV (iatrogenic). The jury spent fifteen minutes in deliberation before reaching a verdict of not guilty.

DISCUSSION

False allegations of sexual abuse by children and adolescents are statistically uncommon, occurring at the rate of 2 to 10 percent of all cases with rates up to 50% in special situations such as heated custody disputes. Nevertheless, when they do occur, they can be extremely detrimental to all involved including the accuser. Thus it is important that those who evaluate these allegations be open to the possibility of a false allegation and have a knowledge of the principal clinical subtypes of false allegation. Our research indicates that it is a narrow focus on the reporter and ignorance or dismissal of the broader contextual factors that often leads to the perpetuation of a false allegation.

The literature and our own clinical research has revealed four clinical subtypes of false allegations:

(1) Allegations arising in the context of custody disputes;

(2) Allegations stemming from psychological disturbances on the part of the accuser;

(3) Allegations resulting from conscious manipulation by the child or adolescent;

(4) Allegations based on iatrogenic elements.

While pure examples exist of all of these subtypes complicated cases will often have elements of more than one subtype although usually one subtype can be seen as the primary factor. Both subtypes I and III involve conscious manipulation. In subtype I an adult is consciously manipulating the child and in subtype three the child is consciously fabricating the allegation for manipulative purposes. Significant inertia on the part of authorities frustrates attempts to correct even recognized false allegations.

This material is presented in the interests of heightening the awareness of this serious miscarriage of clinical and legal processes and its severe and potentially irreversible social consequences. The field would benefit from the further research into the relative frequency of these subtypes of false allegations.

SUMMARY

The authors review the empirical literature concerning the frequency of false allegations of sexual abuse as well as the case report literature that describes individual episodes of false allegations in detail. The authors then construct a clinical typology that is derived from the literature and their own clinical experience with similar cases. The specific subtypes of the typology are: (1) False allegation in the context of a custody dispute, (2) false allegations resulting from psychological disturbance on the part of the accuser, (3) false allegation as a conscious manipulation by the child or adolescent and, (4) false allegations based on iatrogenic factors. Clinical examples of each subtype are presented. The case material presented and reviewed indicates the importance of attending to the contextual factors surrounding the allegation and pursuing a detailed comprehensive evaluation that is as free of bias as possible.

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