

False Allegations of Child Sexual Abuse and Paranoid Disorder: A Report of 2 Cases



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SUMMARY

Allegations of child sexual abuse have considerable consequences for individuals and society. Herein, we report 2 cases of false allegations of child sexual abuse by mothers diagnosed as paranoid disorder. Case 1, a 31-year-old mother accused her husband of sexually abusing her 3 daughters, aged 2, 4, and 6 years. Case 2 is a 30-year-old mother that went to the public prosecutor with allegations of sexual abuse of her 6-year-old daughter by a nursery teacher and a stranger. Examination of both alleged victims did not reveal objective findings of sexual abuse. Based on psychiatric examinations, both mothers were diagnosed with paranoid disorder. Consequently, the public prosecutor decided not to prosecute. Considering the possibility of false allegations in such cases, psychiatric examination of the complainant should be performed in order to provide accurate information necessary for legal proceedings and to protect the child.

Key Words: Paranoid disorder, false allegations, child sexual abuse

INTRODUCTION

Paranoid disorder is a relatively uncommon psychotic pathology and involves systematized hallucinations that may be associated with reality. A subtype of the disorder, persecutory type, is frequently observed. In the persecutory type the patient develops paranoia concerning that he/she or someone with whom the patient is close is being malevolently treated (Wang et al. 2007; Yildiz 2007).

Child abuse may be physical, sexual, and emotional, or negligence. Child sexual abuse is also a frequently observed subtype. Studies (Johnson 2004) show that 2%-62% of men and 3%-16% of women have a history of sexual abuse. In particular, in cases of separation or divorce the prevalence of child sexual abuse is higher (Polat 2007; Yildiz 2007).

Child sexual abuse is an epidemic problem in the US. In 1998 the estimated number of abuse cases reported to child protective services was 315,400, among which 100,928 were sub-

stantiated. In the US 45% of sexual abuse allegations cannot be substantiated. Two previous studies conducted in Australia failed to substantiate 48%-78% of sexual abuse allegations, as well. In those studies the majority (38% and 48%) of allegations were made by mothers. As such, repeated sexual abuse allegations should be comprehensively investigated and substantiated (Horner 2001; Tahiroglu et al. 2008).

While sexual abuse allegations can be true, in particular, during separation and divorce parents may resort to false sexual abuse allegations. In such cases mothers may intentionally choose to make false sexual abuse allegations in order to benefit their cause or avenge perceived or actual wrongdoing (Brown 2003). In a study conducted in Canada in 1998 (Trocme and Bala 2005) 23% child abuse reports were suspicious, whereas 35% were unsubstantiated and 4% were intentionally false. In cases of contested child custody the prevalence of intentional false allegations increases to about 12%.

Munchausen syndrome by proxy is a disorder in which a pa-

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rent or caregiver deliberately induces signs of illness in a child. The most common form is a mother that induces a disease in her child, thereby assuming the sick role by proxy. A child caregiver may present to the hospital many times without any actual reason, and demand medical examinations and investigations by fabricating symptoms and histories. In a study carried out in England 33% of such mothers had a history of Munchausen syndrome by proxy, whereas nearly 50% had marriage problems and 50% had psychiatric symptoms (Polat 2007; Wang et al. 2007).

In cases of false child sexual abuse allegations it is evident that the victims (a person, family, or community) suffer harm. The present study aimed to underscore the influence of the psychiatric status of parents in such cases by presenting 2 cases diagnosed with paranoid personality disorder that made false sexual abuse allegations.

Case 1

A 31-year-old mother filed a complaint with the attorney general against her husband, stating that he had been abusing their 3 girls (aged 2, 4, and 6 years). According to her account, she started to suspect her husband after having difficulty awakening her 4-year-old girl from sleep, observing that she was fatigued. She also reported to have observed an anal swelling the size of a small teacup while dressing her, which the girl explained with rather ambiguous phrases suggestive of a rape by her father. Thereupon, she began to perform regular anal examinations on her children each morning. After observing redness and anal swelling she went to a private physician to have her daughter medically examined; however, the physician found no evidence. In time, she began to think that her older daughter was behaving seductively (e.g. laying down with pantyhose).

First, she separated beds with her husband, then continued her regular anal examinations after separating with her husband and moving into her mother's house, and observed that her daughters no longer had anal swelling. When had been sleeping with her children she witnessed no rape or similar event by her husband, and she reported having difficulty sleeping until late at night and difficulty waking up in the morning. During her psychiatric examination interview she recollected that 3 years earlier her husband had wanted to have sex with her while she was changing the diaper of their second daughter. After that incident, she noted a growing coldness towards her husband and having suspicions about him, but lacking evidence to substantiate those suspicions.

The psychiatric examination and evaluation of the mother showed normal dressing behavior and overall condition for her sociocultural status, a tendency to recount events with extreme detail, monotonous emotionality, failure to recogni-

ze and accept reality, persistence of thoughts, and crystallized delusions via psychometry. She was diagnosed with paranoid disorder. The father exhibited no remarkable psychopathology in his psychiatric examination.

During her interview the 6-year-old girl reported that her father touched her sexual organ and buttocks with his hand over her panties while she pretended to sleep; however, during her examination in the pediatric surgery polyclinic she stated that her mother had told her to recount those events. No psychopathology was observed during the mental and psychometric examinations of the children. The results of the children's genitoanal examinations were as follows: the 4- and 6-year-old children exhibited reduced anal sphincter tonus (thought to be secondary to the daily anal examinations performed by the mother). None of the 3 children had findings that would support child sexual abuse. As expert opinion, we recommended that the mother be institutionalized in a psychiatric clinic for treatment, and that the children be taken into protective custody and subjected to regular medical evaluations. At the end of the legal proceedings the attorney general decided that any further investigation would be unnecessary and our recommendations on treatment for the mother and protection for the children were not fulfilled.

Case 2

A 30-year-old mother filed 2 complaints involving child sexual abuse with the attorney general; the first was against her 6-year-old daughter's kindergarten teacher, and the second, 3 months later, was against a stranger in another kindergarten. According to her account in the first complaint, the kindergarten teacher groped her daughter in his sleeping room and rubbed his penis against her buttocks, repeating this behavior 5-6 times within a period of 6 months. Additionally, the kindergarten administration was accused of taking no measures, despite having been warned. She also reported her suspicions that all the teachers, which might have been relatives of prosecutors and staff at the Turkish National Education Directorate, may have been involved in the incidence. She removed her children from that school nearly 1.5 months ago.

The child's genitoanal examination revealed 2 fissures in the anal mucosa. According to the mother's account of the second complaint, her child was attacked by an elderly man with white-hair in the school's bathroom during recess nearly 1 week ago; he allegedly removed her trousers and pantyhose, rubbed his penis over the front of her body and buttocks, and repeated this act a few times afterwards. The mother surmised something was wrong, as her daughter looked pale and constantly denied going to the bathroom at school. Finally, as a result of her mother's persistent questioning the daughter admitted that she was subjected to sexual abuse. The mother reported the incident to the school's administration and teachers, but they did

not believe her, and denied the existence of any video records for that day. She did not send her daughter to school for 1 week. She was allegedly attacked in the bathroom again by the same person when she returned to the school. Again, video records could not be produced. A second genitoanal examination of the child revealed 4 fissures in the anal mucosa.

Findings of both genitoanal examinations were inconsistent with the mother's version of events; therefore, we reported no findings pertaining to sexual abuse. Mental examination, familial evaluation, and psychometric analysis of the mother revealed persecutory hallucinations, including misinterpretation of perceptions and experiences, constant denial of any reasonable argument, despite the presence of clear evidence, continuing obsessive persistence, emotional unresponsiveness, and social withdrawal. In light of those findings, we considered a diagnosis of paranoid psychosis, and our medical report noted the mother's reluctance to be examined, the inappropriateness of returning the child to her care, and the need to follow-up the child regularly in a polyclinic. As a final legal resolution, the mother was sent to the Mental Health and Diseases Hospital by court order, where she was diagnosed with paranoid personality disorder and institutionalized for treatment against her will in a psychiatric clinic. The father was living separately due to the overbearing suspicion-based behaviors of the mother. As no evidence, other than inconsistent statements and abstract claims, could be obtained, the legal investigation ended and Family Court was notified to take the child into protective custody. As no act of violence or intimidation by the family towards the child was observed, Family Court decided to take no precautionary measures. The divorce suit of the mother is still ongoing.

DISCUSSION AND CONCLUSION

Allegations of child sexual abuse must be taken seriously and investigated in detail. While most allegations of child sexual abuse are true, false claims are not uncommon (Celik et al. 2008). In families in which the father, mother, or both have a history of major depression, bipolar disorder, schizophrenia, antisocial personality disorder, or other psychiatric diseases, the prevalence of physical, sexual, or other forms of abuse is 2-3-fold higher than in families without such a history (Walsh et al. 2002). Moreover, the risk of abuse increases in the presence of such factors as low-level education and low socioeconomic status, intrafamilial violence, divorce, and alcohol use in the family (Oral et al. 2001). In the present study the main problem in both cases was a mother with a paranoid disorder and the filing of false sexual abuse allegations as a result of their illness.

The presence of psychiatric diseases in the presented cases is consistent with the literature; however, the main purpose of the mothers was not to commit sexual abuse. We observed

behavior in case 1 that could be associated with sexual abuse, secondary to the persistent examination of the children by their mother in the hope of finding evidence of sexual abuse, and behavior in case 2 arising from the efforts of the mother to inflict physical signs that would support her claim of sexual abuse. Although there are studies indicating an increase in the risk of child sexual abuse due to the presence of psychiatric disease in the parents, there are no studies involving sexual abuse allegations because of paranoid disorder. We think the presented cases are important because of their unique features.

According to the literature, false allegations are commonly observed during divorce and family disputes, or due to Munchausen syndrome by proxy. Mothers with Munchausen syndrome by proxy are known to bring their children to healthcare centers for various examinations (Meadow 1993; Horner 2001). The results of the present study indicate that paranoid disorder was the underlying cause of the child sexual abuse allegations; however, we think that Munchausen syndrome by proxy should be considered in case 2 as well, due to the fact that the mother repeatedly brought her child to a physician for examination, and the detection of physical signs inconsistent with the history provided by the mother, which were probably induced by the mother herself.

False allegations of sexual abuse are commonly observed, particularly during divorce or family disputes. Mothers tend to claim such false allegations more often than fathers (Horner 2001). Both mothers in our study were living separately from their husbands, awaiting the divorce proceedings to be completed. Both mothers filed a sexual abuse complaint after separating from their husbands. Again, in both cases, there was no evidence indicating divorce or family disputes as the reason for the sexual abuse allegations. The principle reasons underlying the claims of both mothers was not family disputes or divorce. The principal cause appears to have been the recurrent suspicions associated with paranoid disorder. Problems arising from those suspicions caused the couples to divorce. Moreover, it was not clear if the problems between the couples were present prior to the sexual abuse allegations or not.

Mothers with Munchausen syndrome by proxy are known to repeatedly bring their children to healthcare centers for examination, and they generally have a tendency to induce injuries or diseases in the children in order to convince healthcare professionals (Meadow 1993, Polat 2007). No data could be found in the literature concerning the tendency of mothers to induce signs of sexual abuse in their children. In case 1 reduced anal sphincter tonus was detected in 2 children (4 and 6 years old) and it was concluded that it might have been secondary to mother's repeated anal examinations. While there was no deliberate goal of generating physical signs of sexual abuse in case 1, evidence suggesting penetration of an object or sexual organ was a remarkable finding, unlike any other in the related literature. In case 2 signs associated with the penetration of an object

or sexual organ to the anal region, which were inconsistent with the history, was another remarkable and noteworthy finding.

In cases of anal sexual assault, particularly in young children, anal mucosal tears may be minor or serious, and may heal rapidly, so that they may not be detectable after a few days (Poirier 2002; Elder 2007; Karanfil et al. 2008). Signs of anal sexual assault may include redness, edema, and small mucosal tears; however, such signs can also be observed in cases in which there is no allegation of anal sexual assault (Myhre et al. 2001). In the present study case 2 made multiple allegations of sexual abuse. The case was examined twice and all the related evaluations and tests were performed. Both examinations exhibited superficial mucosal tears in the form of fissures. The sexual abuse was claimed to have occurred 1.5 months and 1 week prior to the examination date; however, the allegations and medical findings were not consistent. Findings of both examinations might have been secondary to constipation or other diseases; however, absence of constipation or any other symptom in the history increased the likelihood that new mucosal tears might have been induced by the mother.

The risk of sexual abuse is higher in families with parents that have a history of psychiatric disease, such as major depression, bipolar disorder, schizophrenia, and antisocial personality disorder (Wals et al. 2002). In the presented cases, although there were allegations of sexual abuse, they were determined to be false. The process of investigating the validity of allegations of child sexual abuse has another important aspect; the psychological status of the child. Children may develop psychopathology as a result of such abuse, prolonged investigation (even in cases of false allegations), and repeated examinations (Baker 1997). In the present study the children involved were subjected to repeated examinations, which disturbed them consider-

ably, both mentally and physically. The process of examination was prolonged due to the lack of adequate healthcare staff and, consequently, repeated examinations were performed. In some cases, this process may be even more prolonged and conditions may force the victims to be evaluated at the Turkish Institute of Forensic Medicine. Prolonged forensic examination and repeated examinations in Turkey are due to the lack of an efficient forensic center and a specialized team that can professionally and rapidly evaluate child abuse.

Regarding the final legal resolution of the presented cases, in case 1 the expert medical report recommended that child be taken into protective custody; however, the court decided to end the investigation and no steps were taken to ensure the mother was treated and the child protected. In case 2 the expert medical report suggested taking the child into protective custody, along with conducting a medical follow-up evaluation; however, Family Court decided not to take any precautionary measures due to the absence of any act involving violence or intimidation towards the child by her parents. Since the divorce procedure was unresolved, there is no way to tell if the court will issue an order of protection for the child in the future.

In conclusion, allegations of child sexual abuse must be taken seriously and a comprehensive investigation should be conducted; however, the likelihood of false allegations should always be considered, and if required, the parent making such allegations should undergo psychiatric evaluation. In cases of repeated allegations of sexual abuse, as each medical examination may cause trauma in the child, it would be more appropriate if the entire examination and all evaluations are performed at 1 healthcare center by an expert team comprised of a forensic medicine specialist, adult and pediatric psychiatrist, and a pediatric surgeon.

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