

# HOW CHILDREN EXPERIENCE SEXUAL ABUSE

## Faculty Lecture

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- What Causes Trauma in Victims?
- Dynamics of Child Sexual Abuse
- "What It Was Like To Be an Incest Victim"
- Victim Responses to Child Sexual Abuse

## Required Reading

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Summit, R. C. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, 7, 177-193.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, 55(4), 530-541.

Lyon, T. (2002). Scientific support for expert testimony on child sexual abuse accommodation. In J.R. Conte (Ed.), *Critical Issues in Child Sexual Abuse*, 107-138. Newbury Park, CA: Sage.

# **Dynamics of Child Sexual Abuse**

How Children Experience Their Abuse

## **The Child Sexual Abuse Accommodation Syndrome**

*Roland Summit, M.D.*

- Secrecy
- Helplessness
- Entrapment and Accommodation
- Delayed or Unconvincing Disclosure
- Retraction

## **The Traumagenic Model**

*David Finkelhor, Ph.D. & Angela Browne, Ph.D.*

- Betrayal
- Traumatic Sexualization
- Powerlessness
- Stigmatization

## "What It Was Like To Be an Incest Victim"

Anonymous

I was eleven the first time it happened. My mother was out, but the other kids were upstairs. It was evening. My father had been out drinking. I was in bed. He'd been kind of feeling around before that. He'd pat me when I was in my pajamas and stuff like that. I didn't like it. I felt ashamed. The first time, he came in and started feeling under my pajamas. I was half-asleep and didn't know what was happening. He was drunk, and when he's drunk, he's scary. Before I knew it, he was on top of me, and I kept telling him no, but he said he'd hurt me if I didn't do it. I told him I didn't want to, but he said yes, I'd like it, and he was just showing me how. But I didn't like it. It hurt. He was dirty. I don't remember much about it really. I don't want to.

He told me not to tell my mother. But then, he did it again and again. I didn't know what to do. He came in maybe once or twice a week. Sometimes, he'd come right from my mother. I could hear them, and then he'd come in and make me do it. I don't know why I let it go on so long. I felt ashamed. I was so scared, and I was afraid someone would find out. I got really withdrawn and down. My schoolwork was okay, but I didn't make any friends. I just worried all the time.

It was two years before I couldn't stand it any longer, and I told my mother. She told me to tell her if it happened again. I told her it had been going on for a long time, and she got mad. She and my father called me a whore. My mother didn't seem to care. Finally, I just had to do something, and I told my counselor at school. She took me to the police. There was a man there... I was supposed to talk to a woman, but she wasn't there, and I had to tell all this to the policeman. I was scared. Later, I had to go to a doctor. He got me on this table and used that cold thing. It was just awful... worse than the stuff my father did. I didn't know anything about sex. My mother never told me, and I never had a boyfriend or anything. I still wonder. I worried about getting pregnant; I knew enough to know I could. I still don't know why I didn't. The doctor said I wouldn't.

Now I live in a foster home. I was glad to get away from both my mother and my father. The worst part of it is that after I did tell about it, it seemed like it was all my fault. Sometimes, I think it was. Why didn't I stop it? I used to get extra things from my father for being so nice to him, but it wasn't worth it. I never cared about seeing him again. My mom doesn't want to leave my dad. I don't think she's happy with him, but one reason I'd *like* to go back home, so I could help her. But I don't know if she really wants me. She didn't seem to care what was happening to me at all. She just blamed me for everything. I think she needs some counseling, too. I like it in this foster home. They're really nice here. My dad never used to let me go out. I was only supposed to go to school, go home, and work. Now I get to go out with the other girls at school; we go roller-skating and stuff, and it's fun. But I still flinch if a man touches me. I hate men. Men are dirty and all they want is sex. I'll never marry. I'll adopt children 'cause I like kids.

In fact, that's one of the things that bothers me a lot. I miss my little brothers and sisters, and I know they miss me. I worry about them and feel bad that I'm not home to take care of them. When dad drinks, he gets really mean with them. He hits them with the belt. I want him to get treatment. I don't want him to go to jail. I just couldn't take it anymore. Besides, I'm worried about my sisters. I think he might try something with them, too.

# Victim Responses to Child Sexual Abuse

## Factors Related to Impact\*

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

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\*Adapted from:

Family Resources, Inc. (1998). Safe team curriculum – parent workbook. Volunteer Advocate Training Manual.

Kendall-Tackett, K.A., Williams, L.M., Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113(1), 164-180.

# Victim Responses to Child Sexual Abuse

## Victim/Perpetrator Relationship Continuum\*

This continuum is representative of some “general categories.” These categories can be used to understand how a *child victim* may view the relationship with their perpetrator.



\*Adapted from:  
Ahlquist, A. (1992). CornerHouse.

# How Children Experience Abuse

## Required Reading

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Summit, R. C. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, 7, 177-193.

## **The Child Sexual Abuse Accommodation Syndrome**

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### **Abstract**

Child victims of sexual abuse face secondary trauma in the crisis of discovery. Their attempts to reconcile their private experiences with the realities of the outer world are assaulted by the disbelief, blame and rejection they experience from adults. The normal coping behavior of the child contradicts the entrenched beliefs and expectations typically held by adults, stigmatizing the child with charges of lying, manipulating or imagining from parents, courts and clinicians. Such abandonment by the very adults most crucial to the child's protection and recovery drives the child deeper into self-blame, self-hate, alienation and re-victimization. In contrast, the advocacy of an empathic clinician within a supportive treatment network can provide vital credibility and endorsement for the child.

Evaluation of the responses of normal children to sexual assault provides clear evidence that societal definitions of "normal" victim behavior are inappropriate and procrustean, serving adults as mythic insulators against the child's pain. Within this climate of prejudice, the sequential survival options available to the victim further alienate the child from any hope of outside credibility or acceptance. Ironically, the child's inevitable choice of the "wrong" options reinforces and perpetuates the prejudicial myths.

The most typical reactions of children are classified in this paper as the child sexual abuse accommodation syndrome. The syndrome is composed of five categories, of which two define basic childhood vulnerability and three are sequentially contingent on sexual assault: (1) secrecy, (2) helplessness, (3) entrapment and accommodation, (4) delayed, unconvincing disclosure, and (5) retraction. The accommodation syndrome is proposed as a simple and logical model for use by clinicians to improve understanding and acceptance of the child's position in the complex and controversial dynamics of sexual victimization. Application of the syndrome tends to challenge entrenched myths and prejudice, providing credibility and advocacy for the child within the home, the courts, and throughout the treatment process.

The paper also provides discussion of the child's coping strategies as analogs for subsequent behavioral and psychological problems, including implications for specific modalities of treatment.

### **Introduction**

Child sexual abuse has exploded into public awareness during a span of less than five years. More than thirty books<sup>1-34</sup> on the subject have appeared as well as a flood of newspapers, magazines, and television features. According to a survey conducted by

Finkelhor,<sup>35</sup> almost all American respondents recalled some media discussion of child sexual abuse during the previous year.

The summary message in this explosion of information is that sexual abuse of children is much more common and more damaging to individuals and to society than has even been acknowledged by clinical or social scientists. Support for these assertions comes from first person accounts and from the preliminary findings of specialized sexual abuse treatment programs. There is an understandable skepticism among scientists and a reluctance to accept such unprecedented claims from such biased samples. There is also a predictable counter-assertion that while child sexual contacts with adults may be relatively common, the invisibility of such contacts proves that the experience for the

child is not uniformly harmful but rather neutral or even beneficial.<sup>20, 36-40</sup> Whatever the merits of the various arguments, it should be clear that any child trying to cope with a sexualized relationship with an adult faces an uncertain and highly variable response from whatever personal or professional resources are enlisted for help.

The explosion of interest creates new hazards for the child victim of sexual abuse since it increases the likelihood of discovery but fails to protect the victim against the secondary assaults of an inconsistent intervention system. The identified child victim encounters an adult world which gives grudging acknowledgment to an abstract concept of child sexual abuse but which challenges and represses the child who presents a specific complaint of victimization. Adult beliefs are dominated by an entrenched and self-protective mythology that passes for common sense. "Everybody knows" that adults must protect themselves from groundless accusations of seductive or vindictive young people. An image persists of nubile adolescents playing dangerous games out of their burgeoning sexual fascination. What everybody does not know, and would not want to know, is that the vast majority of investigated accusations prove valid and that most of the young people were less than eight years old at the time of initiation.

Rather than being calculating or practiced, the child is most often fearful, tentative and confused about the nature of the continuing sexual experience and the outcome of disclosure. If a respectable, reasonable adult is accused of perverse, assaultive behavior by an uncertain, emotionally distraught child, most adults who hear the accusation will fault the child. Disbelief and rejection by potential adult caretakers increase the helplessness, hopelessness, isolation and self-blame that make up the most damaging aspects of child sexual victimization. Victims looking back are usually more embittered toward those who rejected their pleas than toward the one who initiated the sexual experiences. When no adult intervenes to acknowledge the reality of the abuse experience or to fix responsibility on the offending adult, there is a reinforcement of the child's tendency to deal with the trauma as an intrapsychic event and to incorporate a monstrous apparition of guilt, self-blame, pain and rage.

Acceptance and validation are crucial to the psychological survival of the victim. A child molested by a father or other male in the role of parent and rejected by the mother is psychologically orphaned and almost defenseless against multiple harmful consequences. On the other hand, a mother who can advocate for the child and protect against re-abuse seems to confer on the child the power to be self-endorsing and to recover with minimum sequellae.<sup>22,41</sup>

Without professional or self-help group intervention, most parents are not prepared to believe their child in the face of convincing denials from a responsible adult. Since the

majority of adults who molest children occupy a kinship or a trusted relationship,<sup>8,22,49,50</sup> the child is put on the defensive for attacking the credibility of the trusted adult, and for creating a crisis of loyalty which defies comfortable resolution. At a time when the child most needs love, endorsement and exculpation, the unprepared parent typically responds with horror, rejection and blame.<sup>22,42</sup>

The mental health professional occupies a pivotal role in the crisis of disclosure. Since the events depicted by the child are so often perceived as incredible, skeptical caretakers turn to experts for clarification. In present practice it is not unusual for clinical evaluation to stigmatize legitimate victims as either confused or malicious. Often one evaluation will endorse the child's claims and convince prosecutors that criminal action is appropriate, while an adversary evaluation will certify the normalcy of the defendant and convince a judge or jury that the child lied. In a crime where there is usually no third-party eyewitness and no physical evidence, the verdict, the validation of the child's perception of reality, acceptance by adult caretakers and even the emotional survival of the child may all depend on the knowledge and skill of the clinical advocate. Every clinician must be capable of understanding and articulating the position of the child in the prevailing adult imbalance of credibility. Without awareness of the child's reality the professional will tend to reflect traditional mythology and to give the stamp of scientific authority to continuing stigmatization of the child.

Clinical study of large numbers of children and their parents in proven cases of sexual abuse provides emphatic contradictions to traditional views. What emerges is a typical behavior pattern or syndrome of mutually dependent variables which allows for immediate survival of the child within the family but which tends to isolate the child from eventual acceptance, credibility or empathy within the larger society. The mythology and protective denial surrounding sexual abuse can be seen as a natural consequence both of the stereotypic coping mechanisms of the child victim and the need of almost all adults to insulate themselves from the painful realities of childhood victimization.

The accommodation process intrinsic to the world of child sexual abuse inspires prejudice and rejection in any adult who chooses to remain aloof from the helplessness and pain of the child's dilemma or who expects that a child should behave in accordance with adult concepts of self-determinism and autonomous, rational choices. Without a clear understanding of the accommodation syndrome, clinical specialists tend to reinforce the comforting belief that children are only rarely legitimate victims of unilateral sexual abuse and that among the few complaints that surface, most can be dismissed as fantasy, confusion, or a displacement of the child's own wish for power and seductive conquest. Clinical awareness of the sexual abuse accommodation syndrome is essential to provide a counterprejudicial explanation to the otherwise self-camouflaging and self-stigmatizing behavior of the victim.

The purpose of this paper then, is to provide a vehicle for a more sensitive, more therapeutic response to legitimate victims of child sexual abuse and to invite more active, more effective clinical advocacy for the child within the family and within the systems of child protection and criminal justice.

### **Sources and Validity**

This study draws in part from statistically validated assumptions regarding prevalence, age relationships and role characteristics of child sexual abuse and in part from

correlations and observations that have emerged as self-evident within an extended network of child abuse treatment programs and self-help organizations. The validity of the accommodation syndrome as defined here has been tested over a period of four years in the author's practice, which specializes in community consultation to diverse clinical and para-clinical sexual abuse programs. The syndrome has elicited strong endorsements from experienced professionals and from victims, offenders and other family members. Hundreds of training symposia shared with specialists throughout the United States and Canada have reached thousands of individuals who have had personal and/or professional involvement in sexual abuse. Discussion of the syndrome typically opens a floodgate of recognition of previously uncorrelated or disregarded observations. Adults who have guarded a shameful secret for a lifetime find permission to remember and to discuss their childhood victimization. Family members who have disowned identified victims find a basis for compassion and reunion. Children still caught up in secrecy and self-blame find hope for advocacy. And professionals who had overlooked indications of sexual abuse find a new capacity for recognition and involvement.

A syndrome should not be viewed as a procrustean bed which defines and dictates a narrow perception of something as complex as child sexual abuse. Just as the choice to sexualize the relationship with a child includes a broad spectrum of adults acting under widely diverse motivations and rationalizations<sup>43</sup>, the options for the child are also variable. A child who seeks help immediately or who gains effective intervention should not be discarded as contradictory, any more than the syndrome should be discarded if it fails to include every possible variant. The syndrome represents a common denominator of the most frequently observed victim behaviors.

In the current state of the art most of the victims available for study are young females molested by adult males entrusted with their care. Young male victims are at least as frequent, just as helpless and even more secretive than young females.<sup>9,44,45</sup>

Because of the extreme reluctance of males to admit to sexual victimization experiences and because of the greater probability that a boy will be molested by someone outside of the nuclear family, less is known about possible variations in accommodation mechanisms of sexually abused males. Various aspects of secrecy, helplessness, and self-alienation seem to apply as does an even greater isolation from validation and endorsement by incredulous parents and other adults. There is an almost universal assumption that a man who molests a boy must be homosexual. Since the habitual molester of boys is rarely attracted to adult males,<sup>46</sup> he finds ready exoneration in clinical examination and character endorsements. While there is some public capacity to believe that girls may be helpless victims of sexual abuse, there is almost universal repudiation of the boy victim.

For the sake of brevity and clarity, the child sexual abuse accommodation syndrome is presented in this paper as it applies to the most typical female victim. There is no intent to minimize nor to exclude the substantial hardships of male victims or to ignore the conspicuously small minority of offenders who are female. A more comprehensive discussion of role variants within an extended syndrome is presented elsewhere.<sup>47</sup> In the following discussion the feminine pronoun is used generically for the child rather than the more cumbersome he/she. This convention is not meant to discourage application of the accommodation syndrome to male victims or to the shared experience of males and female co-victims wherever clinical experience indicates appropriate correlations.

## The Child Sexual Abuse Accommodation Syndrome

The syndrome include five categories, two of which are preconditions to the occurrence of sexual abuse. The remaining three categories are sequential contingencies which take on increasing variability and complexity. While it can be shown that each category reflects a compelling reality for the victim, each category represents also a contradiction to the most common assumptions of adults. The five categories of the syndrome are:

1. Secrecy
2. Helplessness
3. Entrapment and accommodation
4. Delayed, conflicted and unconvincing disclosure
5. Retraction

### 1. Secrecy

Initiation, intimidation, stigmatization, isolation, helplessness and self-blame depend on a terrifying reality of child sexual abuse: it happens only when the child is alone with the offending adult, and it must never be shared with anyone else.

Virtually no child is prepared for the possibility of molestation by a trusted adult; that possibility is a well kept secret even among adults. The child is, therefore, entirely dependent on the intruder for whatever reality is assigned to the experience. Of all the inadequate, illogical, self-serving, or self-protective explanations provided by the adult, the only consistent and meaningful impression gained by the child is one of danger and fearful outcome based on secrecy.<sup>22,48</sup> “This is our secret; nobody else will understand.” “Don’t tell anybody.” “Nobody will believe you.” “Don’t tell your mother; (a) she will hate you, (b) she will hate me, (c) she will kill you, (d) she will kill me, (e) it will kill her, (f) she will send you away, (g) she will send me away, or (h) it will break up the family and you’ll all end up in an orphanage.” “If you tell anyone (a) I won’t love you anymore, (b) I’ll spank you, (c) I’ll kill your dog, or (d) I’ll kill you.” However gentle or menacing the intimidation may be, the secrecy makes it clear to the child that this is something bad and dangerous. The secrecy is both the source of fear and the promise of safety: “Everything will be all right if you just don’t tell.” The secret takes on magical, monstrous proportions for the child. A child with no knowledge or awareness of sex and even with no pain or embarrassment from the sexual experience itself will still be stigmatized with a sense of badness and danger from the pervasive secrecy.

Any attempts by the child to illuminate the secret will be countered by an adult conspiracy of silence and disbelief. “Don’t worry about things like that; that could never happen in our family.” “Nice children don’t talk about things like that.” “Uncle Johnnie doesn’t mean you any harm; that’s just his way of showing how he loves you.” “How could you ever think of such a terrible thing?” “Don’t let me ever hear you say anything like that again!”

The average child never asks and never tells. Contrary to the general expectation that the victim would normally seek help, the majority of the victims in retrospective surveys had never told anyone during their childhood.<sup>22,42,49,50</sup> Respondents expressed fear that they would be blamed for what had happened or that a parent would not be able to protect

them from retaliation. Many of those who sought help reported that parents became hysterical or punishing or pretended that nothing had happened.<sup>42</sup> Yet adult expectation dominates the judgment applied to disclosures of sexual abuse. When the child does not immediately complain, it is painfully apparent to any child that there is no second chance. “Why didn’t you tell me?” “How could you keep such a thing secret?” “What are you trying to hide?” “Why did you wait until now if it really happened so long ago?” “How can you expect me to believe such a fantastic story?” Unless the victim can find some permission and power to share the secret and unless there is the possibility of an engaging, non-punitive response to disclosure, the child is likely to spend a lifetime in what comes to be a self-imposed exile from intimacy, trust and self-validation.

## 2. Helplessness

The adult expectation of child self-protection and immediate disclosure ignores the basic subordination and helplessness of children within authoritarian relationships. Children may be given permission to avoid the attentions of strangers, but they are required to be obedient and affectionate with any adult entrusted with their care. Strangers, “weirdos,” kidnappers, and other monsters provide a convenient foil for both child and parent against a much more dreadful and immediate risk: the betrayal of vital relationships, abandonment by trusted caretakers and annihilation of basic family security. All available research is remarkably consistent in a discomfiting statistic: a child is three times more likely to be molested by a recognized, trusted adult than by a stranger.<sup>9,42,44,50</sup> The risk is not at all remote. Even the most conservative survey implies that about 10% of *all* females have been sexually victimized as children by an adult relative, including almost 2% involving the man in the role of father.<sup>42</sup> The latest and most representative survey reports a 16% prevalence of molestation by relatives. Fully 4.5% of the 930 women interviewed reported an incestuous relationship with their father or father-figure.<sup>50</sup>

A corollary to the expectation of self-protection is the general assumption that uncomplaining children are acting in a consenting relationship. This expectation is dubious even for the mythic seductive adolescent. Given the assumption that an adolescent can be sexually attractive, seductive and even deliberately provocative, it should be clear that no child has equal power to say no to a parental figure or to anticipate the consequences of sexual involvement with an adult caretaker. Ordinary ethics demand that the adult in such a mismatch bear sole responsibility for any clandestine sexual activity with a minor.<sup>51</sup>

In reality, though, the child partner is most often neither sexually attractive nor seductive in any conventional sense. The stereotype of the seductive adolescent is an artifact both of delayed disclosure and a prevailing adult wish to define child sexual abuse within a model that approximates logical adult behavior.

We can believe that a man might normally be attracted to a nubile child-woman. Only perversion could explain attraction to an undeveloped girl or boy, and the men implicated in most ongoing sexual molestations are quiet obviously not perverted. They tend to be hard-working, devoted family men. They may be better educated, more law-abiding, and more religious than average.

As clinical experience in child sexual intervention has increased, the reported age of initiation has decreased. In 1979, a typical average was a surprisingly prepubescent nine years. By 1981, the federally funded national training models reported the average age of initiation as seven years.<sup>52</sup> At the Harborview Sexual Assault Center in Seattle, 25% of the children presenting for treatment are five years of age or younger.<sup>53</sup>

The prevailing reality for the most frequent victim of child sexual abuse is not a street or schoolground experience and not some mutual vulnerability to oedipal temptations, but an unprecedented, relentlessly progressive intrusion of sexual acts by an overpowering adult in a one-sided victim-perpetrator relationship. The fact that the perpetrator is often in a trusted and apparently loving position only increases the imbalance of power and underscores the helplessness of the child.

Children often describe their first experiences as waking up to find their father (or stepfather, or mother's live-in companion) exploring their bodies with hands or mouth. Less frequently, they may find a penis filling their mouth or probing between their legs. Society allows the child one acceptable set of reactions to such an experience. Like the adult victim of rape, the child victim is expected to forcibly resist, to cry for help and to attempt to escape the intrusion. By that standard, almost every child fails.

The normal reaction is to "play possum," that is, to feign sleep, to shift position and to pull up the covers. Small creatures simply do not call on force to deal with overwhelming threat. When there is no place to run, they have no choice but to try to hide. Children generally learn to cope silently with terrors in the night. Bed covers take on magical powers against monsters, but they are no match for human intruders.

It is sad to hear children attacked by attorneys and discredited by juries because they claimed to be molested yet admitted they had made no protest nor outcry. The point to emphasize here is not so much the miscarriage of justice as the continuing assault on the child. If the child's testimony is rejected in court, there is more likely to be a rejection by the mother and other relatives who may be eager to restore trust in the accused adult and to brand the child as malicious. Clinical experience and expert testimony can provide advocacy for the child. Children are easily ashamed and intimidated both by their helplessness and by their inability to communicate their feelings to uncomprehending adults. They need an adult clinical advocate to translate the child's world into an adult-acceptable language.

The intrinsic helplessness of a child clashes with the cherished adult sense of free will. Adults need careful guidance to risk empathizing with the absolute powerlessness of the child; they have spent years repressing and distancing themselves from that horror. Adults tend to despise helplessness and to condemn anyone who submits too easily to intimidation. A victim will be judged as a willing accomplice unless compliance was achieved through overwhelming force or threat of violence. Adults must be reminded that the wordless action or gesture of a parent is an absolutely compelling force for a dependent child and the threat of loss of love or loss of family security is more frightening to the child than any threat of violence.

Questions of free will and compliance are not just legal rhetoric. It is necessary for the emotional survival of the child that adult custodians give permission and endorsement to the helplessness and noncomplicity of the initiate's role. Adult prejudice is contagious. Without a consistent therapeutic affirmation of innocence, the victim tends to become filled with self-condemnation and self-hate for somehow inviting and allowing the sexual assaults.

As an advocate for the child, both in therapy and in court, it is necessary to recognize that no matter what the circumstances, the child had no choice but to submit quietly and to keep the secret. No matter if mother was in the next room or if siblings were asleep in the same bed. The more illogical and incredible the initiation scene might seem to adults, the more likely it is that the child's plaintive description is valid. A caring father would not logically act as the child describes; if nothing else, it seems incredible that he would take such flamboyant risks. That logical analysis contains at least two naive assumptions: (1) the molestation is thoughtful and (2) that it is risky. Molestation of a child is not a thoughtful gesture of caring, but a desperate, compulsive search for acceptance and submission.<sup>54</sup> There is very little risk of discovery if the child is young enough and if there is an established relationship of authority and affection. Men who seek children as sexual partners discover quickly something that remains incredible to less impulsive adults: dependent children are helpless to resist or to complain. A letter to Ann Landers illustrates very well the continuing helplessness and pervasive secrecy associated with incestuous abuse:

Dear Ann:

Last week my 32-year-old sister told me she had been sexually molested by our father from age 6 to 16. I was stunned, because for 20 years I had kept the same secret from anyone. I am now 30. We decided to talk to our three other sisters, all in their 20's. It turned out that our father had sexually molested each and every one of us. We all thought we were being singled out for that humiliating, ugly experience, and were too ashamed and frightened to tell anyone, so we all kept our mouths shut.

Father is now 53. To look at him, you would think he was the all-American dad. Mom is 51. She would die if she had any idea of what he had been doing to his daughters all these years.<sup>55</sup>

### 3. Entrapment and Accommodation

For the child within a dependent relationship sexual molestation is not typically a one-time occurrence. The adult may be racked with regrets, guilt, fear and resolutions to stop, but the forbidden quality of the experience and the unexpected ease of accomplishment seem to invite repetition. A compulsive, addictive pattern tends to develop which continues either until the child achieves autonomy or until discovery and forcible prohibition overpower the secret.<sup>22</sup>

If the child did not seek or did not receive immediate protective intervention, there is no further option to stop the abuse. The only healthy option left for the child is to learn to accept the situation and to survive. There is no way out, no place to run. The healthy, normal, emotionally resilient child will learn to accommodate to the reality of continuing sexual abuse. There is the challenge of accommodating not only to escalating sexual demands but to an increasing consciousness of betrayal and objectification by someone who is ordinarily idealized as a protective, altruistic, loving parental figure. Much of what is eventually labeled as adolescent or adult psychopathology can be traced to the natural reactions of a healthy child to a profoundly unnatural and unhealthy parental

environment. Pathological dependency, self-punishment, self-mutilation, selective restructuring of reality and multiple personalities, to name a few, represent habitual vestiges of painfully learned childhood survival skills. In dealing with the accommodation mechanisms of the child or the vestigial scars of the adult survivor, the therapist must take care to avoid reinforcing a sense of badness, inadequacy or craziness by condemning or stigmatizing the symptoms.

The child faced with continuing helpless victimization must learn to somehow achieve a sense of power and control. The child cannot safely conceptualize that a parent might be ruthless and self-serving; such a conclusion is tantamount to abandonment and annihilation. The only acceptable alternative for the child is to believe that she has provoked the painful encounters and to hope that by learning to be good she can earn love and acceptance. The desperate assumption of responsibility and the inevitable failure to earn relief set the foundation for self-hate and what Shengold describes as a vertical split in reality testing.

If the very parent who abuses and is experienced as *bad* must be turned to for relief of the distress that the parent has caused, then the child must, out of desperate need, register the parent—*delusionally*—as good. Only the mental image of a good parent can help the child deal with the terrifying intensity of fear and rage which is the effect of the tormenting experiences. The alternative—the maintenance of the overwhelming stimulation and the bad parental imago—means annihilation of identity, of the feeling of the self. So the bad has to be registered as good. This is a mind-splitting or a mind fragmenting operation.<sup>56</sup>

Shengold's use of the word *delusionally* does not assume a psychotic process or a defect in perception, but rather the practiced ability to reconcile contradictory realities. As he continues later on the same page,

I am not describing schizophrenia... but the establishment of isolated divisions of the mind that provides the mechanism for a pattern in which contradictory images of the self and of the parents are never permitted to coalesce. (This compartmentalized 'vertical splitting' transcends diagnostic categories; I am deliberately avoiding bringing in the correlatable pathological formations of Winnicott, Korbust, and Kernberg.)<sup>56</sup>

The sexually abusing parent provides graphic example and instruction in how to be good, that is, the child must be available without complaint to the parent's sexual demands. There is an explicit or implicit promise of reward. If she is good and if she keeps the secret, she can protect her siblings from sexual involvement ("It's a good thing I can count on you to love me; otherwise I'd have to turn to your little sister"), protect her mother from disintegration ("If your mother ever found out, it would kill her"), protect her father from temptation ("If I couldn't count on you, I'd have to hang out in bars and look for other women"), and, most vitally preserve the security of the home ("If you ever tell, they could send me to jail and put all you kids in an orphanage").

In the classic role reversal of child abuse, the child is given the power to destroy the family and the responsibility to keep it together. The child, *not the parent*, must mobilize

the altruism and self-control to insure the survival of the others. The child, in short, must secretly assume many of the role-functions ordinarily assigned to the mother.

There is an inevitable splitting of conventional moral values. Maintaining a lie to keep the secret is the ultimate virtue, while telling the truth would be the greatest sin. A child thus victimized will appear to accept or to seek sexual contact without complaint.

Since the child must structure her reality to protect the parent, she also finds the means to build pockets of survival where some hope of goodness can find sanctuary. She may turn to imaginary companions for reassurance. She may develop multiple personalities, assigning helplessness and suffering to one, badness and rage to another, sexual power to another, love and compassion to another, etc. She may discover altered states of consciousness to shut off pain or to dissociate from her body, as if looking on from a distance at the child suffering the abuse. The same mechanisms which allow psychic survival for the child become handicaps to effective psychological integration as an adult. If the child cannot create a psychic economy to reconcile the continuing outrage, the intolerance of helplessness and the increasing feeling of rage will seek active expression. For the girl this often leads to self-destruction and reinforcement of self-hate; self-mutilation, suicidal behavior, promiscuous sexual activity and repeated runaways are typical. She may learn to exploit the father for privileges, favors and material rewards, reinforcing her self-punishing image as “whore” in the process. She may fight with both parents, but her greatest rage is likely to focus on her mother, whom she blames for abandoning her to her father. She assumes that her mother must know of the sexual abuse and is either too uncaring or too ineffectual to intervene. Ultimately the child tends to believe that she is intrinsically so rotten that she was never worth caring for. The failure of the mother-daughter bond reinforces the young woman’s distrust of herself as a female and makes her all the more dependent on the pathetic hope of gaining acceptance and protection with an abusive male.

For many victims of sexual abuse the rage incubates over the years of facade, coping and frustrating, counterfeit attempts at intimacy, only to erupt as a pattern of abuse against offspring in the next generation. The ungratifying, imperfect behavior of the young child and the diffusion of ego boundaries between parent and child invite projection of the bad introject and provide a righteous, impulsive outlet for the explosive rage.

The male victim of sexual abuse is more likely to turn his rage outward in aggressive and antisocial behavior. He is even more intolerant of his helplessness than the female victim and more likely to rationalize that he is exploiting the relationship for his own benefit. He may cling so tenaciously to an idealized relationship with the adult that he remains fixed at a preadolescent level of sexual object choice, as if trying to keep love alive with an unending succession of young boys. Various admixtures of depression, counterphobic violence, misogyny (again, the mother is seen as non-caring and unprotective), child molestation and rape seem to be part of the legacy of rage endowed in the sexually abused boy.<sup>45</sup>

Substance abuse is an inviting avenue of escape for the victim of either gender. As Myers recalls, “On drugs, I could be anything I wanted to be. I could make up my own reality; I could be pretty, have a good family, a nice father, a strong mother, and be happy... drinking had the opposite effect of drugs... Drinking got me back into my pain; it allowed me to experience my hurt and my anger.”<sup>57</sup>

It is worth restating that all these accommodation mechanisms—domestic martyrdom, splitting of reality, altered consciousness, hysterical phenomena, delinquency,

sociopathy, projection of rage, even self-mutilation—are part of the survival skills of the child. They can be overcome only if the child can be led to trust in a secure environment which can provide consistent, *noncontingent* acceptance and caring. In the meantime, anyone working therapeutically with the child (or the grown-up, still-shattered victim) may be tested and provoked to prove that trust is impossible,<sup>22</sup> and that the only secure reality is negative expectations and self-hate. It is all too easy for the would-be therapist to join the parents and all of adult society in rejecting such a child, looking at the results of abuse to assume that such an “impossible wretch” must have asked for and deserved whatever punishment had occurred, if indeed the whole problem is not a hysterical or vengeful fantasy.

#### 4. Delayed, Conflicted, and Unconvincing Disclosure

Most ongoing sexual abuse is *never* disclosed, at least not outside the immediate family.<sup>8,22,49,50</sup> Treated, reported or investigated cases are the exception, not the norm. Disclosure is an outgrowth either of overwhelming family conflict, incidental discovery by a third party, or sensitive outreach and community education by child protective agencies.

If family conflict triggers disclosure, it is usually only after some years of continuing sexual abuse and an eventual breakdown of accommodation mechanisms. The victim of incestuous abuse tends to remain silent until she enters adolescence when she becomes capable of demanding a more separate life for herself and challenging the authority of her parents. Adolescence also makes the father more jealous and controlling, trying to sequester his daughter against the “dangers” of outside peer involvement. The corrosive effects of accommodation seem to justify any extreme of punishment. What parent would not impose severe restrictions to control running away, drug abuse, promiscuity, rebellion and delinquency?

After an especially punishing family fight and a belittling showdown of authority by the father, the girl is finally driven by anger to let go of the secret. *She seeks understanding and intervention at the very time she is least likely to find them.* Authorities are alienated by the pattern of delinquency and rebellious anger expressed by the girl. Most adults confronted with such a history tend to identify with the problems of the parents in trying to cope with a rebellious teenager. They observe that the girl seems more angry about the immediate punishment than about the sexual atrocities she is alleging. They assume there is no truth to such a fantastic complaint, especially since the girl did not complain years ago when she claims she was forcibly molested. They assume she has invented the story in retaliation against the father’s attempts to achieve reasonable control and discipline. The more unreasonable and abusive the triggering punishment, the more they assume the girl would do anything to get away, even to the point of falsely incriminating her father. Unless specifically trained and sensitized, average adults, including mothers, relatives, teachers, counselors, doctors, psychotherapists, investigators, prosecutors, defense attorneys, judges and jurors, cannot believe that a normal, truthful child would tolerate incest without immediately reporting or that an apparently normal father could be capable of repeated, unchallenged sexual molestation of his own daughter. The child of any age faces an unbelieving audience when she complains of ongoing sexual abuse. The troubled, angry adolescent risks not only disbelief, but scapegoating, humiliation and punishment as well.

Not all complaining adolescents appear angry and unreliable. An alternative accommodation pattern exists in which the child succeeds in hiding any indications of conflict. Such a child may be unusually achieving and popular, eager to please both teachers and peers. When the honor student or the captain of the football team tries to describe a history of ongoing sexual involvement with an adult, the adult reaction is all the more incredulous. "How could such a thing have happened to such a fine young person?" "No one so talented and well-adjusted could have been involved in something so sordid." Obviously, it did not happen or, if it did, it certainly did not harm the child. So there is no real cause for complaint. Whether the child is delinquent, hypersexual, countersexual, suicidal, hysterical, psychotic, or perfectly well-adjusted, and whether the child is angry, evasive or serene, the immediate affect and the adjustment pattern of the child will be interpreted by adults to invalidate the child's complaint.

Contrary to popular myth most mothers are not aware of ongoing sexual abuse. Marriage demands considerable blind trust and denial for survival. A woman does not commit her life and security to a man she believes capable of molesting his own children. The "obvious" clues to sexual abuse are usually obvious only in retrospect. Our assumption that the mother "must have known" merely parallels the demand of the child that the mother must be in touch intuitively with invisible and even deliberately concealed family discomfort.

The mother typically reacts to allegations of sexual abuse with disbelief and protective denial. How could she not have known? How could the child wait so long to tell her? What kind of mother could allow such a thing to happen? What would the neighbors think? As someone substantially dependent on the approval and generosity of the father, the mother in the incestuous triangle is confronted with a mind-splitting dilemma analogous to that of the abused child. Either the child is bad and deserving of punishment or the father is bad and unfairly punitive. One of them is lying and unworthy of trust. The mother's whole security and life adjustment and much of her sense of adult self-worth demand a trust in the reliability of her partner. To accept the alternative means annihilation of the family and a large piece of her own identity. Her fear and ambivalence are reassured by the father's logical challenge, "Are you going to believe that lying little slut? Can you believe I would do such a thing? How could something like that go on right under your nose for years? You know we can't trust her out of our sight anymore. Just when we try to clamp down and I get a little rough with her, she comes back with a ridiculous story like this. That's what I get for trying to keep her out of trouble."

Of the minority of incest secrets that are disclosed to the mother or discovered by the mother, very few are subsequently reported to outside agencies<sup>50</sup>. The mother will either disbelieve the complaint or try to negotiate a resolution within the family. Now that professionals are required to report any suspicion of child abuse, increasing numbers of complaints are investigated by protective agencies. Police investigators and protective service workers are likely to give credence to the complaint, in which case all the children may be removed immediately into protective custody pending hearing of a dependency petition. In the continuing paradox of a divided judicial system, the juvenile court judge is likely to sustain out-of-home placement in the "preponderance of the evidence" that the child is in danger, while no charges are even filed in the adult court which would consider the father's criminal responsibility. Attorneys know that the uncorroborated testimony of a child will not convict a respectable adult. The test in

criminal court requires specific proof “beyond a reasonable doubt,” and every reasonable adult juror will have reason to doubt the child’s fantastic claims. Prosecutors are reluctant to subject the child to humiliating cross-examination just as they are loath to prosecute cases they cannot win. Therefore, they typically reject the complaint on the basis of insufficient evidence.

Out-of-family molesters are also effectively immune from incrimination if they have any amount of prestige. Even if several children have complained, their testimony will be impeached by trivial discrepancies in their accounts or by the countercharge that the children were willing and seductive conspirators.

The absence of criminal charges is tantamount to a conviction of perjury against the victim. “A man is innocent until proven guilty,” say adult-protective relatives. “The kid claimed to be molested but there was nothing to it. The police investigated and they didn’t even file charges.” Unless there is expert advocacy for the child in the criminal court, the child is likely to be abandoned as the helpless custodian of a self-incriminating secret which no responsible adult can believe.

The psychiatrist or other counseling specialist has a crucial role in early detection, treatment intervention and expert courtroom advocacy. The specialist must help mobilize skeptical caretakers into a position of belief, acceptance, support and protection of the child. The specialist must first be capable of assuming that same position. The counselor who learns to accept the secrecy, the helplessness, the accommodation and the delayed disclosure may still be alienated by the fifth level of the accommodation syndrome.

## 5. Retraction

*Whatever a child says about the sexual abuse, she is likely to reverse it.* Beneath the anger of impulsive disclosure remains the ambivalence of guilt and the martyred obligation to preserve the family. In the chaotic aftermath of disclosure, the child discovers that the bedrock fears and threats underlying the secrecy are true. Her father abandons her and calls her a liar. Her mother does not believe her or decompensates into hysteria and rage. The family is fragmented, and all the children are placed in custody. The father is threatened with disgrace and imprisonment. The girl is blamed for causing the whole mess, and everyone seems to treat her like a freak. She is interrogated about all the tawdry details and encouraged to incriminate her father, yet the father remains unchallenged, remaining at home in the security of the family. She is held in custody with no apparent hope of returning home if the dependency position is maintained. The message from the mother is very clear, often explicit. “Why do you insist on telling those awful stories about your father? If you send him to prison, we won’t be a family anymore. We’ll end up on welfare with no place to stay. Is that what *you* want to do to us?”

Once again, the child bears the responsibility of either preserving or destroying the family. The role reversal continues with the “bad” choice being to tell the truth and the “good” choice being to capitulate and restore a lie for the sake of the family.

*Unless there is special support for the child and immediate intervention to force responsibility on the father, the girl will follow the “normal” course and retract her complaint.* The girl “admits” she made up the story. “I was awful mad at my dad for punishing me. He hit me and said I could never see my boyfriend again. I’ve been really bad for years and nothing seems to keep me from getting into trouble. Dad had plenty of reason to be mad at me. But I got real mad and just had to find some way of getting out

of that place. So I made up this story about him fooling around with me and everything. I didn't mean to get everyone in so much trouble."

This simple lie carries more credibility than the most explicit claims of incestuous entrapment. It confirms adult expectations that children cannot be trusted. It restores the precarious equilibrium of the family. The children learn not to complain. The adults learn not to listen. And the authorities learn not to believe rebellious children who try to use their sexual power to destroy well-meaning parents.

## Discussion

It should be obvious that, left unchallenged, the sexual abuse accommodation syndrome tends to reinforce both the victimization of children and societal complacency and indifference to the dimensions of that victimization. It should be obvious to clinicians that the power to challenge and to interrupt the accommodation process carries an unprecedented potential for primary prevention of emotional pain and disability, including an interruption in the intergenerational chain of child abuse.

What is not so obvious is that mental health specialists may be more skeptical of reports of sexual abuse and more hesitant to involve themselves as advocates for children than many professionals with less specific training. The apparent cause-and-effect relationships and the emphasis on unilateral intrusions by powerful adults may seem naive and regressive to anyone trained in more sophisticated family dynamics, where events are viewed as an equilibrium of needs and provocations within the system as a whole.<sup>58</sup> Freud led a trend from the victim-perpetrator concept to a more universal and intellectually stimulating view in 1897 when he renounced his own child seduction theory of hysteria for the seductive child thesis of the Oedipus complex.<sup>16,59-61</sup> Even if a substantial number of descriptions of sexual victimization prove to be valid, how can they be distinguished from those that should be treated as fantasy or deception? Rosenfeld<sup>62</sup> has addressed these questions in a general sense but a nagging uncertainty persists. The victim of child sexual abuse is in a position somewhat analogous to that of the adult rape victim prior to 1974. Without a consistent clinical understanding of the psychological climate and adjustment patterns of rape, women were assumed to be provocative and substantially responsible for inviting or exposing themselves to the risk of attack. The fact that most women chose not to report their own victimization only confirmed the unchallenged suspicion that they had something to hide. Those who reported often regretted their decision as they found themselves subjected to repeated attacks on their character and credibility.

The turnaround for adult victims came with publication of a landmark paper in the clinical literature during a time of aroused protest led by the women's movement. *Rape Trauma Syndrome* by Burgess and Holmstrom appeared in 1974.<sup>63</sup> It provided guidelines for recognition and management of the traumatic psychological sequelae and established a logical sequence of the victim's shame, self-blame, and secrecy which so typically camouflaged the attack. Its publication initiated what proved to be a trend toward more sympathetic reception of rape victims both in clinics and in courts.

A similar reception is long overdue for juvenile victims.<sup>24</sup> Ironically, the same clinical study that defined the rape trauma syndrome led the authors to describe a related set of circumstances observed in children treated within the Boston Hospital Victim Counseling

Program. *Sexual Trauma of Children and Adolescents: Pressure, Sex and Secrecy* was published in 1975.<sup>64</sup> The first paragraph concludes: “The emotional reactions of victims result from their being pressured into sexual activity and from the added tension of keeping the act secret.”

The narrative describes the elements of helplessness and the pressure to maintain secrecy. The fear of rejection and disbelief is documented by poignant clinical vignettes as are several mechanisms of accommodation and the traumatic effects of unsupported disclosure. The discussion challenges earlier studies indicating willing or seductive participation.

In reviewing our data on child and adolescent victims, we have tried to avoid traditional ways of viewing the problem and instead to describe, from the victim’s point of view, the dynamics involved between offender and victim regarding the issues of inability to consent, adaptive behavior, secrecy, and the disclosure of the secret... Our data clearly indicates that a syndrome of symptom reaction is the result of pressure to keep the activity secret as well as the result of the disclosure... It may be speculated that there are many children with silent reaction to sexual trauma. The child who responds to the pressure to go along with the sexual activity with adults may be viewed as showing an adaptive response for survival in the environment.<sup>65</sup>

If there had been an aroused protest for protection of children in 1975, the vanguard observations of Burgess and Holmstrom might have marked a turnaround for more sympathetic reception of child victimization. Since child advocacy suffers in competition with adult interests, there has been at best an evolutionary rather than a revolutionary response within the clinical and judicial fields. It is, therefore, appropriate to recall the rape trauma syndrome as a model for increasing the sensitivity of counselors and of legal counselors and to restate the sexual trauma of children and adolescents as seen with an additional eight years of multiagency experience and nationwide correlation.

## Conclusion

Sexual abuse of children is not a new phenomenon although its true dimensions are emerging only through recent awareness and study. Children have been subject to molestation, exploitation and intimidation by supposed caretakers throughout history.<sup>66</sup> What is changing most in our present generation is the sensitivity to recognize exploitation, to identify blatant inequities in parenting among otherwise apparently adequate families, and to discover that such inequities have a substantial impact on the character development, personality integration and emotional well-being of the more deprived and mistreated children.

Freud could find no precedent in 1897 for any number of respectable parents victimizing their children. “Then there was the astonishing thing that in every case... blame was laid on perverse acts by the father, and the realization of the unexpected frequency of hysteria, in every case of which the same applied, though it was hardly credible that perverted acts against children were so general.”<sup>67</sup>

In the 1980's we can no longer afford to be incredulous of basic realities of child abuse. The growing body of literature emanating from the now classic paper, *The Battered Child Syndrome*,<sup>68</sup> published in 1962, gives ample precedent and a 20-year perspective for the certain recognition that perverted acts against children are, in fact, so general. Sexual molestation was called the last frontier in child abuse in 1975 by Sgroi, an internist, who was already in a position to identify the reluctance of many clinicians to accept the problem.<sup>69</sup>

*Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist. Unfortunately, willingness to consider the diagnosis of suspected child sexual molestation frequently seems to vary in inverse proportion to the individual's level of training. That is, the more advanced the training of some, the less willing they are to suspect molestation.*

It is urgent in the interests both of treatment and of legal advocacy and for the sake of primary, secondary and tertiary prevention of diverse emotional disabilities that clinicians in every field of the behavioral sciences be more aware of child sexual abuse. It is countertherapeutic and unjust to expose legitimate victims to evaluations or treatment by therapists who cannot suspect or "believe in" the possibility of unilateral sexual victimization of children by apparently normal adults.

The sexual abuse accommodation syndrome is derived from the collective experience of dozens of sexual abuse treatment centers in dealing with thousands of reports or complaints of adult victimization of young children. In the vast majority of these cases the identified adult claimed total innocence or admitted only to trivial, well-meaning attempts at "sex education," wrestling, or affectionate closeness. After a time in treatment the men almost invariably conceded that the child had told the truth. Of the children who were found to have misrepresented their complaints, most had sought to *understate* the frequency or duration of sexual experiences, even when reports were made in anger and in apparent retaliation against violence or humiliation. Very few children, no more than two or three per *thousand*, have ever been found to exaggerate or to invent claims of sexual molestation.<sup>70</sup> 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.<sup>8</sup>

The clinician with an understanding of the child sexual abuse accommodation syndrome offers the child a right to parity with adults in the struggle for credibility and advocacy. Neither the victim, the offender, the family, the next generation of children in that family, nor the well-being of society as a whole can benefit from continuing secrecy and denial of ongoing sexual abuse. The offender who protects an uneasy position of power over the silent victims will not release his control unless he is confronted by an outside power sufficient to demand and to supervise a total cessation of sexual harassment.<sup>13,22,25,32,71</sup>

The counselor alone cannot expect cooperation and recovery in an otherwise reluctant and unacknowledged offender. The justice system alone can rarely prove guilt or impose sanctions without preparation and continuing support of all parties within an effective

treatment system. All agencies working as a team give maximum promise of effective recovery for the victim, rehabilitation of the offender and survival of the family.<sup>24,71</sup> The child sexual abuse accommodation syndrome provides a common language for the several viewpoints of the intervention team and a more recognizable map to the last frontier in child abuse.

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## The Traumatic Impact of Child Sexual Abuse: A Conceptualization

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### Abstract

A framework is proposed for a more systematic understanding of the effects of child sexual abuse. Four traumagenic dynamics—traumatic sexualization, betrayal, stigmatization, and powerlessness—are identified as the core of the psychological injury inflicted by abuse. These dynamics can be used to make assessments of victimized children and to anticipate problems to which these children may be vulnerable subsequently. Implications for research are also considered.

### Introduction

The literature on child sexual abuse is full of clinical observations about problems that are thought to be associated with a history of abuse, such as sexual dysfunction, depression, and low self-esteem. However, such observations have not yet been organized into a clear model that specifies how and why sexual abuse results in this kind of trauma. This paper is an attempt to provide such a model. Based on a review of the literature on the effects of sexual abuse,<sup>6</sup> the paper suggests a conceptualization of the impact of sexual abuse that can be used in both research and treatment.

The model proposed here postulates that the experience of sexual abuse can be analyzed in terms of four trauma-causing factors, or what we will call *traumagenic dynamics*—traumatic sexualization, betrayal, powerlessness, and stigmatization. These traumagenic dynamics are generalized dynamics, not necessarily unique to sexual abuse: they occur in other kinds of trauma. But the conjunction of these four dynamics in one set of circumstances is what makes the trauma of sexual abuse unique, different from such childhood traumas as the divorce of a child's parents or even being the victim of physical child abuse.

These dynamics alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities. For example, the dynamic of stigmatization distorts children's sense of their own value and worth. The dynamic of powerlessness distorts children's sense of their ability to control their lives. Children's attempts to cope with the world through these distortions may result in some of the behavioral problems that are commonly noted in victims of child sexual abuse. This paper will describe the model and suggest some of its ramifications and uses. We will first describe each of the four dynamics and then show how each dynamic is associated with some of the commonly observed effects of sexual abuse. We will conclude by illustrating how the model can be used in clinical work and in research.

## Four Traumagenic Dynamics

**Traumatic sexualization** refers to a process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. This can happen in a variety of ways in the course of the abuse. Traumatic sexualization can occur when a child is repeatedly regarded by an offender for sexual behavior that is inappropriate to his or her level of development. It occurs through the exchange of affection, attention, privileges, and gifts for sexual behavior, so that a child learns to use sexual behavior as a strategy for manipulating others to satisfy a variety of developmentally appropriate needs. It occurs when certain parts of a child's anatomy are fetishized and given distorted importance and meaning. It occurs through the misconceptions and confusions about sexual behavior and sexual morality that are transmitted to the child from the offender. And it occurs when very frightening memories and events become associated in the child's mind with sexual activity.

Sexual abuse experiences can vary dramatically in terms of the amount and kind of traumatic sexualization they provoke. Experiences in which the offender makes an effort to evoke the child's sexual response, for example, are probably more sexualizing than those in which an offender simply uses a passive child to masturbate with. Experiences in which the child is enticed to participate are also likely to be more sexualizing than those in which brute force is used. However, even with the use of force, a form of traumatic sexualization may occur as a result of the fear that becomes associated with sex in the wake of such an experience. The degree of a child's understanding may also affect the degree of sexualization. Experiences in which the child, because of early age or developmental level, understands few of the sexual implications of the activities may be less sexualizing than those involving a child with greater awareness. Children who have been traumatically sexualized emerge from their experiences with inappropriate repertoires of sexual behavior, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities.

**Betrayal** refers to the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm. This may occur in a variety of ways in a molestation experience. For example, in the course of abuse or its aftermath, children may come to the realization that a trusted person has manipulated them through lies or misrepresentations about moral standards. They may also come to realize that someone whom they loved or whose affection was important to them treated them with callous disregard. Children can experience betrayal not only at the hands of offenders, but also on the part of family members who were not abusing them. A family member whom they trusted but who was unable or unwilling to protect or believe them—or who has a changed attitude toward them after disclosure of the abuse—may also contribute to the dynamics of betrayal.

Sexual abuse experiences that are perpetrated by family members or other trusted persons obviously involve more potential for betrayal than those involving strangers. However, the degree of betrayal may also be affected by how taken in the child feels by the offender, whomever the offender. A child who was suspicious of a father's activities from the beginning may feel less betrayed than one who initially experienced the contact as nurturing and loving and then is suddenly shocked to realize what is really happening. Obviously, the degree of betrayal is also related to a family's response to disclosure. Children who are disbelieved, blamed, or ostracized undoubtedly experience a greater sense of betrayal than those who are supported.

**Powerlessness**—or what might also be called disempowerment, the dynamic of rendering the victim powerless—refers to the process in which the child’s will, desires, and sense of efficacy are continually contravened. Many aspects of the sexual abuse experience contribute to this dynamic. We theorize that a basic kind of powerlessness occurs in sexual abuse when a child’s territory and body space are repeatedly invaded against the child’s will. This is exacerbated by whatever coercion and manipulation the offender may impose as part of the abuse process. Powerlessness is then reinforced when children see their attempts to halt the abuse frustrated. It is increased when children feel fear, are unable to make adults understand or believe what is happening, or realize how conditions of dependency have trapped them in the situation.

An authoritarian abuser who continually commands the child’s participation by threatening serious harm will probably instill more of a sense of powerlessness. But force and threat are not necessary: any kind of situation in which a child feels trapped, if only by the realization of the consequences of disclosure, can create a sense of powerlessness. Obviously, a situation in which a child tells and is not believed will also create a greater degree of powerlessness. However, when children are able to bring the abuse to an end effectively, or at least exert some control over its occurrence, they may feel less disempowered.

**Stigmatization**, the final dynamic, refers to the negative connotations—e.g., badness, shame, and guilt—that are communicated to the child around the experiences and that then become incorporated into the child’s self-image. These negative meanings are communicated in many ways. They can come directly from the abuser, who may blame the victim for the activity, demean the victim, or furtively convey a sense of shame about the behavior. Pressure for secrecy from the offender can also convey powerful messages of shame and guilt. But stigmatization is also reinforced by attitudes that the victim infers or hears from other persons in the family or community. Stigmatization may thus grow out of the child’s prior knowledge or sense that the activity is considered deviant and taboo, and it is certainly reinforced if, after disclosure, people react with shock or hysteria, or blame the child for what has transpired. Children may be additionally stigmatized by people in their environment who now impute other negative characteristics to the victim (loose morals, “spoiled goods”) as a result of the molestation. Stigmatization occurs in various degrees in different abusive situations. Some children are treated as bad and blameworthy by offenders and some are not. Some children, in the wake of a sexual abuse experience, are told clearly that they are not at fault, whereas others are heavily shamed. Some children may be too young to have much awareness of social attitudes and thus experience little stigmatization, whereas others have to deal with powerful religious and cultural taboos in addition to the usual stigma. Keeping the secret of having been a victim of sexual abuse may increase the sense of stigma, since it reinforces the sense of being different. By contrast, those who find out that such experiences occur to many other children may have some of their stigma assuaged. These four traumagenic dynamics, then, account in our view for the main sources of trauma in child sexual abuse. They are not in any way pure or narrowly defined. Each dynamic can be seen, rather, as a clustering of injurious influences with a common theme. They are best thought of as broad categories useful for organizing and categorizing our understanding of the effect of sexual abuse.

## Traumagenic Dynamics in the Impact of Sexual Abuse

With the four traumagenic dynamics as an organizing framework, it is useful to reconsider the literature on the effects of sexual abuse. Although a great many behavioral and emotional problems have been related to a history of sexual abuse,<sup>6</sup> unfortunately the sum total of literature adds up to little more than a list of possible outcomes. This is conceptually frustrating and does not encourage deeper understanding of the phenomenon.

The notion of traumagenic dynamics, however, offers a way both to organize and theorize about many of the observed outcomes. Most of the outcomes, it will be noted, can be conveniently categorized according to one or two of these dynamics. It would seem as though certain traumagenic dynamics are more readily associated with certain effects. Obviously, there is no simple one-to-one correspondence. Some effects seem logically associated with several dynamics. But there are clear general affinities. In this section, we will briefly describe the effects that seem to be associated with the four dynamics.\*

### Traumatic Sexualization

There are many observed effects of sexual abuse that seem readily connected to the dynamic of traumatic sexualization. Among young child victims, clinicians have often noted sexual preoccupations and repetitive sexual behavior such as masturbation or compulsive sex play. Some children display knowledge and interests that are inappropriate to their age, such as wanting to engage school-age playmates in sexual intercourse or oral-genital contact.<sup>1-3,12,21,22</sup> Some children who have been victimized, especially adolescent boys, but sometimes even younger children, become sexually aggressive and victimize their peers or younger children. Clinicians have remarked about promiscuous and compulsive sexual behavior that sometimes characterizes victims when they become adolescents or young adults, although this has not been confirmed empirically.<sup>5,19,32</sup>

The sexual problems of adult victims of sexual abuse have been among the most researched and best established effects. Clinicians have reported that victimized clients often have an aversion to sex, flashbacks to the molestation experience, difficulty with arousal and orgasm, and vaginismus, as well as negative attitudes toward their sexuality and their bodies.<sup>8,12,29,34,38</sup>

The frequently demonstrated higher risk of sexual abuse victims to later sexually assault may also be related to traumatic sexualization,<sup>11,13,17,30</sup> and some victims apparently find themselves inappropriately sexualizing their children in ways that lead to sexual or physical abuse.<sup>14,18,21,30,34</sup> All these observations seem connected to the traumagenic dynamic of sexualization. Such problems and behavior, as well as victims' self-reports, suggest the various psychological effects produced by traumatic sexualization. At its most basic level, sexual abuse heightens awareness of sexual issues, which may be particularly true among young children who might not otherwise be concerned with sexual matters at their stage of

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\* Tabular presentation of these traumagenic dynamics, roughly broken down into psychological impact and behavioral manifestations, is available from the authors.

development. Part of the preoccupation is associated simply with the sexual stimulation of the abuse and the conditioning of behavior that may go along with it, but it is also very much a function of the questions and conflicts provoked by the abuse about the self and interpersonal relations. Confusion often arises especially about sexual identity.

Victimized boys, for example, may wonder whether they are homosexuals. Victimized girls wonder whether their sexual desirability has been impaired, and whether later sexual partners will be able to “tell.”

Traumatic sexualization is also associated with confusion about sexual norms and standards. Sexually victimized children typically have misconceptions about sex and sexual relations as a result of things offenders may have said and done. One common confusion concerns the role of sex in affectionate relationships. If child victims have traded sex for affection from the abuser over a period of time, this may become their view of the normal way to give and obtain affection<sup>17,20,24</sup>. Some of the apparent sexualization in the behavior of victimized children may stem from this confusion. Another impact that traumatic sexualization may have is in the negative connotations that come to be associated with sex. Sexual contact associated in a child’s memory with revulsion, fear, anger, a sense of powerlessness, or other negative emotions can contaminate later sexual experiences. These feelings may become generalized as an aversion to all sex and intimacy, and very probably also account for the sexual dysfunctions reported by victims.

### **Stigmatization**

Other effects of sexual abuse seem naturally grouped in relation to the dynamic of stigmatization. Child victims often feel isolated, and may gravitate to various stigmatized levels of society. Thus they may get involved in drug or alcohol abuse, in criminal activity, or in prostitution.<sup>3,4,17</sup> The effects of stigmatization may also reach extremes in forms of self-destructive behavior and suicide attempts.<sup>4,11,17,21,34,35</sup>

The psychological impact of these problems has a number of related components. Many sexual abuse victims experience considerable guilt and shame as a result of their abuse.<sup>2,10,11</sup> The guilt and shame seem logically associated with the dynamic of stigmatization, since they are a response to being shamed and encountering negative reactions from others regarding the abuse. Low self-esteem is another part of the pattern, as the victim concludes from the negative attitudes toward abuse victims that they are “spoiled merchandise.”<sup>3,9,18,21,34,38</sup> Stigmatization also results in a sense of being different based on the (incorrect) belief that no one else has had such an experience and that others would reject a person who had.

### **Betrayal**

A number of the effects noted in victims seem reasonably to be connected with the experience of betrayal that they have suffered, in the form of grief reactions and depression over the loss of a trusted figure.<sup>1,3,7,20,21</sup> Sexual abuse victims suffer from grave disenchantment and disillusionment. In combination with this there may be an intense need to regain trust and security, manifested in the extreme dependency and clinging seen in especially young victims.<sup>20,23</sup> This same need in adults may show up

in impaired judgment about the trustworthiness of other people<sup>4,9,21,34,36,38</sup> or in a desperate search for a redeeming relationship.<sup>34,35</sup> As mentioned before, several studies of female incest victims have remarked on the vulnerability of these women to relationships in which they are physically, psychologically, and sexually abused.<sup>4,11,13,17,25,30</sup> Some victims even fail to recognize when their partners become sexually abusive toward their children. This seems plausibly related to both an overdependency and impaired judgment. An opposite reaction to betrayal—characterized by hostility and anger—has also been observed among sexually abused girls.<sup>4,9,26</sup> Distrust may manifest itself in isolation and an aversion to intimate relationships. Sometimes this distrust is directed especially at men and is a barrier to successful heterosexual relationships or marriages. Studies have noted marital problems among sexual abuse victims that also may represent the surfacing of mistrust and suspicion. The anger stemming from betrayal is part of what may lie behind the aggressive and hostile posture of some sexual abuse victims, particularly adolescents.<sup>1,8,10,21,27,39,41</sup> Such anger may be a primitive way of trying to protect the self against future betrayals. Antisocial behavior and delinquency sometimes associated with a history of victimization are also an expression of this anger and may represent a desire for retaliation. Thus, betrayal seems a common dynamic behind a number of the observed reactions to sexual abuse.

### **Powerlessness**

There is also a configuration of effects of sexual abuse that seem plausibly related to the dynamic of powerlessness. One reaction to powerlessness is obviously fear and anxiety, which reflect the inability to control noxious events. Many of the initial responses to sexual abuse among children are connected to fear and anxiety. Nightmares, phobias, hypervigilance, clinging behavior, and somatic complaints related to anxiety have been repeatedly documented among sexually abused children.<sup>1,2,7,8,10,14,15,21,22,26,33,35,39</sup> These fears and anxieties may extend into adulthood as well.

A second major effect of powerlessness is to impair a person's sense of efficacy and coping skills. Having been a victim on repeated occasions may make it difficult to act without the expectation of being re-victimized. This sense of impotence may be associated with the despair, depression, and even suicidal behavior often noted among adolescent and adult victims. It may also be reflected in learning problems, running away, and employment difficulties, which researchers have noted in victims who feel unable to cope with their environments<sup>1,2,7,17,22,24,26</sup>. Finally, it seems readily related to the high risk of subsequent victimization (noted in previous sections) from which sexual abuse victims appear to suffer: these victims may feel powerless to thwart others who are trying to manipulate them or do them harm.

Attempts to compensate for the experience of powerlessness may account for a third cluster of effects. In reaction to powerlessness, some sexual abuse victims may have unusual and dysfunctional needs to control or dominate. This would seem particularly to be the case for male victims, for whom issues of power and control are made very salient

by male sex role socialization.<sup>16,28</sup> Some aggressive and delinquent behavior would seem to stem from this desire to be tough, powerful, and fearsome, if even in desperate ways, to compensate for the pain of powerlessness. When victims become bullies and offenders, reenacting their own abuse, it may be in large measure to regain the sense of power and domination that these victims attribute to their own abuser. All these effects seem related to the traumatic dynamic of powerlessness that is integral to the sexual abuse experience.

The preceding should give a sense of how the four traumagenic dynamics are connected to the common patterns of reactions seen among victims. It should be clear, however, that the reactions are overdetermined. Some effects seem plausibly connected to two or even three traumagenic dynamics; for example, depression can be seen as growing out of stigmatization, betrayal, or powerlessness. There is no one-to-one correspondence between dynamics and effects. It may be that stigma-related depression has different manifestations and therefore calls for a different therapeutic approach than depression related to powerlessness. Such hypotheses suggested by the model are worthy of further clinical and empirical investigation.

### **Clinical Assessment Using the Model of Traumagenic Dynamics**

Of the many possible uses for the conceptual model described here, an obvious one is in making clinical assessments of the possible effects of abuse. Up to the present, clinicians have evaluated abuse experiences on the basis of unsystematic and untested assumptions about what causes trauma. There have been some attempts to classify abuse experiences to aid in assessment, but these classifications have various shortcomings.

One common classification scheme looks at the characteristics of the offender: for example, whether the abuse was at the hands of a “regressed” or “fixated” abuser.<sup>16</sup> However, this conceptualization provides little insight into the nature of the trauma experienced by the child. More often, experiences have been classified according to simple dichotomies which reflect collective clinical judgment about what kinds of abuse are “more traumatic.” Thus, abuse is commonly distinguished by whether it occurred inside or outside the family, on the belief that abuse inside the family has more serious effects on the child. Abuse is also commonly categorized according to whether or not penetration occurred and whether force was used.

This approach to assessing the potential for trauma has real limitations. Beyond the fact that its assumptions are largely untested, the approach results in an overly simplistic classification of experiences as either more or less serious. Nothing about the *character* of the effect is inferred, and nothing about how the trauma is likely to manifest itself is suggested.

The model of traumagenic dynamics proposed here allows for a more complex assessment of the potential for trauma. With the assistance of these concepts, the clinician can evaluate an abuse experience on four separate dimensions. The question is not whether it was more or less serious, but rather what specific injurious dynamics were present. The characteristics of the experience itself can be examined for their contribution to each of the traumagenic processes. On the basis of the configuration of traumagenic dynamics most present in an experience, the clinician can anticipate what would be the most likely types of effects.

Thus, a clinician might proceed through the model dynamic by dynamic, asking first: How traumatically sexualizing was this experience? Facts about the experience, such as

whether intercourse occurred, how long it went on, and the degree to which the child participated, all might contribute to an assessment of the degree of sexualization. Next a clinician would ask: How stigmatizing was the experience? Factors such as how long it went on, the age of the child, the number of people who knew about it, and the degree to which others blamed the child subsequent to the disclosure would all add to the assessment of this dynamic. Similarly, with regard to betrayal, facts about the relationship between the victim and the offender, the way in which the offender involved the victim, and the attempts—successful and unsuccessful—of the victim to get assistance and support from other family members would all be taken into account. Finally, the facts about the presence of force, the degree to which coercion was brought to bear, the duration of the abuse, and the circumstances under which the abuse was terminated would be particularly relevant to a determination of the degree to which powerlessness was a major dynamic.

Once an assessment is made about the experience according to the four traumagenic dynamics, a clinician should be able to draw inferences about some of the predominant concerns of the victim and about some of the subsequent difficulties to be expected. An assessment based on the traumagenic dynamics would also be useful for formulating intervention strategies. If, for example, assessment suggested greatest trauma in the area of stigmatization, interventions might be aimed specifically at reducing this sense of stigma. Such interventions might include involvement with a survivors group, where the victim could get support from other victims, or other activities to repair the sense of a stigmatized and devalued self.

### **Traumagenesis Before and After Abuse**

Although the sexual abuse itself is assumed to be the main traumatic agent in victims, it is important to emphasize that any assessment approach to understanding trauma must take into account the child's experiences both prior to *and* subsequent to the abuse. Abuse will have different effects on children depending on their prior adjustment and on how others respond to it. The conceptual framework being proposed here is easily adapted to this need.

The four traumagenic dynamics do not apply solely to the abuse event. They are ongoing processes that have a history prior to and a future subsequent to the abuse. They can be assessed in each phase. In the pre-abuse phase, the traumagenic dynamics need to be understood particularly in relation to a child's family life and personality characteristics prior to the abuse. For example, a child who was a previous victim of physical or emotional abuse may have already been suffering from a disempowering dynamic before the abuse occurred. However, an eldest child with important responsibilities, living in a fairly healthy family environment, may have acquired a well developed sense of personal efficacy and powerfulness. In such a context, the disempowering aspects of a sexual abuse experience may have only a minor or transient effect. If the child had experienced an unstable family configuration, in which the loyalty of significant others was in doubt, then the dynamic of betrayal may have already been strongly potentiated. However, the betrayal dynamic from the sexual abuse experience might be substantially less for a child who had a sense of trust firmly established.

The operation of the traumagenic dynamics can also be assessed in the events subsequent to the sexual abuse. Two main categories of subsequent events have particular importance: (1) the family reaction to disclosure, if and when it occurs, and (2) the social and institutional response to the disclosure. For example, much of the stigmatization

accompanying abuse may occur *after* the experience itself, as a child encounters family and societal reactions. A child who was relatively unstigmatized by the molestation itself may undergo serious stigmatization if later rejected by friends or blamed by family and if having been abused remains a focus for a long time. The dynamic of powerlessness is also greatly affected by a child's experiences subsequent to sexual abuse. If, for instance, a great many authorities become involved in the experience and the child is forced to testify, forced to leave home, forced to tell the story on repeated occasions, and subjected to a great deal of unwanted attention, this can also greatly increase the child's sense of powerlessness. But, if the child has a sense of having been able to end the abuse and obtain support and protection, this may greatly mitigate any sense of powerlessness that resulted from the experience itself. Thus, in assessing the experience, the contributions of the pre-and post-abuse situation must be included in relation to the four traumagenic dynamics.

### Implications for Research

The four traumagenic dynamics described in this paper have implications for both research and intervention. Perhaps most importantly, they can be used as a conceptual guide in the development of assessment instruments. Up until now, research on child sexual abuse has been conducted using either broad psychological inventories like the MMPI<sup>37</sup> or the California Psychological Inventory<sup>31</sup> or else ad hoc, investigator-invented measures. The broad inventories have subscales like neuroticism or self-acceptance that can assess a variety of pathological conditions, but these are not necessarily the pathologies related most closely to sexual abuse. The ad hoc measures, by contrast, are more sensitive to the specific pathology that may result from sexual abuse, but they are not based on any theory, and often suffer from lack of methodological rigor.

The model of traumagenic dynamics can be the basis for developing instruments specifically designed to assess the impact of sexual abuse. Sections of the instruments would be geared to tap each of the four dynamics. Two separate instruments might be developed, one for direct administration to the children and another for completion by parents or professionals. Forms of the instruments might be tailored for different age groups. Such instruments are badly needed to further research on sexual abuse.

### Conclusion

This paper has tried to suggest a framework for a more systematic understanding of the effects of sexual abuse. It has introduced four traumagenic dynamics, which are seen as the four links between the experience of sexual abuse and the sequelae that have been widely noted. Developing a conceptualization of these links may serve as a step in the direction of advancing our understanding of sexual abuse and mitigating the effects of these experiences on its victims.

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## **Scientific Support for Expert Testimony on Child Sexual Abuse Accommodation**

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Roland Summit's article on child sexual abuse accommodation (CSAA) (Summit, 1983) describes sexually abused children's secrecy, helplessness, entrapment, delayed disclosure, and retraction. The paper is both admired and maligned. On the one hand, it has been hailed as one of the most influential papers ever written on child abuse (Oates & Donnelly, 1997). On the other hand, testimony on accommodation is often dismissed as "dangerous pseudoscience" by both commentators and the courts (Summit, 1992).

There are two reasons for this difference of opinion. The first is because of a misunderstanding regarding the relevance of accommodation in diagnosing abuse. The fact that a child exhibits sexual abuse accommodation does not *increase* the likelihood that the child was abused. For example, learning that a child alleging abuse retracted her allegation does not make it *more* likely that her allegation was true. However, it is important for jurors to hear that a surprising number of sexually abused children retract their allegations. Otherwise, they may assume that retractions conclusively prove that abuse did *not* occur. Those who insist that accommodation ought to be diagnostic of child sexual abuse in order to be useful information in court fault accommodation for failing a standard it was never intended to meet.

The second reason CSAA provokes disagreement is because of uncertainty whether it is a "scientific" concept. There is a judicial trend toward insisting that expert testimony be scientifically valid, regardless of whether it is intended to diagnose or to educate. If scientific research does not support the existence of accommodation, then any use of it in court may be challenged.

I will argue that there is scientific support for child sexual abuse accommodation, based on both observational and experimental research. Observational research demonstrates that a substantial proportion of abused children either delay reporting or fail to report their abuse. Abused children are afraid and embarrassed to tell. Children who do manage to tell are often not believed, and even when they are believed, are often not identified by social services or the police as abused. Experimental research documents children's tendency to keep secrets for others, particularly when the other is a loved one.

I will also argue that research casting doubt on the existence of accommodation often suffers from a methodological problem attributable to the effects of accommodation on the substantiation of sexual abuse. Because accommodation suppresses convincing reports of abuse, much of the research on abused children underestimates the extent to which accommodation occurs. If a child's secrecy suppresses disclosure, a parent's reluctance to believe suppresses reporting, and a child's reluctance to discuss makes

substantiation unlikely, research limiting itself to substantiated cases will paint a skewed picture of the disclosure process. I hope to paint a more complete picture here.

First, I will discuss the most common objection to CSAA: It is not diagnostic of abuse. I will explain why this objection misunderstands the purpose and utility of accommodation. Second, I will consider the claim that CSAA is unscientific. I will show that in part this second claim is merely a restatement of the first objection, but in part a potentially valid criticism. I will discuss recent case law that makes it imperative to address the criticism. I will discuss recent case law that makes it imperative to address the criticism head on, given the courts' appetite for expert testimony that is "scientific." Third, I will review the observational and experimental research on children's disclosure process and argue that there is indeed evidence that accommodation occurs among a substantial proportion of abused children. Fourth, I will discuss the methodological problems that create inconsistencies among the research findings, and emphasize that the exact frequency of accommodation symptoms among abused children is unknown. Although Summit (1983) sometimes asserts that *most* abused children exhibit a particular accommodation symptom, it is safer to conclude that many abused children do so. As I will argue, however, such a conclusion does not undercut CSAA's usefulness as a means by which jurors can be educated about the dynamics of sexual abuse.

### **Is the Fact That a Child Has CSAA Evidence that the Child Was Abused?**

Child sexual abuse accommodation documents how repeated sexual abuse is initiated and maintained in secrecy. It describes how sexual abuse is initiated through threats to keep the abuse a secret and through exploitation of the helpless and dependent child. It describes how the child's inability to report the first acts of abuse guarantees future victimization, and how attempts to maintain a sense of control and positive feelings for the abuser lead the child to blame herself for the abuse and turn any anger inward. CSAA describes how disclosure, if and when it occurs, is delayed and unconvincing, due to the child's ambivalence about the utility of telling, the child's adjustment problems preceding disclosure (which undermine credibility), and the reluctance of the nonoffending parent to believe the child. Finally, CSAA describes how abused children frequently recant their allegations in response to the negative consequences of disclosure, most notably the rejection by those to whom they turn for support, and their removal from their homes.

One criticism of child sexual abuse accommodation is that it is not proof of abuse. Although true, the criticism is misguided, because it reflects a misunderstanding of what the existence of child sexual abuse accommodation proves (Summit, 1992; see also Kalman, 1998; Lyon & Koehler, 1996; Mosteller, 1996; Myers, 1992). When a child exhibits one or more symptoms of child sexual abuse accommodation (e.g., delayed disclosure), this does not increase the likelihood that the child was abused. There is no reason to believe that true allegations are more likely than false allegations to be delayed. Therefore, it is inappropriate to use accommodation symptoms as "substantive evidence" of abuse. The purpose of accommodation symptoms, however, is to challenge the assumption that children who exhibit accommodation symptoms must *not* have been abused. It is appropriate to tell the jury that accommodation frequently occurs among abused children, in order to disabuse the jury or misconceptions regarding how abused children ought to behave. In legal terms, describing the symptoms of accommodation is

an appropriate means by which one may “rebut” attacks on or “rehabilitate” a child’s credibility (Myers, 1992). For example, if the defense argues that because the child did not report abuse until long after exposure to the defendant, the abuse did not occur, the prosecution could offer expert testimony that victims of abuse often delay reporting due to guilt and fear.

Critics may have misunderstood the purpose of child sexual abuse accommodation because of Summit’s (1983) reference to it as a “syndrome.” Using the term “syndrome” invites analogies to battered child syndrome, in which a child’s symptoms, taken together, suggest that otherwise innocent injuries are abusive. In contrast, accommodation is not evidence of abuse. Moreover, a child need not show a cluster of accommodation symptoms in order to be accommodating abuse. For example, a child may delay reporting, yet never recant. Summit (1992) states that had he anticipated misunderstandings of child sexual abuse accommodation “syndrome,” he would have avoided the term. I have done so in this chapter.

Most courts allow child sexual abuse accommodation testimony to rebut attacks on a child’s credibility (Myers, 1992). Although overzealous prosecutors and experts may stray beyond the permissive use of accommodation, and suggest to a jury that a child’s symptoms prove abuse (Mason, 1995), courts have the power to exercise control. In California, accommodation testimony is admissible only if the prosecutor specifically identifies the misconception the testimony is designed to rebut (e.g., delay undermines credibility), the expert limits testimony to abused children as a class, and describes how the reactions in question are not inconsistent with abuse (rather than diagnostic of abuse) (*People v. Bowker*, 1988). Restrictions on the scope of accommodation testimony minimize the likelihood that it will be misused by the prosecution or misunderstood by the jury.

### **The Scientific Basis for CSAA: Why Does It Matter?**

A second criticism of accommodation is that it is not supported by scientific evidence. Most of the time, the criticism is simply an elaborate way of saying that various reactions to abuse are not proof of abuse, and constitutes a misunderstanding of what accommodation includes and what it is intended to accomplish. For example, in disallowing expert testimony on purportedly diagnostic indicators of abuse such as sexualized behavior and sleep disturbances, the Florida Supreme Court held that “Child Sexual Abuse Accommodation Syndrome has not been proven by a preponderance of scientific evidence to be generally accepted by a majority of experts in psychology” (*Hadden v. State*, 1997, p. 575), thus using the word “accommodation” to refer to indicators having nothing to do with accommodation. Similarly, Mason (1995) cites reviews of research that is critical of “clear indicators of sexual abuse” as responsive to “Summit’s model” (p. 402), despite the fact that Summit’s model neither posits that accommodation is an indicator of sexual abuse nor incorporates the purported indicators. The reviews cited by Mason do not examine the prevalence of accommodation symptoms (such as delayed reporting and recantation) among abused children because they focus on examining differences between abused children and nonabused children (Berliner & Conte, 1993; Kendall-Tackett, Williams, & Finkelhor, 1993).

Commentators who recognize accommodation for what it is, but nevertheless find its scientific foundation lacking, present a more serious challenge. Kovera and Borgida (1997) point to the “absence of well-controlled empirical studies that might support or refute Summit’s clinical observations” (p. S112). Ceci and Bruck (1995) argue that there is surprisingly little scientific support for the assertion that abused children who are threatened are reluctant to reveal their abuse. Bradley and Wood (1996) contend that there is a lack of scientific support for the proposition that abused children are reluctant to discuss their abuse, and that they frequently recant.

Whether Summit would aggressively defend the scientific status of child sexual abuse accommodation is unclear. He often emphasizes the extent to which the accommodation is *not* scientific. For example, Summit has stated that “it should be understood without apology that [accommodation] is a clinical opinion, not a scientific instrument” (Summit, 1992, p. 156). He has described the origins of the article on accommodation as “clinical study” (Summit, 1983, p. 179), producing “correlations and observations that have emerged as self-evident within an extended network of child abuse treatment programs and self-help organizations” (p. 180). This point has not been lost on critics, who highlight how Summit’s views were derived from “clinical experience” (Mason, 1995, p. 402).

Although once a generally accepted source of wisdom, clinical experience has come under increasing attack. Experimental psychologists argue that clinicians are subject to confirmatory biases, in which they seek out, interpret, and generate information consistent with their prejudices and preconceptions. Experience may not increase knowledge, but only spawn arrogant confidence that one’s pet theories are correct (Dawes, 1994). Without research to back them up, claims about what is common or typical among abused children may say more about clinicians’ tools for evaluating child abuse cases than about the true nature of abused children (Ceci & Bruck, 1995).

I suspect that Summit went out of his way to deny that CSAA is a “scientific instrument” in order to counter claims that accommodation testimony should satisfy the Frye rule (*Frye v. U.S.*, 1923), which requires that expert testimony based on a novel scientific method of proof be generally accepted in the field in which it belongs. The rule is most often applied to recently developed techniques that produce quantifiable results with little apparent subjective interpretation. Calling CSAA a clinical opinion rather than a scientific instrument makes it less novel and more subjective, and thus potentially less susceptible to exclusion under Frye.

Recently, however, the U.S. Supreme Court held that the Frye rule did not survive the Federal Rules of Evidence (*Daubert v. Merrell-Dow Pharmaceuticals*, 1993). The opinion is binding on all federal courts applying the Federal Rules, and has already influenced a number of state courts, most of which have rules of evidence modeled after the Federal Rules (Mueller & Kirkpatrick, 2000). The Supreme Court held that trial courts should screen out expert testimony that is unscientific by asking several questions: Is the theory or technique testable? Has the theory or technique been subjected to peer review and publication? What is the known or potential rate of error? Are there standards controlling the technique’s operation? “General acceptance” is still relevant, but takes a

back seat to the courts' own evaluation of the scientific validity of the proffered testimony.

The Court's opinion leaves no doubt that it is enamored of the scientific method, and that it thinks the lower courts should be, too. The strategic value of denying oneself scientific status is, therefore, at best unclear. Some commentators argued that the *Daubert* criteria might apply only to expert testimony that is self-avowedly "scientific" (Mueller & Kirkpatrick, 1999). Because the Federal Rules of Evidence allow for expert testimony based on "scientific, technical, or other specialized knowledge," (2000, Rule 702) clinical judgment might qualify as "specialized" knowledge and be exempt. Such an approach has now been rejected by the Supreme Court, which recently held that no expert testimony is categorically exempt from *Daubert's* requirements (*Kumho Tire Co., Ltd. v. Carmichael*, 1999). Whether state courts will follow *Kumho's* lead and apply *Daubert* criteria to all expert testimony is unknown.

Even before *Kumho*, experts were not always successful in claiming that because their work was unscientific, they were not subject to the requirements of *Frye* or *Daubert*. Consider *State v. Foret* (1993), a case decided by the Louisiana Supreme Court, which applied the *Daubert* criteria to expert testimony regarding behavioral symptoms of sexual abuse. The court adopted the position that only scientific expert testimony was subject to the *Daubert* rules, but then assumed "for the purposes of argument" that the expert's testimony was scientific (*State v. Foret*, 1993, p. 1123, n. 7). The court then rejected the testimony, in part because of admissions that use of CSAA "is partly a science and partly an art form" (p. 1125).

Touting CSAA as more art than science neither prevents courts from applying standards for scientific evidence nor increases the likelihood of acceptance under those standards. Clinicians who call themselves artists in order to avoid scrutiny under *Daubert* risk being hoist by their own petard. If there is scientific support for accommodation, experts ought to say so.

### **Scientific Support for Accommodation**

In court, the most frequently discussed aspects of accommodation are secrecy, delayed disclosure, and retraction. A large body of observational research has examined the prevalence of these characteristics among abused children. Moreover, a fair amount of research has examined children's willingness to keep secrets to protect others. This research provides a basis for assessing the scientific validity of accommodation.

### **DO CHILD VICTIMS DISCLOSE THE ABUSE?**

Summit cited research that "the majority of the victims in retrospective surveys had never told anyone during their childhood" (Summit, 1983, p. 181). Rates of nondisclosure among women run from 33% to 92% (Bagley & Ramsay, 1986 [92% never reported to an adult]; Finkelhor, 1979 [63%]; Finkelhor, Hotaling, Lewis, & Smith, 1990 [33%]; Russell, 1986 [of those for whom information was available regarding reporting, 47%]), and among men from 42% to 85% (Finkelhor, 1979 [73%]; Finkelhor et al., 1990 [42%]; Johnson & Shrier, 1985 [85%]).

These numbers might be exaggerated if respondents are reporting abuse that never occurred. On the other hand, if adults who never revealed their abuse as children continue to deny being abused, these numbers are conservative. For example, Ferguson, Lynskey, and Horwood (1996) found that 87% of respondents who had been sexually abused as children had reported the abuse to at least one other person, a much higher percentage than found in several other surveys. However, because they questioned women who had just turned 18 years of age, they may have missed women who were still concealing their abuse. The authors acknowledge the potential for underreporting when they discuss their prevalence figures, which were lower than those in other surveys. Underreporting would reduce estimates of prevalence and increase the proportion of abuse that had been previously disclosed.

Because most known cases of child sexual abuse are based at least in part on the child's report of abuse, it is difficult to estimate rates of nondisclosure among children. The exception is when a child suffers from a sexually transmitted disease (STD), or presents with clear medical signs of abuse, because in such cases one can be confident that sexual abuse occurred without confirmation from the child. In such cases, 25% to 57% of children fail to disclose when questioned. Dubowitz, Black, and Harrington (1992) found that 25% of children with medical evidence indicative of sexual abuse (e.g., hymenal scarring) failed to disclose when questioned by an interdisciplinary team. Elliot and Briere (1994) discovered that 34% of children with external evidence of abuse (primarily diagnostic medical evidence, a confession, or an eyewitness) failed to disclose abuse at a crisis center interview. Gordon and Jaudes (1996) observed that 36% of children with an STD failed to disclose the name of the perpetrator both in the emergency room interview and at the investigative interview. Lawson and Chaffin (1992) noted that 57% of children with a sexually transmitted disease failed to disclose. Finally, Muram, Speck, and Gold (1991) found that 49% of children with medical evidence diagnostic of sexual abuse failed to disclose. Of course, some of these children may have forgotten their abuse, in which case the numbers exaggerate reluctance to some unknown extent. Nevertheless, the numbers are suggestive that substantial numbers of abused children fail to reveal.

Summit (1983) argued that even when children do reveal, their disclosures are often conflicted and delayed. In Dubowitz et al. (1992), in addition to the 25% who disclosed nothing, another 28% of the children with medical findings indicative of sexual abuse "partially" disclosed, defined as suggestive doll play or an inconclusive account of alleged abuse. Similarly, in Gordon and Jaudes (1996), 21% of the children with an STD initially failed to disclose the name of the perpetrator. Wade and Westcott (1997) questioned children about their experience with investigative interviews, and children often reported that they provided incomplete reports, attributing this

to the difficulty of talking about the abuse; lack of knowledge about what was happening; anxiety about the investigation would lead to; concern that what they would say would cause distress to people they cared for; the stress of the interview itself; or their dislike of the interviewer. (p. 58)

Bradley and Wood (1996) observed a lower percentage of reluctance when examining social service records of substantiated cases of abuse, a finding that will be discussed in the section dealing with methodological difficulties.

Studies examining the time at which the abuse occurred find that although large percentages of children report the abuse immediately, a number do so only after substantial delay. In a sample of 248 cases in which an investigative multidisciplinary team concluded that abuse had occurred, Elliot and Briere (1994) discovered that 75% of the subjects failed to disclose the abuse within the year that it first occurred. Sauzier (1989) reported that only 24% of the 156 children evaluated and treated at a family crisis program for sexually abused children reported abuse within a week after it occurred, whereas 17 % delayed more than a year, and 39% told no one before the evaluation (their delay was not calculated). Immediate reporting appeared to be less likely when the offender was related to the children, when the abuse was more serious than fondling or attempted touching, and when compliance was obtained through threat or manipulation (rather than aggression).

In Sas and Cunningham's (1995) sample of 524 children whose sexual abuse was prosecuted in criminal court, one-third of the children waited more than one year after the first incident to disclose. Immediate reporting was less likely when the victim and perpetrator were emotionally close and when the perpetrator practiced preabuse grooming (rather than force). Somewhat smaller percentages of delay have been reported in other criminal court samples. Goodman et al. (1992) examined 218 children whose sexual abuse was prosecuted in criminal court, and found that whereas 42% reported their abuse within 48 hours of the last assault, 15% waited more than six months. Whitcomb et al. (1994) examined 431 cases of sexual abuse referred to a prosecutor for potential criminal prosecution, and found that although 52% reported abuse within one week of the last incident, 14% waited more than six months to do so. These numbers may be smaller because of the way in which some researchers define delay; if one measures delay from the last time the abuse occurred, rather than the first time, one understates the delay among children who are abused over time. Sas and Cunningham (1995) noted that if a child did not report abuse within 48 hours of the first time it occurred, there was a 70% chance that he or she would be abused again. In Goodman et al. (1992), abuse lasted longer than six months for 25% of the children. If these children reported abuse shortly after the last time they were abused, they were not counted as delayed reports.

#### WHY DON'T ABUSED CHILDREN DISCLOSE?

The most commonly mentioned reason for nondisclosure is fear: Abuse victims fear harm to themselves, harm to loved ones, and harm to the perpetrator. "[T]he only consistent and meaningful impression gained by the child is one of danger and fearful outcome based on secrecy" (Summit, 1983, p. 181). Russell (1986) questioned the 44 women in her survey who had been abused but who had never told anyone, in an effort to determine why they kept the abuse a secret. "[T]he two most common reasons were fear of punishment by the perpetrator and /or someone else, including abandonment and rejection and a desire to protect the perpetrator, or fear of hurting someone else" (Russell, 1986, p. 132). Similar fears are reported by children who disclosed for the first time when evaluated at a family crisis center. In Sauzier's (1989) review of 156 abused children seen for evaluation and treatment, initially silent children who were victims of more serious abuse "described the fear of losing the affection and goodwill of the offender; fear of the consequences of telling (being blamed or punished for the abuse by the non-offending parent); fear of being harmed; and fear of retaliation against someone

in their family” (p. 460; see also Finkelhor, 1980, in which some female college students who did not reveal childhood abuse “were afraid of retaliation by the older partner, and did not believe parents or other authorities could adequately defend them” [p. 267]; Johnson & Shrier, 1985, noting that adolescent males revealing abuse for the first time explain “that they wanted to forget about the incident, wanted to protect the assailant, or were afraid of the reactions of their peers and family members” [p. 374]); and Palmer, Brown, Rae-Grant, & Loughlin, 1999, documenting a community sample who had not disclosed sexual, physical, emotional abuse, or all three, mention “fear of the abuser (85%), fear of negative reactions from other family members (80%), fear that no one would believe them (72%)” (p. 269). Similar disincentives were discovered by Sas and Cunningham (1995) in their review of criminal cases:

Many powerful factors work to prevent immediate disclosure: the adult/child power imbalance, the child’s training to defer to elders, the existence of a trust and/or dependency relationship, admonishments to keep the secret, implied or imagined negative consequences of telling, and feelings of guilt, self-blame, stigmatization and isolation. (p. 87)

Victims of abuse are frequently threatened by the abuser. Most of Herman’s (1981) sample of 40 women who were outpatients in psychotherapy and who had suffered incest as children

were warned not to tell anyone about the sexual episodes. They were threatened with the most dreadful consequences if they told: their mothers would have a nervous breakdown, their parents would divorce, their fathers would be put in jail, or they themselves would be punished and sent away from home. (p. 88)

Children in forensic samples also report having been threatened. In Smith and Elstein’s (1993) nationwide survey of 954 criminal cases of child sexual abuse, 27% of the children reported having been specifically warned not to reveal the abuse. Furthermore,

[t]hese warnings ranged from pleas that the abuser would get into trouble if the child told (or that the abuser would be sent away and the child would never see them again—a powerful message to a young child whose abuser is also a “beloved” parent), to threats that the child would be blamed for the abuse (especially troubling were children who were told that the defendant’s intimate—the child’s mother—would blame the child for “having sex” with the defendant and would thus turn against him or her), to ominous warnings that the defendant would hurt or kill the child (or someone he or she loved) if they revealed the abuse. (p. 93).

Sas and Cunningham (1995) found that children who delayed reporting were more likely to have been warned not to tell than children who reported immediately. Among children who reported abuse within the first 48 hours, 15% were warned not to tell. On the other hand,

About half of delayed disclosers reported that the abusers never made an overt request that the child not tell. One fifth said there had been a threat of physical harm or death with the child or a family member as the intended victim. Among the remainder of cases, the most common admonishments not to tell were a simple statement that it is a secret or that they should not tell, a warning that the child would be in trouble, a warning that the

abuser would be in trouble, a threat of withdrawing privileges, a warning that it would hurt the mother to know, and a promise of money for not telling. (p. 122)

In her sample of 390 child victims in criminal sexual abuse cases, Gray (1993) found that 33% of the children had been threatened not to tell. Threats were not related to whether children told before being asked; Gray did not examine whether threats increased delay.

The lack of a specific warning not to tell does not mean that a child is unafraid to reveal. It is not always necessary for the offender to threaten the child for the child to recognize the dangers of revealing the abuse. Herman (1981) reports that “[t]hose who remembered no warnings simply intuited that guarding the incest secret was part of their obligation to keep the family together” (p. 88). Sas and Cunningham (1995) found that immediate disclosure was less likely when the abuser had physically abused the child, the child’s mother, or both; they concluded that “overt threats were not necessary if the man had a history of violence within the home” (p. 122).

Often, abuse victims believe that they are at least partially responsible for the abuse, and are therefore ashamed to reveal (Summit, 1983). As noted above, Sauzier (1989) and Sas and Cunningham (1995) found that children sometimes mention their fears of being blamed for the abuse (see also Finkelhor, 1980, regarding female college students who never revealed abuse, that “many feared that they would be blamed themselves for what had happened” [p. 267]; and Russell, 1986, who notes that “self-blame made [some victims] feel too ashamed or guilty to tell. Some expressed fear of being blamed or of not being believed” [p. 132]). Several studies have reported self-blame among sexual abuse victims, and self-blame appears to be related to the extent to which the non-offending parent blames the child (Hazzard, Celano, Gould, Lawry, & Webb, 1995; Moore, McPhee, & Trought, 1986).

That many threatened children nevertheless reveal their abuse might lead one to argue that threats do not deter disclosure. However, this fact only justifies the conclusion that threats do not completely deter disclosure, not that they fail to reduce the likelihood that disclosure occurs. Moreover, cases in which threats are effective will be underrepresented in studies of children known to be abused, because an effective threat will suppress disclosure, and children who fail to disclose will rarely appear in research on abused children. Therefore, studies of cases in which children ultimately revealed abuse exclude the very children for whom threats are most effective.

## IS THERE EXPERIMENTAL EVIDENCE THAT CHILDREN WILL KEEP SECRETS TO PROTECT OTHERS?

Experimental work has the potential to supplement the observational research on the effects of fear on disclosure. Laboratory research has both advantages and disadvantages. In the lab, researchers know whether a transgression occurred, and have control over the variables that may or may not influence children’s reporting. On the other hand, researchers do not abuse children or threaten them with serious consequences should they tell. One can therefore question the applicability of experimental research to the disclosure of sexual abuse. More serious transgressions than those studied in the lab might provide stronger motives for disclosure, whereas stronger warnings would increase the need for secrecy. Nevertheless, when considered in tandem with observational work,

the experimental data provides useful information confirming the effects of fear on children's disclosure of misdeeds.

There is a quite impressive body of laboratory research suggesting that inducements to secrecy reduce disclosure. Wilson and Pipe (1989), in a study involving 5-year-old children, had a magician perform magic tricks for the child, and then accidentally spill ink on "magic gloves" that the child was wearing. The magician hid the gloves, "saying if they were discovered she (the magician) would be reprimanded and that therefore they should not tell anyone about the ink spill" (pp. 66-67). The child was questioned after 10 days and then 2 months later. The interviewer first asked the child to relate everything that the magician did, and ultimately asked the child whether he or she knew anything about a pair of stained gloves the interviewer had found. None of the children spontaneously mentioned the gloves after 10 days, and 75% failed to do so after 2 months. Twenty-five percent denied knowing anything about the gloves at both interviews when directly asked, and another 33% denied knowing anything at one of the two interviews.

Pipe and Wilson (1994) found similar rates of nondisclosure among 6-year-olds, and less reluctance to disclose among 10-year-olds. Most 6-year-olds failed to mention the gloves in their free recall (75% at two weeks, 81% at two months), and more than 30% failed to reveal what happened after the specific question was asked (40% at two weeks, 32% at two months). The 10-year-olds were less inclined to keep the incident a secret, but nevertheless, more than 30% failed to mention the gloves in free recall (34% at two weeks, 44% at two months), and 16% did not reveal when specifically asked (at both interviews).

Bussey and colleagues (Bussey, Lee, & Richard, 1990) tested 3- and 5-year-olds' willingness to remain silent about a male experimenter who had accidentally broken a prized glass and hidden the pieces. "The experimenter expressed a great deal of concern about the event and asked the child not to disclose." A female experimenter later asked the child questions about the glass, including "Did [the male experimenter] touch the glass?" (if the child had not already revealed this information). Among the 3-year-olds, 14% kept the secret and the rate was 43% of 5-year-olds. If the experimenter sternly told the child not to tell, 43% of the 3-year-olds and 71% of the 5-year-olds either denied that the mishap occurred or refused to discuss it. In a separate paper, Bussey (1993) reported lower rates of nondisclosure among 9-year-olds (approximately 15% after being asked not to tell).

Peters (1990, 1991) examined 5- to 9-year-olds' reluctance to disclose that a thief had stolen a book in their presence, after the thief asked the child to keep the theft a secret. As reported by McGough,

When the children were asked about the loss of the book in the presence of both their parents and the thief (who lied about the theft), only 5 percent of the children told what they knew. Later, when the thief was not present, nearly one-third (32.5 percent) of the children still feigned ignorance. The children gave two reasons for their denials: they thought they had made a commitment not to tell and they feared him. As one child said, "I think there is going to be some trouble. I'm afraid something bad might happen. That guy might get angry." (1994, p. 91)

The experimental research I have discussed thus far examined children's reluctance to implicate a stranger. What would happen if the transgressor were someone close to the child? "[A] child is three times more likely to be molested by a recognized, trusted adult than by a stranger" (Summit, 1983, p. 182). Most sexually abused children are victimized by someone they know, and most forensic and clinical cases involved intrafamilial abuse (Finkelhor, 1979; Gray, 1993; Smith & Elstein, 1993; Whitcomb et al., 1994). A child will have greater sympathy for a loved one, and is probably less inclined to get that person in trouble. If the loved one is in the child's home, or close to others the child loves, threats and inducements to secrecy may be more effective because the offender has continuing contact with the child and others in the family, and because the child cannot count on being supported by other loved ones should the child reveal.

Bottoms and colleagues (1990) divided their 3- to 4-year-old and 5- to 6-year-old participants into two groups. Both groups of children saw their mother accidentally break the head off a Barbie doll. In the secrecy group, the mother and child had been told not to play with the toys, and the mothers "asked their children to keep the fact they had played with the toys a secret, suggesting the mother would get into trouble if the child told, and offering the child a toy as a present if the child kept the secret" (Bottoms, Goodman, Schwartz-Kenney, Sachsenmaier, & Thomas, 1990; in Pipe & Goodman, 1991, p. 37). In the control group, the mother and child were free to play with the toys, and the mothers did not give their children any instructions about secrecy. Only 1 of the 49 children in both age groups told an interviewer about the doll when asked what happened, and 5-year-olds refused to disclose what their mother had done, even when asked leading questions.

In a study by Devitt and colleagues (1994, described in Honts, 1994; see also Tye, Amato, Honts, Devitt, & Peters, 1999), involving 4- to 11-year-olds, a confederate stole a book in the presence of the child, and told the child "that the theft was a secret and that the child should not tell anyone that the researcher had taken the book." The owner of the book discovered it was missing, and explained that it was needed for an exam the next day. The child was then questioned by the owner and an experimenter, the child and his or her parent were asked to wait for the police to arrive, and the child was then interviewed by a person identified as an officer; 19% of the children failed to name the thief. In a condition in which the child watched as his or her parent stole the book, and the parent told the child to name one of the experimenters as the thief, 81% of the children failed to name the thief (56% falsely accused the experimenter named by the parent, and 25% failed to name anyone).

Ceci and Leichtman (1992) have experimentally demonstrated that the loved one need not be a parent. In a study involving 3- and 4-year-olds, an experimenter spent 20 hours with each child, in order to become a "loved one." The experimenter and the child were told by a nursery school teacher not to play with a toy. While the teacher was gone, the "loved one" touched and broke the toy, and exclaimed, "Gee, I didn't mean to break it. I hope I don't get into trouble." Note that the loved one did not elicit a promise from the child or threaten the child not to tell. The teacher returned and asked the child who broke the toy. "[M]ost children, when confronted with the choice of disclosing that their loved one broke it, either refused to say anything or provided misleading information (e.g., 'A gremlin came in through the window and broke it')" (Ceci & Leichtman, 1992, p.6).

Experimental work clearly supports the contention that children may be reluctant to reveal the wrongdoing of an adult, particularly when that adult is someone close to the child. Mild inducements not to reveal minor transgressions have profound effects in the laboratory, supporting observational research suggesting that stronger inducements not to reveal sexual abuse have equally profound effects in the real world.

#### ARE CHILDREN'S COMPLAINTS ALWAYS REPORTED TO THE AUTHORITIES?

“Of the minority of incest secrets that are disclosed to the mother or discovered by the mother, very few are disclosed to outside agencies” (Summit, 1983, p. 187). Even if a victim overcomes reluctance and reports abuse to an adult, this does not guarantee that the abuse allegation is brought to the attention of the authorities. Bagley and Ramsay (1986) found that 75% of children's reports of abuse to an adult were not reported to social services (see also Arata, 1998, noting that of undergraduates who had disclosed their sexual abuse, 10% had subsequent contact with the police; Hanson, Resnick, Saunders, Kilpatrick, & Best, 1999, discussing that of women in a national sample who reported having been molested as children, 13% of cases were reported to the police or other authorities; Palmer, Brown, Rae-Grant, & Loughlin, 1999, in which 6% of cases resulted in police charges; and Russell, 1986, who noted that 47% reported to an adult and 2% to 6% were reported to the police).

Little research has directly addressed why adults fail to report a child's complaint of abuse. The most relevant research has examined the nonoffending mother's reaction to her child's disclosure of abuse. “The mother typically reacts to allegations of sexual abuse with disbelief and protective denial” (Summit, 1983, p. 187). Although the once-popular portrayal of the mother as implicitly condoning incest (Nakashima & Zakus, 1977) has been rejected, research consistently finds that mothers are often ambivalent or unsupportive of the child's claims (Adams-Tucker, 1982; DeJong, 1988; Elliot & Briere, 1994; Everson, Hunter, Runyon, Edelson, & Coulter, 1989; Faller, 1988; Heriot, 1996; Leifer, Shapiro, & Kassem, 1993; Myer, 1984/1985; Sas & Cunningham, 1995; Sirles & Franke, 1989; Tufts New England Medical Center, 1984). The research will overstate maternal supportiveness to the extent that it examines the mother's attitude after the disclosure has been validated by authorities. The Tufts study (1984; see also Myer, 1984/1985) found that “[w]hen a mother discovers that her child has been sexually abused, her initial reaction is often shock and denial” (p. 212). If the unsupportive attitude continues, the case is less likely to find its way into the research samples. Indeed, the Tufts (1984) researchers noted that 58% of the families approached for participation in the study refused to do so, largely because they denied abuse or denied that services were needed.

That parental support is related to the child's willingness to reveal abuse when questioned by others is supported by Lawson and Chaffin (1992), who found that in their sample of children with sexually transmitted disease, 63% of children with supportive caretakers disclosed abuse compared with only 17% of children with unsupportive caretakers. Elliot and Briere (1994) found that 78% of children who disclosed abuse had supportive mothers compared to 40% of children who failed to disclose (but who nevertheless could be diagnosed as abused). In both studies, to be “supportive” a parent had to accept the possibility that the child was abused.

The reasons why mothers are often unsupportive of their children's allegations are similar to the reasons why children fail to report. DeJong (1988) notes that

[s]ome of the internal factors include denial, guilt, frustration, anger, fear of repercussions, feelings of inadequacy, ignorance, previous behavior or emotional problems of the child, or general distrust of or reluctance to involve the police, child protective services, or other agencies in personal matters. External factors would include pressures by family members or friends to protect the abuse [and] specific economic pressures that might arise from loss of support by the abuser. (p. 18)

Similar considerations have been mentioned by other research (Faller, 1988; Herman, 1981; Myer, 1984/1985). DeJong (1988) adds that even after a report is made, a mother may fail to support her child because of the lack of support from the police and social services agencies involved.

In sum, both observational and experimental research supports the existence of accommodation among a large percentage of abused children. Children who are abused often fail to reveal, or reveal only after a delay. Children who reveal are often not believed. Children who are believed are often not reported to social services or the police. Child sexual abuse accommodation is not merely a term of art, but a scientifically supported phenomenon.

### **Methodological Difficulties Due to Accommodation and Its Implications for Recantation**

"Treated, reported or investigated cases are the exception, not the norm" (Summit, 1983, p. 186). The sexually abused child has to overcome a number of hurdles in order for his or her case to be brought to official attention. As a result of the child's reluctance to discuss the abuse, and the caretaker's reluctance to believe that abuse occurred, cases that have been substantiated by official action are unrepresentative of sexual abuse because they contain a disproportionate percentage of children who are relatively forthcoming about their abuse. Therefore, observational research supports the existence of accommodation, but is likely to underestimate the frequency with which accommodation occurs.

More than half of all sexual abuse reports are not substantiated by social service investigation (Eckenrode, Munsch, Powers, & Doris, 1988). Substantiation is less likely if the child is not forthcoming with the investigator about abuse. Everson and Boat (1989) interviewed child protective workers regarding 29 cases in which the worker had concluded that abuse had not occurred, and found that "the most frequently cited reason for disbelieving the child's report of abuse was a later retraction by the child. In the words of one worker, 'She admitted it herself, that she had been lying all along.'" (p. 232). In interviews with 20 child protective workers regarding the process by which they evaluate sexual abuse cases, Haskett, Wayland, Hutcheson, & Tavana (1995) found that "[b]y far, the most important factor in this process was the child's verbal disclosure or denial of abuse" (p. 40). That substantiation rates increase with the age of child is likely to be at least partially attributable to older children's greater ability to provide convincing verbal reports of abuse (Eckenrode et al., 1988; Haskett et al., 1995; Winfield & Bradley, 1992).

It is possible that a report could be filed without any previous statement from the child, if the reporter had other reasons for believing that abuse had occurred. In the majority of substantiated cases, however, there was a statement by the child prior to investigation (Bradley & Wood, 1996, of 234 substantiated cases, 6% of reports were filed by the victim and 72% of victims had disclosed to someone else before the report was filed; Farrell, 1988, of 108 substantiated sexual abuse cases, 80% were “self-disclosure”; Whitcomb et al., 1994, of 431 substantiated cases referred to prosecutors, 86% of victims had disclosed the abuse prior to the report).

Whereas cases substantiated by social services may contain a disproportionate number of forthright victims, cases seen by clinicians in self-help groups and in treatment may contain a much higher percentage of abuse victims who failed to report the abuse or who were ambivalent about reporting. As Ceci and Bruck (1995) have argued, “Children in forensic samples may be those who readily disclose, whereas children in clinical samples who delay making disclosures may not go through the criminal system as readily; these may be the children for whom it is difficult to extract a report, and thus they are brought by adults for treatment” (p. 35).

There is some support for the view that forensic and clinical samples look different. Compare two studies: Bradley and Wood (1996) and Sorensen and Snow (1991). In their review of 234 cases of sexual abuse substantiated by social services, Bradley and Wood found that 4% of the children failed to disclose abuse when questioned by social services or the police. Moreover, initial denial of abuse was reported among 6% of the cases, and reluctance to discuss abuse only among 10%. In a review of 116 cases of sexual abuse “in which the authors had been involved as therapists and/or evaluators,” and which had been referred to the authors by “child protective service, law enforcement, other mental health personnel and agencies, and private referral” (pp. 4-5), Sorensen and Snow (1991) found that 72% of the children initially denied abuse when questioned by an authority figure or in the formalized investigative process, and 78% exhibited “tentative disclosure” as a middle step, in which they often minimized or claimed to forget aspects of the abuse.

Bradley and Wood (1996) acknowledge that their sample was limited to substantiated cases, but argue that this does not explain why the rate of reluctance to disclose was so low. They emphasize that “caseworkers sometimes responded to an initial denial by scheduling additional interviews or arranging for the child to see a counselor” (p. 889). However, as long as caseworkers *often* close cases based on denials or unconvincing disclosures by ambivalent children, reviews of cases substantiated by social services will exaggerate the extent to which abused children in general are forthcoming about abuse. Because Bradley and Wood did not examine unsubstantiated cases, they were unable to determine how often initial denial was followed up by the investigator. As noted above, research suggests that denial and recantation do indeed reduce the likelihood of substantiation (Everson & Boat, 1989; Haskett et al., 1995; see also Gordon & Jaudes, 1996).

Bradley and Wood (1996) point out that Sorensen and Snow (1991) also examined only substantiated cases of abuse. However, the process by which cases were substantiated in Sorensen and Snow was likely to be quite different. As Ceci and Bruck (1995) suggest, it

may be that children referred to Sorensen and Snow for treatment were particularly likely to be ambivalent about disclosing abuse and, therefore, more inconsistent in doing so. Bradley and Wood recognize that children in treatment might look different than children seen by social services, although they speculate that children in treatment *become* reluctant over multiple therapy sessions, rather than *begin* therapy reluctant to disclose.

Besides the issue of substantiation, there are other possible explanations for the differences between Bradley and Wood (1996) and Sorensen and Snow (1991), which will be discussed below. Nevertheless, it is reasonable to assume that research on substantiated cases of abuse will understate the reluctance of abused children to reveal, as well as other symptoms of child sexual abuse accommodation. On the other hand, clinical research that relies on samples of children referred for treatment is likely to contain a disproportionate number of children who are reluctant to disclose. Both samples miss the children for whom accommodation was most effective: those children who never gave any indication of having been abused. Claims regarding the exact percentage of abused children who exhibit accommodation symptoms must be tempered by the characteristics of the populations from which the samples were drawn.

#### DO ABUSED CHILDREN RECANT?

Whether abused children often recant their allegations of abuse is probably the most controversial element of CSAA. Summit (1983) asserted that “[w]hatever a child says about sexual abuse, she is likely to reverse it” (p. 188). The two studies just described (Bradley & Wood, 1996; Sorensen & Snow, 1991) illustrate the competing claims. Bradley and Wood found that only 4% of children whose abuse was substantiated by child protective services and who originally claimed that abuse occurred subsequently recanted their allegations. In contrast, Sorensen and Snow found that 22% of abused children recanted when questioned by therapists.

Percentages also vary among other research. Jones and McGraw (1987) found a recantation rate of 9% among 309 substantiated cases of sexual abuse investigated by Denver Social Services. Bybee and Mowbray (1993), examining investigatory records from a single day care abuse case in which 62 children made allegations of abuse, found that 11% of the children recanted abuse at some point during the investigatory process. Keary and Fitzpatrick (1994) found that 14% of the 123 children who had disclosed abuse prior to being seen by a sexual abuse assessment unit failed to repeat their allegation at the investigative interview. Gordon and Jaudes (1996) found that 17% of 103 children reporting abuse during an emergency room interview recanted abuse at the subsequent investigative interview. Gonzalez, Waterman, Kelly, McCord, and Oliveri (1993) found that 27% of 63 children in treatment for ritualistic abuse (in the McMartin case) recanted at some point during therapy.<sup>1</sup> Devoe and Faller (1999) found that 30% of 56 children who had disclosed abuse before being evaluated for sexual abuse failed to disclose abuse at their first interview.

There are several plausible explanations for these differences. One possibility is that many of the children in the studies finding the highest rates of recantation were not, in fact, abused. Ceci and Bruck (1995) raise this point with respect to Sorensen and Snow’s (1991) study, both criticizing Snow’s interviewing technique and questioning the validity

of the criteria whereby the cases were classified as true allegations of abuse. (Specifically, they note that a criminal conviction could be the result of a plea by an innocent defendant afraid of a long sentence should he be convicted after a trial.) The allegations of ritual abuse in the Gonzalez et al. (1993) study could be similarly questioned, given criticism of the investigative methods in the McMartin case and the ultimately inconclusive trial outcome.

To address this problem, one solution is to identify only those cases in which there is clear corroborative evidence that abuse occurred, such as a confession or highly suggestive medical findings. Such a breakdown is possible for the Gordon and Jaudes (1996) study and for Elliot and Briere (1994). In Gordon and Jaudes, 14 children had a sexually transmitted disease; 6 of these children disclosed abuse to the emergency room physician, and 3 subsequently recanted abuse at the investigative interview, for a recantation rate of 50%. In Elliot and Briere, 118 children had evidence of abuse independently of the child's statements.<sup>ii</sup> Nineteen of these children never revealed abuse, leaving as many as 99 who may have revealed abuse before the evaluation (the authors do not report the exact number). Because 20 of these children recanted at the evaluation, the recantation rate is at least 20%. Based on this limited data, recantation does not seem to be an artifact of the misclassification of false allegations as true abuse. Rather, recantation rates are quite high among cases one can confidently say are true.

Indeed, the rates of recantation among cases with corroborative evidence are among the highest across the studies. Although this might seem counterintuitive, it reflects the fact that corroborative evidence increases the likelihood that a child will be diagnosed as abused. If a child recants, and there is no other evidence of abuse, it is likely that investigators will fail to conclude that he or she has been abused. On the other hand, if a child recants but there is clear external evidence that abuse occurred, investigators are more likely to diagnose abuse. The result is that a focus on cases with clear evidence of abuse will reveal higher percentages of children who only inconsistently acknowledge that the abuse occurred.

Another explanation for the differences in recantation rates among studies is that they are attributable to the differences, already discussed, between children drawn from substantiated cases of abuse investigated by social services and children drawn from sexual abuse treatment. If recantation decreases the likelihood that abuse is substantiated, then substantiated cases will have a disproportionately small number of children who recant. On the other hand, if recantation increases the likelihood that a child is referred to a therapist, then treatment samples will have a disproportionately large number of recanters.

One can directly test the effects of substantiation on the percentage of abused children who recant by looking more closely at the Gordon and Jaudes (1996) study. The percentages in that study are based on all children reported as abused to social services. Because the authors provide percentages of the cases that were subsequently substantiated by social services investigation, one can determine whether substantiation affects the apparent frequency of recantation. The authors note that "[t]he ability of the state to conclude officially that sexual abuse had occurred was much higher when the child identified the alleged perpetrator in at least the investigative interview than when

the child recanted at the second interview” (Gordon & Jaudes, 1996, p. 319). Indeed, the substantiation rate when the child disclosed at both the emergency room interview and the investigative interview was 91%, compared to 29% when the child recanted at the investigative interview. Because recantation decreased the likelihood that cases would be substantiated, one ought to see fewer recantations among substantiated cases than among the cases overall. And this is indeed the pattern. The entire sample contained 141 children. Of the 103 children who reported abuse in the emergency room, 17 (17%) recanted at the investigative interview. The entire group of substantiated cases numbered 108. Of the 83 children who reported abuse in the emergency room, 5% or 6% recanted at the investigative interview.

In addition to the substantiation problem, another factor that increases the difficulty of identifying recantation among abused children is that few of the studies follow the cases beyond the initial investigation. Jones and McGraw (1987) suggest that this leads to an underestimation of recantation in their sample, and Bradley and Wood (1996) speculate that “an abused child who is willing to discuss abuse during an initial [social work] interview may become reluctant to continue the discussion during multiple therapy sessions” (p. 889). Although Bradley and Wood discuss what happened postinvestigation in many of their cases, their information-based on child protective service records-was often spotty (1996, p. 887). In contrast, the two studies on treatment (Gonzalez et al., 1993; Sorensen & Snow, 1991) were able to track children over relatively long periods.

It is reasonable to assume that many children who recant do so only after the negative effects of their disclosure become clear-continued lack of support by a nonoffending parent, inability to return home, the initiation of criminal proceedings against a loved one, to name a few. In my experience as an attorney in child abuse court, I have found that recantation tended to occur after the child had been in foster care for some time, and certainly after the initial phase of child protective services investigation. Unfortunately, I know of no research examining the extent to which recantation occurs over the entire course of legal intervention. A suggestive finding, however, is that by Gray (1993), who analyzed a group of 114 sexual abuse cases that were referred to the prosecutor’s office but for whom charges were not filed. In 22% of the rejected cases, the reason for a failure to file charges in the case file was that the “victim changed her story,” which “could include simply inconsistent accounts of the abuse, or outright refutation of the original claim” (p. 94). In the county from which the cases were drawn, prosecutors rejected almost 40% of the cases presented to them for prosecution, which would mean that about 8% of all cases presented for prosecution were rejected due to inconsistency, recantation, or both. The findings hint at the problem of recantation after police and social services investigation is complete, because the prosecutor’s decision whether to file charges is only one of several hurdles before a case is brought to trial.

A final reason for the differences in recantation rates among studies may be biases in reporting. Bradley and Wood (1996) and Bybee and Mowbray (1993) note that for legal reasons, investigators may not make note of recantation or reluctance in their reports. On the other hand, therapists who believe that accommodation occurs may unconsciously exaggerate the extent to which abused children are inconsistent-a form of confirmatory bias. Exaggeration is especially likely to occur if recantation rates are based on

retrospective report, as was used by Sorensen and Snow (1991) and Gonzalez et al. (1993).

For methodological reasons, it is difficult to draw clear conclusions from the research on recantation. There is no evidence that recantation occurs in most cases, and there is equivocal evidence that recantation is rare. I believe an expert is justified in stating that recantation often occurs among children known to have been abused, particularly if the expert's primary goal is to explain how recantation occurs rather than how often. Such a conclusion may seem weak, but only if we are attempting to precisely quantify the frequency with which recantation occurs among abused children. If we are simply trying to teach jurors that recantation does not necessarily mean that the original allegation was false—the usual judicial justification for testimony regarding CSAA—then such a conclusion is helpful without being misleading.

## Conclusion

A review of the research on CSAA clearly supports the conclusion that a substantial proportion of abused children exhibit accommodation. The significance of this conclusion must be interpreted in light of the limited purpose for which accommodation is offered in court. If accommodation is intended to prove that abuse occurred, then it must occur more frequently among abused children than among nonabused children. None of the research examined here allows for such a comparison. Indeed, it is somewhat nonsensical to speak of accommodation among nonabused children—for example, how does one define delay in reporting when the child was never abused? On the other hand, if accommodation is intended merely to rebut the assumption that certain witness characteristics prove that abuse did not occur, then it must occur among *some* abused children. The research is relevant for assessing accommodation's utility as rebuttal evidence, and supports its use as such.

Let me end with a caveat. The purpose of this chapter is to refute the criticism that CSAA is unsupported by scientific evidence. Establishing a scientific basis for CSAA testimony goes a long way toward supporting its admissibility in court. It is not a sufficient basis for admissibility, however, because there are other prerequisites to the admissibility of expert testimony. Under the Federal Rules of Evidence, which govern the federal courts and is a model for most states' rules of evidence, an expert's testimony must "assist the trier of fact" (2000, Rule 702). In part this means that the expert must tell the jury something they don't already know.

Do lay people understand the dynamics of sexual abuse? Summit (1983) contended that they do not. At least one critic of CSAA testimony has argued that "it does not take an expert witness to explain that children may delay or recant the telling of an experience as sensitive as sexual abuse" (Mason, 1995, p. 408), and at least one state supreme court has rejected CSAA testimony in part because of this argument (*Commonwealth v. Dunkle*, 1992). Research examining lay people's understanding of sexual abuse is limited (Gray, 1993; Kovera & Borgida, 1997; Morison & Greene, 1992), and provides only moderate support for the assertion that lay people are skeptical of children with CSAA symptoms. For example, Morison and Greene (1992) found that individuals summoned for jury duty "slightly disagreed" with the assertion that "[I]ndividuals should be suspicious about

allegations made by a child following a lengthy delay in reporting,” whereas sexual abuse experts “disagreed” (p. 603). Kovera and Borgida (1997) reported that 97% of students and 84% of community members (compared to 97% of experts) agreed with the statement that “delays in reporting child sexual abuse to the police or other authorities are quite common” (see also Gray, 1993). Although Morison and Greene (1992) identified discrepancies between lay and expert opinion, whether those differences are large enough to justify expert testimony is subject to dispute. Moreover, if experts merely testify that *many* rather than *most* children exhibit CSAA, the need for expert testimony is even more questionable.

Ironically, the greatest challenge to CSAA testimony may be that it is a scientific truism rather than a clinical myth. Summit (1992) noted that his article was originally rejected by a psychiatric journal “because the reviewers felt it was so basic it contributed nothing new to the literature” (p. 155; compare Ceci, Bruck, & Rosenthal, 1995, stating that it is “a point of no dispute among researchers” that “truly abused children are often unlikely to disclose sexual abuse out of a sense of embarrassment or fear,” p. 506). Whether lay people intuit what researchers think obvious is an open question and awaits further research and argument. At any rate, whatever can be said about CSAA, it certainly cannot be said that it is unscientific. Roland Summit the clinician divined facts even the scientists could accept.

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## Notes

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<sup>i</sup> Commentators often cite Sahd (1982) or Goodwin, Sahd, and Rada (1982) for the proposition that 30% of abused children recant. Sahd fails to cite authority for the claim that "[t]he literature indicates that nearly 1/3 of children who report incest consider retracting the allegations at some time" (p. 82). Goodwin and colleagues state that "[r]efusal to talk or testify about the incest is more common than false denial and may occur on the part of as many as 30% of victims" (p. 21). They cite Nakashima and Zakus (1977), but I was unable to find the 30% figure in that article.

<sup>ii</sup> External evidence included diagnostic medical findings in 64 cases (e.g., hymenal transections to the base, STDs that can be contracted only through sexual contact, semen found in the vaginal canal), confession in 27 cases, a witness to the abuse in 35 cases, and other evidence in 25 cases (pornographic pictures of the child, the child described graphic details of the alleged perpetrator's bedroom when the alleged perpetrator denied the child ever being in his home).