Pergamon

Child Abuse & Neglect, Vol. 24, No. 1, pp. 9–23, 2000
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0145-2134/00/$–see front matter

PII S0145-2134(99)00113-1

EXTRAFAMILIAL SEXUAL ABUSE: TREATMENT FOR CHILD VICTIMS AND THEIR FAMILIES

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ABSTRACT

Objectives: To decrease the emotional distress of child victims of extrafamilial sexual abuse (ESA) and their families. To provide crisis intervention, individual and group treatment in response to an expressed need in the community. To pilot the use of group treatment for child victims of ESA under age 10.
Method: This discussion describes intervention with a sample of 246 child victims, ages 2–14 years, and 323 parents who participated in the program from 1984 to 1991. This pilot project operated at a university medical facility and was located off campus in an outpatient child abuse center. Priority was given to child victims under age 7. Child victims and their families were evaluated after investigative interviews by law enforcement agencies were completed. A treatment plan was developed based on clinical assessment. Families participated in crisis counseling, individual treatment for the child victim and/or parent, Children's Treatment Groups, Parent Support Groups, or were referred to other resources. Clinical assessment of treatment progress included weekly case review by child and parent therapists, video analysis and observation of Children's Treatment Group sessions, consultation with parents and collateral contacts.
Results: A family approach and services for parents in addition to intervention for child victims were determined to be key components in facilitating recovery. Clinical observations and client feedback showed positive outcomes for child victims and parents with crisis counseling, Children's Treatment groups, and Parent Support Groups. The extent of intervention ranged from one session to 24 months with an average participation of 6–9 months. Follow up surveys were returned by parents for 48 child victims and results are reported. Themes, parallels in responses, and recovery factors for child victims and parents are discussed.
Conclusions: The need for intervention and a community-based program was demonstrated by (1) the significant disruption in functioning that occurred for child victims of ESA and their families, (2) the risk for long term sequelae, (3) the high incidence of extrafamilial sexual abuse, and 4) the consistent, large number of requests for services. Family-centered crisis services, Children's Treatment Groups, and Parent Support Groups can be effectively based at child advocacy centers, out patient care clinics, or other community agencies. The results of formal outcome measures and longitudinal studies is needed to determine how child victims and parents benefit from specific treatment modalities and to better guide the use of limited resources. © 1999 Elsevier Science Ltd

Key Words—Children, Parents, Sexual abuse, Extrafamilial, Group treatment, Parent support group.

NEED FOR SERVICES AND PROGRAM OBJECTIVES

THE RECOVERY FOR Children and Parents (ReCAP) program was initiated in July 1984 at the Kempe National Center to provide services to child victims of extrafamilial sexual abuse (ESA). Many parents were calling to seek counseling for their children after a particular case of ESA and

Primary funding for this pilot project was provided by Hasbro Children's Foundation, VOCA Assistance through Division of Criminal Justice, Colorado Department of Public Safety for up to 20% of program costs, Junior League of Denver, Victim Assistance and Law Enforcement-First Judicial District of Colorado.

Submitted for publication December 8, 1997, final revision received January 5, 1999, accepted January 11, 1999.

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Table 1. Age and Sex of Children Evaluated

Age of Child	Boys	Girls	Total	% of Total
0–2 Years	8	19	27	11
3–5 Years	41	76	117	48
6–11 Years	46	43	89	36
12+ Years	8	5	13	5
Total	103	143	246 Children	100

this pilot project responded to an expressed need from the community (Jones & Krugman, 1984). Initial goals were to decrease the trauma for child victims and to determine the effectiveness of group treatment for child victims of extrafamilial child sexual abuse who were under age 10.

Early experience showed that a crucial element in recovery for the child victim was the family's response to the disclosure of sexual abuse and the family's ability to support the child victim. The importance of the family's response has been described by other professionals (Adams & Fay, 1992; Cohen & Mannarino, 1996a, 1996b, 1997, 1998a, 1998b; Hagans & Case, 1988; Kiser, Pugh, McColgan, Pruitt, & Edwards, 1991; Manion et al., 1996, 1998; MacFarlane, 1986; Pelletier & Handy, 1986; Regehr, 1990; Reyman, 1990; Roesler, Savin, & Grosz, 1993; Sgroi, 1984; Spaccarelli & Kim, 1995; Van Scoyk, Gray, & Jones, 1988; Winton, 1990).

The symptoms of child victims in this sample included many indicators of Post Traumatic Stress Disorder (PTSD), such as re-experiencing the traumatic event through intrusive memories or recurrent distressing dreams, persistent avoidance of thoughts, feelings, and activities associated with the trauma, and persistent symptoms of increased anxiety arousal to include sleep difficulties, nightmares, angry outbursts, hyper-vigilance, and decreased concentration (American Psychiatric Association, 1994). As described by other authors, the degree to which child victims were affected by the sexual abuse depended on the severity of the abuse, the degree of the intrusion, the length of time the abuse had occurred before its disclosure, the relationship with the perpetrator, the amount of threat or violence employed by the perpetrator to obtain the child's cooperation or silence, the child's own strengths and personality, and the family's response (Hazzard, Celano, Gould, Lawry, & Webb, 1995; MacFarlane & Waterman, 1986; Mian, Marton, & LeBaron, 1996). The incidence of ESA cases and the need for intervention to facilitate recovery and prevent long term sequelae has been discussed by many authors (Esquilin, 1987; Finkelhor & Berliner, 1995; Finkelhor, Hotaling, Lewis, & Smith, 1990; Haase, Kempe, & Grosz, 1990; Ligezinska et al., 1996; Mandell & Damon, 1989; Cohen & Mannarino, 1998a; Russell, 1983; Sesan, Freeark, & Murphy, 1986).

PROGRAM DESCRIPTION AND METHOD

Sample

Statistical data is presented on a sample of 246 children of ESA who were evaluated in the ReCAP program from 1984 through 1991. This sample included 103 boys and 143 girls from 219 families (see Table 1). The families included 323 parents with 206 biological mothers, 3 grandmothers, 2 adoptive mothers, 1 step-mother, 108 biological fathers, 11 step-fathers, 1 adoptive father, and 1 grandfather. There were multiple child victims in 24 families (2 victims in 20 families and 3 victims in 4 families). In this pilot project, priority was given to evaluating child victims under age 7 because there were fewer resources in the community for this young age group.

Evaluation indicated that no sexual abuse had occurred in 7 cases (2.8%) of this sample of 246 children. These children were brought for evaluation after behavioral indicators were observed,

Table 2. Perpetrator's Relationship to the Child Victim

Babysitter	47	20%
Friend	45	19%
Neighbor	40	17%
Daycare or School Staff	34	14.5%
Relative at Daycare Home	34	14.5%
Daycare Mother	13	6%
Stranger	11	5%
Relative	9	4%
Total	233 Child victims	100%

usually sexual play with other children or with toys. In 6 additional cases (2.4%) evaluation yielded inconclusive findings and it was undetermined whether sexual abuse had occurred. Therefore, the total for child victims as shown in Tables 2 and 3 is 233 children.

Perpetrators

The sexual abuse in these cases was not a sudden, isolated assault by a stranger in a public place. The perpetrator was a stranger in 11 cases, 5% of this sample (see Table 2). Perpetrators were well known to child victims and parents as friends, neighbors, child care providers, or relatives who were not part of the nuclear family. They were male and female, adult and adolescent (see Table 3). Some perpetrators abused more than one child and in some cases a clear identification of the perpetrator was not possible. Child victims in this sample were sexually abused in their own homes 32% of the time (see Table 4). Child victims reported all types of sexual abuse activities and the extent ranged from mild to severe (Table 5). Many child victims reported experiencing more than one type of sexual activity. The relationship between perpetrator and child victim extended over all combinations with the male perpetrator and female victim the most prevalent (see Table 6).

This sample of extrafamilial sexual abuse cases included all sectors of the community and represented a very diverse population in economic, educational and social parameters. Families were residents in 20 counties throughout the state and some traveled long distances to participate in weekly group sessions.

Staffing for Pilot Project

This pilot project was staffed by a child psychiatrist, social worker, child psychologist, and child services specialist. The combined staff level from these positions ranged from 1 to 2.3 full time equivalent (FTE) and the program operated one or 2 days a week. Student interns (2–4 per year) from undergraduate and graduate programs in social work, psychology, medicine, and child psychiatry expanded staffing resources. The preferred staffing for group intervention was female and male co-therapists but staff availability did not allow this on a continuous basis. Community volunteers (25–30 per year) provided child care for siblings, videotaping, data collection, and other support to staff members. Each year evaluation and treatment services were provided to approximately 45 families which included 50 child victims, 75 parents, and 20 siblings.

Table 3. Age and Sex of Perpetrator

	Males	%	Females	%	Total	%
Adolescent	92	43	10	5	102	48
Adult	91	42	21	10	112	52
Total	183	86	31	14	214	100

Table 4. Where the Sexual Abuse Occurred

Child's Own Home	74	32%
Licensed Daycare Home	42	18%
Neighborhood	41	17.5%
Other	21	9%
Friend's Home	20	8.5%
Daycare Center or School	18	8%
Unlicensed Daycare Home	17	7%
Total	233 Child victims	100%

Evaluation and Crisis Services

Evaluation included family sessions and individual interviews with child victims, parents, and siblings to (1) further validate the sexual abuse, (2) provide crisis counseling, and (3) determine treatment needs. All members of the family were asked to participate and the evaluation was explained as a chance for family members to talk about their worries regarding the sexual abuse. Many parents and child victims noted that coming to a big house instead of a law enforcement agency decreased their anxiety and helped them participate more openly.

The sexual abuse had been validated in investigative interviews by law enforcement officers. Child Protective Services focused on intrafamilial sexual abuse and did not usually provide evaluation or intervention for ESA child victims. Some cases were referred to the program when there was insufficient information to pursue an investigation. When the case was referred to the ReCAP program before it was reported, parents were helped to contact the law enforcement agency that had jurisdiction before ReCAP evaluation interviews with the child victim were conducted. When ReCAP interviews elicited more details regarding the sexual abuse than had been disclosed during the investigative interviews, this information was shared with law enforcement officers, district attorneys, and social services workers after written consent or within mandated reporting statutes. Consultation with prosecutors or other attorneys was essential to prepare child victims, parents, and staff members for court hearings, maintain case records that were appropriate for legal systems, provide evidence for criminal and civil courts, and protect confidentiality. Individual evaluation sessions with child victims were videotaped to document the disclosure prior to treatment, provide a more accurate record, and to allow clinical review. Careful clinical evaluation was essential prior to participation in the Children's Treatment Group or Parent Support Group to determine the need and appropriateness for these interventions.

Helpful intake questions were "what have you discussed about coming here today?" and "how would you like us to help you?" Some families came with a well articulated list of worries such as nightmares or acting out behavior. Others had talked minimally and uncomfortably about the sexual abuse and what had happened since disclosure and reporting. Some families hoped we would be able to speed incarceration of the perpetrator or prompt more investigation.

Table 5. Extent of Sexual Abuse Experienced by Child Victims. $N = 233$ child victims

Types of Sexual Abuse Reported	Number of Child Victims Reporting This Type
Fondling	181 (78%)
Masturbation	15 (6%)
Oral-Genital Contact	67 (29%)
Digital Penetration	43 (19%)
Object Penetration	16 (7%)
Penile Penetration	46 (20%)
Other	5 (2%)

Table 6. Sex of Child Victim and Sex of Perpetrator

Sex of Perpetrator-Sex of Child Victim	Number Reporting This Combination
Male-Male	91 Child victims (39%)
Male-Female	105 Child victims (45%)
Female-Male	12 Child victims (5%)
Female-Female	25 Child victims (11%)
Total	233 Child victims (100%)

Evaluation included assessment of marital discord, previous physical or sexual abuse to any family member, financial and health stressors, and the family's capacity to use therapy. The formal evaluation was completed after three sessions of individual and family interviews, usually over the course of several weeks. A treatment plan was presented to the family with recommendations for the child victim, parents and siblings.

Special Considerations in Determining Treatment Plans

Referral was made to other resources when intervention was required for issues independent of the extrafamilial sexual abuse or beyond the scope of the program. These situations included children and parents with serious mental health conditions and children with major developmental disabilities or seriously disruptive behavior.

Families with active disputes regarding custody of the children were not accepted for treatment and were referred to other Kempe Center or community resources. Divorced parents where custody issues were settled did successfully participate in evaluation and treatment. Usually the custodial parent participated in the Parent Support Group and the non-custodial parent participated in evaluation and family sessions with the child victim to review progress and discuss pertinent issues.

Children with extensive sexualized behavior were referred to specialized treatment programs because the ReCAP Children's Treatment Group could not adequately address the needs of these children. The work of Gil and Johnson (1993) was a guide in evaluating these children and determining appropriate treatment.

Seventy four of 323 parents (23%) had experienced sexual abuse themselves as children. This was determined by asking all parents, "Has anything like this ever happened to you?" Some parents needed treatment that focused on their own previous sexual abuse in addition to participation in treatment for the sexual abuse of their child. Parents who themselves had been child victims often had taken extra precautions to protect their children. When this protection failed, they were especially distraught (Berliner, 1995; Green, Coupe, Fernandez, & Stevens, 1995).

Siblings

Siblings of the child victims sometimes had observed the sexual abuse or had additional information, even when parents were certain the siblings had no knowledge of the sexual abuse. Parents were cautioned to avoid saying "Nothing happened to you, did it?" so that siblings could disclose pertinent information.

Older siblings often felt much guilt about the sexual abuse and felt responsible for not protecting their younger siblings. Some siblings knew the perpetrator well and needed to work through their feelings of anger, sadness, loss or confusion about this person. In this sample there were 12 siblings who participated in individual counseling. Siblings were not included in the Children's Treatment Group unless they were also victims. Siblings were included in family sessions to review treatment progress. Child care for very young siblings was provided by volunteers whenever possible since

many parents had lost trust in child care providers as result of the sexual abuse experience and wanted to bring them to the sessions.

Crisis Intervention

During family sessions the therapists helped the child victims share more information with their parents about what had happened. Some parents had exaggerated the extent of the sexual abuse before they heard the actual disclosure information. Other parents had minimized the extent or the impact of the sexual abuse, insisted that their child was just fine, and tried to move on too quickly. Parents were given suggestions of how they might talk about the sexual abuse with their children in ways that were appropriate for the child's age, would allow further disclosure, and would not blame the victim directly or inadvertently. Suggestions included acknowledging and accepting the child's delay in disclosure and the reluctance to tell his/her parents directly. Frequent themes were the fears and guilt felt by child victims as a result of their participation in the sexual abuse, and the responsibility that child victims felt for the upset of family members caused by disclosure. Parents were helped to understand that disclosure was sometimes a gradual process with information emerging over time that might reveal more extensive abuse. Parents were advised to say, "Maybe you will remember more later" when the child was reluctant to disclose. Our experience showed that disclosure was difficult for victims of extrafamilial sexual abuse with elements similar to disclosure for victims of intrafamilial sexual abuse (Berliner & Conte, 1995; Bradley & Wood, 1996; Jones, 1996).

Treatment

In this sample of 233 child victims, 71 children (43%) participated in the Children's Treatment Group and 104 parents (32%) of the sample of 323 parents participated in the Parent Support Group. At least one parent was required to participate in Parent Support Group when their children participated in Children's Treatment Group. Several parents participated in the Parent Support Group when their child was not appropriate for the Children's Treatment Group.

Simultaneous children's and parents' groups met weekly for 1.5 hours. The average participation in group treatment was 6 to 9 months and the range of participation was one session to 15 months. The schedule for groups generally followed the school year calendar with new groups initiated in the fall because attendance often diminished during the summer months. Families joined following an open-ended format and attendance usually included 3–8 participants per group session. New families benefitted greatly from the support of families who had made progress in recovery. Experienced families could better appreciate their own progress when they were able to extend support to families in the initial crisis stages just after disclosure.

Implementing Group Treatment for Child Victims

Child victims ages 4–10 years were clustered by age and developmental level for the Children's Treatment Group. Boys and girls participated in the same group in the younger age range (4–6 years). For child victims over age 7, the groups were same sex or mixed depending on the compatibility of each cluster of child victims. It was generally more effective to have same sex groups for child victims over age 7. When sufficient participation was possible, an early afternoon group met for children ages 4–6 and an after school group met for children ages 7–12.

The goals of the Children's Treatment Group were to (1) enhance coping behaviors, (2) facilitate expression of feelings, questions, and fears, and, (3) teach problem solving and prevention skills. Introductions made it clear that each of the children had experienced sexual touching without discussing explicit details of what had happened. As they met in the group setting, the children showed immediate relief that they were not the only victims. The Children's Treatment Group met

in a large preschool room for 90-minute sessions. Sessions began with expressive play to include arts and crafts, puppets, role play, stories and group activities. The group then moved together to sit around a large table, share snacks and "talk about their worries." The focus was to enable the children to talk about their worries, feelings, the responses of their families and others, and to prepare for court participation in some cases. The therapists initiated discussion of themes to include the responsibility of the perpetrators for the sexual abuse and the child's responsibility for his/her own behavior toward others. Clinical review was continuous to determine progress or the need for alternative interventions through weekly case discussion with all staff, observations by child psychiatrist during sessions, review of videotapes of Children's Treatment Group sessions, and written or verbal reports from parents.

Parent Support Group

Parents were initially emotionally immobilized and many said they did not know what to do to help their child. They felt they had failed as parents because they had not been able to protect their child from the sexual abuse. This was intensified when the sexual abuse occurred over a period of time, and when their child was unable to disclose directly to them. Many families had functioned well until this crisis but found the disclosure of sexual abuse overwhelming. Their trust in safety of the family, friends, and the community was shattered. Some were blamed by others for not preventing the abuse. Some were criticized for voicing allegations against perpetrators who appeared to be good citizens or neighbors. Parents needed a supportive adult to talk with since it was important that they not express the full extent of their anger or sadness with their children. Others have recommended this also (Davies, 1995; Deblinger & Heflin, 1996; Regehr, 1990).

The Parent Support Group provided an effective and appropriate resource to address their own distress and to increase support for the child victims from their parents. Themes included responding to child victims and siblings, understanding the parent's own feelings of distress, interacting with the legal systems, and dealing with friends, relatives, school personnel, and neighbors about the sexual abuse. The therapists monitored the families' needs for more individualized intervention. The therapists for the Parent Support Group provided information about the major themes of the Children's Treatment Group and solicited information about the children's behavior at home and at school. This information was shared with the children's therapists at weekly staff meetings to coordinate the treatment of child victims and parents.

It was important to help parents understand that the recovery of their family could go forward whether criminal prosecution was possible, successful, or not. Parents felt powerless and re-victimized by the criminal justice system when they were not informed of decisions, there were delays, or their case could not be prosecuted. When cases were prosecuted, the Parent Support Group offered increased support when the process was slow, there were continuances, and repeated preparation for court appearances was needed. It was also beneficial to families whose cases could not be prosecuted to help them refocus on the priority of recovery for family members.

RESULTS

Intervention Services for Child Victims and Parents

Table 7 summarizes intervention services for child victims and parents in this sample. Fifty six child victims (24%) did not show a need for further intervention after evaluation and crisis counseling. These were cases where the sexual abuse was minor, there were few behavioral symptoms, and parental support for the child victim was effective. Parent-child discussions were facilitated and families were encouraged to contact the program again as needed.

Some child victims received several types of intervention and the numbers shown reflect this

Table 7. Intervention Services. $N = 233$ child victims; $N = 323$ parents

Crisis Counseling Only	56 Child victims (24%)
Referral to Other Resources	57 Child victims (25%)
Children's Treatment Groups	71 Child victims (31%)
Individual Counseling	102 Child victims (44%)
Parent Support Groups	104 Parents (32%)

overlap among categories. In some cases, individual sessions were interspersed with group participation to address crises and issues of privacy. Adults who had experienced sexual abuse as children were referred for services specific to that issue as an adjunct for the Parent Support Group. Some child victims and parents received individual counseling and did not participate in group sessions. Clinical evaluation and staff resources determined the intervention that was provided.

Parallels in Responses of Child Victims and Parents

After disclosure child victims and parents reported that they experienced many similar symptoms which included sleep disturbances, nightmares, emotional fragility, low frustration tolerance, frequent crying, and feeling overwhelmed. They described that the anxiety they experienced from the sexual abuse disrupted their thoughts, sleep, family relationships, peer relationships, and school or work performance.

Child victims feared upsetting their parents and being punished for their participation in the sexual abuse or their delay in disclosing. In a similar way, some parents were unable to tell their own parents, i.e., the grandparents, about the sexual abuse. Many parents described that it was better not to tell the grandparents because it would be too upsetting for them or that the grandparents would be critical and blame the parents in some way for the sexual abuse.

Child victims and parents blamed themselves for the sexual abuse. Children voiced reasons that included not saying no, accepting gifts, enjoying the attention, being curious about the sexual touching, or because the child went into the perpetrator's bedroom, etc. Parents blamed themselves for going to work, using child care, or trusting someone. It seemed more manageable to blame themselves and then be determined to do things differently than to think they could not have protected themselves and therefore remain vulnerable to future sexual abuse. The goal of therapeutic intervention was to help child victims and parents learn strategies to better protect themselves in the future and to also diminish the self-blame.

The betrayal by the perpetrator was felt sharply by both the parents and children. They had trusted someone who had tricked them and abused them. The betrayal of trust left parents and children blaming themselves, doubting their judgement in choosing caretakers and friends, and questioning their competence in many areas. Some parents described an early uneasiness that they had minimized or disregarded since they thought that they knew the child care person well.

Recovery Factors for Children

Each child moved through recovery at his own pace which was determined by the circumstances of the abuse, the age and personality of the child, and the family's response. Some children tried to minimize the extent of the abuse or recanted as anxiety provoking issues surfaced. Child victims wanted the sexual abuse to stop but they were not prepared to deal with the upset of their families and the stress of investigation and prosecution that followed disclosure. Group treatment offered relief and support by showing them that other children had found ways to cope effectively.

Symptoms of fear were generally seen early in the therapeutic process. Some children were fearful of the threats made to keep the secret and they feared retaliation by the perpetrator. Others

felt unsafe and feared that sexual abuse might happen again. It was important to recognize the seriousness of the threats from the child's perception, especially when the threats and coercion appeared to be minor or trivial to adults. Specific problem solving was needed to help children feel safe and be able to summon help when they felt threatened. The focus was to determine who the child could trust and how he could tell without delay.

Sadness and depression were sometimes masked by other behaviors such as angry outbursts and emotional fragility. Low self-esteem and negative feelings about themselves as bad, damaged, or different were commonly seen. Some children withdrew while others experienced somatic illnesses such as eating disorders, stomachaches, or headaches. For some child victims, their sadness focused on being tricked by the perpetrator and this loss of friendship.

It seemed as if the disclosure by the child victim was the problem rather than the sexual abuse by the perpetrator. Child victims worried that they were to blame for the distress of their parents and siblings, the disruption of the family routines and relationships, and "trouble" for the perpetrator. It was important to explore how the child and the parents were tricked by the perpetrator and to repeatedly clarify the perpetrator's responsibility for the sexual abuse and its consequences. It was important to acknowledge the participation and pleasure the child victims experienced from the attention, gifts and favors from the perpetrator. Child victims needed help to realize that the perpetrator was responsible by virtue of his/her age and position of trust. Many child victims had little ability to stop the sexual abuse and expressed feelings of helplessness and vulnerability. Feelings of powerlessness were more exaggerated if the perpetrator had forcefully assaulted the child.

Some child victims tried to control peers or identified with the perpetrator and acted out the same perpetrating behaviors they had experienced (Gil & Johnson, 1993). Therapists redirected sexualized and aggressive behaviors. When sexualized behavior by child victims was reported by parents, recommendations were made for positive intervention. Follow up with parents and children was done to monitor behavior, continue specific interventions, and consider other treatment services.

Some children responded well to clarifying all the "mixed up feelings" that converged after disclosure. During discussion in the Children's Treatment Group themes included fears, confusions, angry, sad and guilty feelings. Child victims often expressed fears that: (1) no one would believe them, (2) parents would reject or punish them, (3) everyone would know what had happened, (4) they were unsafe, (5) threats from the perpetrator might come true, and (6) they were bad, damaged, or different. They had difficulty trusting others and were apprehensive about participating in court.

Their confusion sometimes included questions about physical pleasure and sexual activities, sexual identity, and sexuality especially when the perpetrator was the same sex. Some children needed a chance to talk about the sexual acts and what had happened to them. They felt guilty regarding (1) their inability to say no and stop the abuse, (2) their participation in the sexual abuse, (3) upsetting their parents and the disruption for family members, and (4) what might happen to the perpetrator because they had disclosed.

Expressions of anger were varied, complex, came at different times and reflected many aspects of the sexual abuse beyond the sexual exploitation itself. Many child victims did not direct anger specifically at the perpetrators until late in the treatment process. Child victims were angry with parents for not knowing about and stopping the abuse, and angry with the perpetrator with thoughts of retaliation. Some were angry about the confusion or loss they felt, or angry for reasons they could not articulate. They needed assistance to direct their anger appropriately and to be able to move on in the healing process.

A decrease in behavioral symptoms based on clinical observation and parent reports was the major indicator that children had improved sufficiently to graduate from treatment. A four year old girl explained how she was feeling much better by saying, "My worries don't hurt anymore." Children could talk about the sexual abuse without distress or blaming themselves, and with

minimal anxiety. There was recognition of the responsibility of the perpetrator and resolution of the mixed up feelings about the perpetrator. More generalized indicators included demonstrating effective ways to express feelings, an improved self-image, and feeling more in control. It was important that children understood how to seek help when difficulties arise and would be able to tell someone if they experienced sexual abuse again. Overall child victims could report the restoration of normalcy and pleasure in daily activities.

Progress observed in children after participation in group treatment included significant decreases in sleep disturbances (nightmares, night terrors, and waking up), angry outbursts, moodiness, clinging behaviors, separation anxiety, fearfulness, emotional fragility, and belligerence. Parents reported improvement in children's self-esteem, self-confidence, school performance, and relationships with parents, siblings and peers.

Recovery Factors for Parents

Major themes for parents after disclosure of sexual abuse were similar to those of grief and loss: shock and denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969). Initially, many parents experienced an extended period of shock and disbelief. The disclosure seemed so incredible, parents could not initially accept the occurrence of sexual abuse even though they believed their children's disclosures. The anger and rage many parents felt toward the perpetrator was described as all-consuming and disrupting their life schedules, sleep and relationships. Sometimes friends or relatives said, "If it was my child, I would kill the guy." Some parents needed help to avoid acting out these enraged feelings. Parents suffered much guilt and anguish about how they might have prevented the sexual abuse. Many perpetrators were close friends who were trusted or child care staff who had been carefully selected by the parents. This betrayal left parents feeling seriously inadequate and unable to trust their own judgment.

Many parents suffered depression, feeling that this crisis would never end, and that there was no way for their family to recover. The Parent Support Group offered a lifeline during a time when many parents described feeling isolated and cut off from normal support systems. Relatives and friends criticized the parents' responses or offered seriously inadequate guidance. Some criticized the parents' attempts to get treatment for the child victims, claiming the children would be able to forget the sexual abuse if they did not talk about it. Some parents and children were stigmatized and avoided by friends or neighbors after they shared information about the sexual abuse. Parents sometimes then decided to present a facade of well-being rather than share with others the despair they were feeling about the sexual abuse. Others withdrew and found it very difficult to trust anyone after this betrayal by the perpetrator.

A major fear for parents was that their child was irrevocably damaged and that he/she might become a perpetrator or be homosexual as a result of the sexual abuse. Parents mourned the loss of innocence that their children had experienced. Many parents became over-protective, and were unable to give their children appropriate freedom to be on their own or with others. If prolonged, this could disrupt the children's normal development, increase the fears of the children and the parents, and diminish their ability to cope with day-to-day life.

Fathers participated less frequently in Parent Support Group by attending less and by not discussing their feelings openly. Some fathers said that talking about the sexual abuse made them more angry and it was then more difficult to control their desire to retaliate against the perpetrators. Some fathers minimized the extent or impact of the abuse. Fathers at times felt that mothers were overreacting when they were depressed and overwhelmed. Fathers seemed more concerned with continuing the normal family routine and keeping things going adequately. It seemed that they were unwilling to acknowledge the extent of the emotional distress because they feared that it might lead to a more serious breakdown in coping for the family. Some fathers seemed to experience a delayed emotional response and dealt with their feelings after the mothers had made progress in recovery.

Table 8. Changes in Symptoms Observed by Mothers in Child Victims After Intervention. *N* = 48 Child Victims

Symptoms Improved	Symptoms Present–No Change	Symptoms Not Observed
Sleep Disturbances 36 Children, 75% Regressive Behavior 28 Children, 58% Dependent, Clinging 27 Children, 56% Fears Threats from Abuser 26 Children, 54% Guilt-Participation in Abuse 26 Children, 54% Unhappy, Sad, Depressed 25 Children, 52% Feels Responsible for Abuse 24 Children, 50% Feels Damaged, Different 24 Children, 50% Cries a lot 22 Children, 46%	Wants own way 23 Children, 48% Stubborn 22 children, 46% Relieved abuse not a secret 22 Children, 46% Bossy 20 Children, 42%	Hurts self 39 Children, 81% Cruelty to animals 37 Children, 77% Threatens other people 34 Children, 71% Apprehension re: legal system 33 Children, 69% Teased a lot by others 31 Children, 65% Destroys property of others 30 children, 65% Fears no one believes them 30 children, 63%

As parents worked through these emotional issues, they regained confidence that they could go on, repair their lives and recover. As the child victims began to feel better and their behavioral problems decreased, parents gained hope and concurrently improved. When there was resolution of the legal issues, the family began to put the experience behind them. This came when prosecution or civil actions were completed, or when a final decision was made not to pursue prosecution. An important factor was that parents felt they had done all they could to curb the abusive behavior by the perpetrator, to protect other children in the community, and to improve the system's response to child victims and families.

When the family experienced anniversaries of the sexual abuse and disclosure, they began to review the progress they had made. After they had successfully managed several crises, they realized their strengths, and this provided momentum for continuing recovery.

Significant indicators of recovery for parents were decreases in anxiety, anger, sadness, and guilt felt about the sexual abuse. Parents demonstrated a renewed confidence in their parenting ability and in the well-being of their children. They had a realistic perspective of how to be helpful and protective, and they could allow their children an appropriate degree of independence. They could again trust others and self-blame was diminished. Parents also demonstrated an improved self-image and an improved marital relationship. There was a restoration of normalcy and pleasure in daily routines, social activities, job pursuits, and plans for the future.

Table 9. Recovery Factors for Child Victims from Follow-Up Survey. *N* = 48 Child Victims

Support from Mother	24 Responses (50%)
Individual Counseling for Child Victim	17 Responses (35%)
Support from Father	15 Responses (31%)
Parents Believed the Child's Disclosure	11 Responses (23%)
Group Treatment for the Child Victim	11 Responses (23%)
Change in School, Daycare, etc.	10 Responses (21%)
Child Realized Sexual Abuse Not His Fault	4 Responses (8%)
Child's Inner Strength	3 Responses (6%)
Disclosure of the Abuse	3 Responses (6%)
Perpetrator Received Some Penalty	3 Responses (6%)

Table 10. Recovery Factors for Parents from Follow-Up Survey. $N = 30$ Parents

Group Treatment for Parents	15 Responses (50%)
Individual Treatment for Parents	14 Responses (47%)
Help from Spouse	13 Responses (43%)
Improvement in the Child Victim	13 Responses (43%)
Help from Friends	8 Responses (27%)
Reading, Self Education	5 Responses (17%)
Reporting the Sexual Abuse	4 Responses (13%)
Working to Change the System	4 Responses (13%)
Employment	3 Responses (10%)
Personal Writing, Diary, Journal	3 Responses (10%)

Factors Extending Treatment

Some children required only a few months of treatment, others required a much longer course. Important factors extending treatment included the extent of the sexual abuse, the use of threats or violence, an inability of the parents to resolve their own despair, and a prolonged course in criminal or civil court.

An alternative, shorter course for group treatment was scheduled to determine the effectiveness of a more didactic 16 week session. The families in this session were not willing to terminate after 16 weeks and treatment was then extended. A more focused, time limited treatment course may be successful when goals, expectations, and limitations are clarified and prioritized with families during evaluation.

Follow-up Surveys

Follow-up surveys were returned by parents for 48 child victims from this sample, a return rate of 21%. Information was requested regarding changes in symptoms for child victims and recovery factors for child victims and parents. The survey was done by mail and was completed by mothers, while a few fathers added comments. The survey sample includes child victims from a wide range of age and developmental groups, extent of sexual abuse, extent of intervention, and time elapsed since sexual abuse, disclosure or treatment interventions. The goal of the survey was evaluation of program goals and objectives with a plan to develop specific outcome measures subsequently. Mothers provided information which indicated whether symptoms in their children were: (1) improved, (2) present with no change, or (3) not observed (see Table 8). Some of the child victims were young enough that certain symptoms were not age appropriate or were difficult to determine.. These reports were provided retrospectively, after participation in the ReCAP program. Baseline data from time of referral was not collected in the same format to allow a more objective analysis.

Parents were asked to identify the three most important factors in recovery for child victims and for themselves. A list of 26 factors for parents and 28 factors for child victims was given to consider. The response was open ended so that parents could also write in other factors. Tables 9 and 10 summarize the factors that were listed most often as first, second, or third choices. These factors correlated with clinical observations. Generalizations are limited because of the informal nature of this information, the small sample, and bias within the sample. The follow up surveys report the mothers' perceptions of change in symptoms and are based on the accuracy of the mothers' memories regarding the symptoms that resulted from the sexual abuse. This information is best used as a guide to program development and in planning for formal outcome measures.

DISCUSSION AND CONCLUSIONS

The requests for services always greatly exceeded the capacity of the program and demonstrated the need for increased services. Consultation, crisis counseling by phone, and referral services were

provided for an additional 350 cases (approximately 50 cases per year) that were not included in this sample. Our experience indicated that a significant factor in recovery for child victims was the parents' capacity to resolve their own distress and to support the child victim. A family centered approach to intervention was considered essential and does not require a separate project. Children's Treatment Groups and Parent Support Groups offered interventions of significant benefit to one third of the sample of child victims and their parents. Each of these services extends the continuum of intervention and can be added to existing child services programs.

Programs for ESA can be effectively based at outpatient medical settings, mental health clinics, private or public social service agencies. Child advocacy centers provide an ideal setting for this intervention because investigations can be completed in a child friendly manner. Supportive services for the whole family can then be extended in an effective way for cases that will be prosecuted as well as those that are not prosecuted. In the time since this pilot project, many authors have reported success in providing intervention with child victims of ESA and their families. Treatment modalities are more refined. As formal out measures are completed, the knowledge and skill for intervention with this population will benefit the large numbers of child victims and their families that are identified each year. With more community awareness and increased services, early intervention will be possible for a greater number of child victims.

Acknowledgements—The authors would like to thank Carol C. Haase for her significant contributions as a member of the ReCAP program staff and co-therapist of the Children's Treatment Group.

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RÉSUMÉ

Objectif: Réduire la détresse psychologique des enfants victimes d'abus sexuels et celle de leur famille, dans des situations où les agresseurs ne sont pas des membres de la famille. Offrir une intervention d'état de crise et des services individuels ainsi que le traitement en groupe, afin de répondre aux besoins de la communauté. Faire un essai pilote d'un programme de traitement de groupe pour enfants de moins de 10 ans qui ont ét´ victimes d'abus sexuels hors-famille.
Méthode: Cet article décrit des interventions auprès de 245 enfants victimes, âgés de 2 à 14 ans et de 323 parents. Tous ont participé au programme de 1984 à 1991. Ce projet pilote s'est tenu dans un service médical universitaire qui se trouvait à l'extérieur du campus, dnas un centre de services externes pour enfants maltraités. On accordait la priorité aux enfants de moins de 7 ans. Les enfants et elurs familles ont été évalués une fois les enquêtes légales terminées. Un programme de traitement a été élaboré suite à une évaluation clinique. Les familles ont participé à du counseling de crise. Un traitement individuel ou en groupe a été prodigué aux enfants et/ou aux parents, ou encore on les a orientés vers d'autres services. L'évaluation clinique des progrès se faisait toutes les semaines au moyen d'une revue de cas par le thérapeute de l'enfant et celui des parents. On a aussi fait une analyse des vidéos, des observationss des sessions de groupes des enfants et des consultations avec les parents et autres personnes proches de l'enfant.
Résultats: On a observé qu'une approche familiale et des services prodigués aux parent, en plus des interventions auprès des enfants victimes, constituaient des éléments clés pour assurer le rétablissement. À partir des obeservations cliniques et

des opinions des usagers, on note que les services de counseling de crise apportent des résultats positifs tant pour les enfants que pour les parents. Le nombre des interventions variait, allant d'une seule session jusqu'à 24 mois. En moyenne, le degré de participation était de 6 à 9 mois. Pour faire le suivi, on a demandé aux parents de participer à une enquête qui a porté sur 48 enfants victimes. Les réultats de ces enquêtes sont rapportés. L'article discute des thèmes, des chevauchements dans les réonses et des factuers contribuant au rétablissement des enfants et des parents.
Conclusions: On a démontré qu'il faut fournir une intervention et un programme branchés dans la communauté parce que: (1) le fonctionnement des enfants et des familles est gravement dérangé lorsqu'il y a abus sexuels hors-famille; (2) on risque des séquelles à long terme; (3) il y a une incidence élevée d'abus sexuels hors-famille et (4) il existe und demande régulière et considérable pour des services. Les services de crise axés sur les familles, les groupes de traitements pour enfants et les groupes d'appuis pour les parents peuvent être offerts avec succès dans des centres qui s'occupent de la défense des droits des enfants, ou dans des cliniques externes ou autres agences communautaires. Il faut poursuivre des études longitudinales et adopter des moyens pour mesurer les résultats des divers types d'interventions afin de mieux connaître comment les enfants et les parents bénéficient de ces programmes et comment utiliser les ressources de la communauté de façon économique.

RESUMEN

Objetivos: (1) Disminuir el malestar emocional de las víctimas de abuso sexual extrafamiliar (ASE) y sus familias. (2) Proporcionar intervención en crisis y tratamiento individual y grupal en respuesta a una demanda de la comunidad. (3) Evaluar la utilización del tratamiento grupal para niños/as vítimas de ASE de edades inferiores a diez años.
Método: Este artículo describe la intervención llevada a cabo con una muestra de 246 niños/as víctimas de ASE, de edades comprendidas entre 2 y 14 años, y 323 padres/madres que participaron en el programa entre 1984 y 1991. Este proyecto piloto se desarrolló en un centro médico universitario y estaba ubicado fuera del campus, en un centro de visitas extrnas de maltrato infantil. Tenían prioridad los niños/as víctimas de ASE de edades inferiores a siete años. Los niños/as vítimas y sus familias eran sometidos a una evaluación una vez que la policía había terminado las entrewvistas de investigación. En base a esta evaluación clínica se formulaba un plan de tratamiento. Las familias participaron en actividades de apoyo/intervención en crisis, tratamiento individual para el niños/as, grupos de apoyo para los padres/madres, o fueron derivada a otros servicios. Se evaluó la evolución del tratameinto a través de revisiones semanales de los terapeutas de los niños/as y de los padres/addres, análisis de vídeos y observación de las sesiones de tratmiento grupal de los niños/as, revisiones con los padres/madres y contactos colaterales.
Resultados: La perspectiva familiar y la provisión de servicios a los padres/madres, además de la intervención con los niños/as víctimas de ASE, dueron componentes esenciales para posibilitar la recuperación. Las observaciones clínicas y las manifestaciones de los clientes indicaron que se obtuvieron resultados positivos para los niños/as víctimas y los padres/madres con el apoyo/intervención en crisis, con el tratamiento grupal para los niños/as, y con los grupos de apoyo para los padres/madres. La duración de la intervención varió entre una sesió y 24 meses, con una participación media de 6–9 meses. Los padres/madres de 48 niños/as víctimas constestaron a una encuesta de seguimiento. Se comentan cuestiones relativas a los contenidos de esa encuesta, semejanzas en las respuestas, y factores de recuperación.
Conclusiones: Se demonstró la necesidad de un programa de intervención comunitario por (1) el importante trastorno que suponen los episodios de ASE en el funcionamiento de los niños/as víctimas y sus familias, (2) el riesgo de secuelas a largo plazo, (3) la elevada incidencia del abuso sexual extrafamiliar, y (4) la elevada y consistente demanda de servicios de este tipo. Los servicios de atenció/intervención familiar en crisis, los grupos de tratamiento para niños/as, y los grupos de apoyo para padres/madres, pueden ser implantados de manera adecuada en los "child advocacy centers," en los centros de salud mental, o en otros servicios comunitarios. Es nacesario utilizar medidas formales para evaluar resultados y llevar a cabo estudios longitudinales para determinar cómo los niños/as víctimas de ASE y sus familias se benefician de modalidades de tratamiento específicas, de manera que ello sirva como quía para una mejor utilización de unos recursos que son limitados.