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Child Sexual Abuse Victims and Their Treatment

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by
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Foreword

Complex factors influence how and to what extent a child is harmed by sexual abuse. Developing effective intervention strategies for dealing with cases of child sexual abuse requires recognizing the range of sexual abuse experiences. The types and extent of treatment, and the steps taken to ensure that the family receives treatment are likely to be different in each case. Treatment programs must be attuned to both the common issues and significant variations in child abuse cases.

This study tested the appropriateness of a treatment model for child abuse victims that concentrated on the complex relationships among the child's development prior to the sexual abuse, the nature of the sexual contact, the manner in which the abuse was revealed, the reactions of family members, and treatment interventions.

The research sample concentrated on 156 children who were referred to the Family Crisis Program for intervention and who met other predetermined criteria. The Family Crisis Program is an agency created by the Division of Child Psychiatry at the Tufts New England Medical Center in Boston. The study attempted to determine the circumstances under which children were likely to be harmed by sexual abuse and whether psychotherapeutic intervention could reduce the risk of emotional harm.

In an evaluation of treatment success, clinicians felt that 76 percent of the families experienced at least moderate benefits. However, the study found that the greater the delay between the time families were referred to the program and the time they began treatment, the less likely they were to benefit from the intervention.

Data collected from families of sexual abuse victims 1 to 2 years after they were referred to the Family Crisis Program offer preliminary insights into the range of interventions and the changes in emotional distress that occur in the children after the sexual abuse has been revealed. The sample of victims, as a whole, showed a significant decrease in overall psychopathology and an increase in positive self-esteem at the conclusion of the followup study.

The Family Crisis Program's experiences with families suggested that most (78 percent) required further services once initial intervention was concluded. However, in most cases, followup services were limited.

Results of the study will help professionals who investigate child sexual abuse and treat its victims learn more about the effectiveness of psychotherapeutic intervention and other types of treatment. The treatment model tested by the Family Crisis Program can help professionals identify the type and degree of harm caused by abuse and the implications for a child's development. The data from this study, we hope, will be used to improve the treatment available to the sexually abused child.

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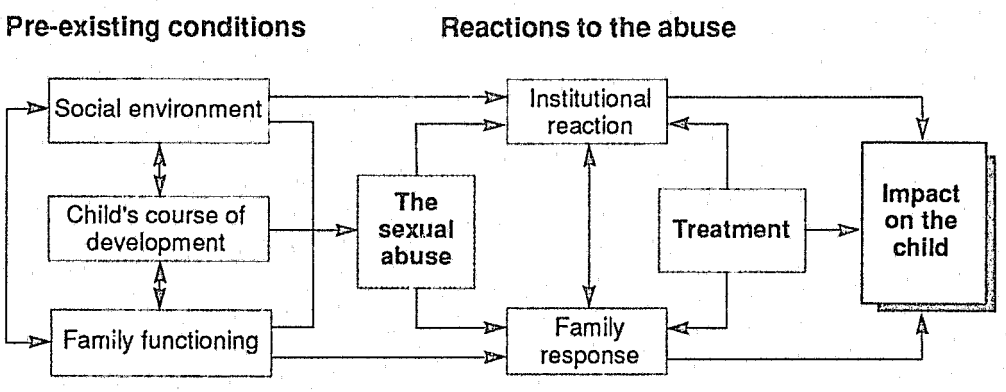
I. Introduction

The primary goal of this research was to test the appropriateness of a treatment model based on the premise that the sexual abuse of a child and/or the revelation of the abuse create a crisis for both the victimized child and the family. A major objective, therefore, was to test the treatment model by collecting extensive data on children with diverse sexual abuse experiences. To collect this data, the Division of Child Psychiatry at the Tufts New England Medical Center in Boston created the Family Crisis Program (FCP) to provide clinical services to the victims of sexual abuse and their families. A major aim was to develop a data base useful in determining the circumstances under which children were likely to be emotionally harmed by sexual abuse and whether psychotherapeutic intervention could reduce the risk of emotional harm.

A. The Conceptual Framework

To conceptualize and understand the complex factors that influence to what extent a child is harmed by sexual abuse, the FCP developed a model that focused on the complex relationships between factors in the child's development prior to the sexual abuse; the nature of the sexual contact; the manner in which the abuse was revealed; the reactions of others, especially family members and community agencies; and the interventions that occurred after the abuse was revealed. As illustrated in the proposed model, parental and societal reactions to the abuse influence each other and are influenced by knowledge of the sexual experience and circumstances preceding the abuse. While these reactions contribute to the impact of the sexual abuse upon the child, they may be mediated by treatment intervention.

A Model of Child Abuse



B. Criteria for Treatment Eligibility

The treatment model was based on the premise that the experience of being sexually abused or the revelation of sexual abuse creates a crisis for the victimized child and family. Therefore, it was necessary to restrict case selection to those families most likely to be experiencing major disruption in their lives because of the occurrence and/or revelation of sexual abuse. Although disagreement exists as to the length of time a victim remains in crisis after a traumatic experience, only those children who had been victimized within 6 months prior to referral, or who had first revealed the occurrence of ongoing sexual abuse during this same period, were eligible for FCP services.

To determine whether different types of sexual abuse occurred in specific types of children, or whether such abuse resulted in different effects on the victimized child, the National Center on Child Abuse and Neglect definition for child sexual abuse was used as a guideline. The Center defines child sexual abuse as "contact and interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over another." For FCP purposes "significantly older" represented a 5-year age difference between the victim and perpetrator. The definition used by the FCP did not include mutual sexual activity among peers, sexual stimulation, or even sexual intercourse between mutually consenting adolescents.

C. The Research Sample

Between July 1980 and January 1982, 314 children were referred to the FCP for clinical services. This group included four subsets: (1) children who were referred for services but did not participate in the treatment program (115 cases); (2) children evaluated by the program and judged to have been sexually abused (156 cases); (3) children for whom the allegations of sexual abuse either could not be confirmed or were judged to be untrue (25 cases); and (4) children who were referred for services because they had allegedly sexually victimized others (18 cases). Since the study's major concern was child sexual abuse victims, the full report focuses on the 156 children who met the criteria for inclusion, although data are presented for the three other categories described above.

A variety of measures was used to collect data on the characteristics of the sexually abused child, the parents, family environment, social milieu, and the nature and extent of the sexual abuse. Whenever possible, standardized self-report measures were used so that the characteristics of this population of sexually abused children could be contrasted with the general population or broad psychiatric population. These measures were supplemented by questionnaires developed for programs studying child sexual abuse and by an extensive series of interview questionnaires developed for this study.

Followup interviews were also completed within 12 to 18 months after a patient had completed crisis intervention. These interviews included questions to assess changes in the child's and the family's lives since they entered treatment, as well as the parents' evaluation of both the sexual abuse experience and the services they received in conjunction with the abuse.

II. The Nature and Extent of Child Sexual Abuse

A. *Victim Characteristics*

A child's average age on entry into the FCP was 10.1 years, with 65 percent of the children under 13 years old. The average age of first abuse was 9.1 years. The data provide increased support for the premise that prepubertal children are the most likely victims of sexual abuse. At the time of treatment at the FCP, 58 percent of the girls and 79 percent of the boys had not yet reached puberty. Since the sexual abuse had been ongoing for years in some cases, the proportion of children who were not pubertal when the abuse first started is probably higher. Popular explanations presented in literature and films—that child sex offenders are stimulated by the victim's budding sexuality—are at odds with evidence indicating that most of the victims had not yet begun to exhibit secondary sex characteristics.

A minority of the children came from intact, two-parent families; in only 31 percent of the cases did a child live with both natural parents. A substantial proportion of the children (27 percent) lived with a biologically unrelated man, either a stepfather or the mother's boyfriend. The proportion of sample households headed by a mother, i.e., 43 percent with a mother living alone with her children or with other adults such as a grandmother or boyfriend, contrasted with a figure of 24 percent found in the larger population from which the families came.

A substantial proportion of the children also evidenced other signs of family disorganization or disruption. Before the age of 6, 38 percent of the children had been separated from their natural fathers for more than 6 months and 17 percent had been separated from both parents for similar periods. The average child in the study had experienced two changes in parental figures during childhood. Among children over the age of 7, 21 percent had had four or more changes in parenting. Clinicians judged that 78 percent of the children had experienced some degree of disruption of the family unit, with some of these disruptions due in part to intervention by protective services. In 38 percent of the cases, the children had been officially identified as victims of abuse or neglect prior to the sexual abuse, with 19 percent of the victims having been removed from their homes because of such abuse.

The data provide support for the hypothesis that family disruption combined with poverty may increase the likelihood that a child will be sexually abused. Poor families, especially those led by a single parent, often lack the financial resources to sustain a stable home environment. Families may move frequently; caretakers for the children may shift often because mothers must rely on an assortment of relatives or friends to provide intermittent help. As families become more disorganized, more people become involved in a child's life. Boundaries between adult caretaker and child become less clear, thereby making it easier for aberrant behavior to occur and go unnoticed by other adults in the household. The research data also indicate that child sexual abuse in

multiproblem families may be readily identified by professionals because such families appear more frequently on public assistance rosters and in public health clinics. In contrast, when the family presents an external image of stability and conformity to community norms, sexual abuse may be much more difficult to uncover, thereby leading to fewer cases of sexual abuse within upper-strata families being reported to authorities.

B. Seriousness of the Sexual Abuse

Children referred to the FCP experienced a wide variety of sexual victimization, with a majority having more than one sexual contact with either the same (55 percent) or multiple offenders (14 percent). In 31 percent of the cases, the sexual abuse had gone on for more than a year before the child was seen at the FCP. For most of the children, the sexual contact was a current issue; 43 percent experienced sexual contact as recently as 1 month before intake into the FCP, while an additional 39 percent had sexual contact more than 1 month but less than 6 months before entering treatment. Longer delays between the last sexual contact and intake into the FCP were more likely in cases of long-standing or frequent sexual abuse, with younger children being abused for less time and seen sooner after their most recent sexual experience.

There were two major subgroups of cases: (1) children who had a limited amount of sexual contact shortly before referral to the FCP, and (2) children who had extended, repetitive sexual experience that may have discontinued in the period immediately before referral, either because the sexual abuse had been revealed, or because various agencies had already intervened with the family before referral to the FCP.

Table 1

Sexual Abuse by Level of Severity

Type of abuse	No.	Percent
Intercourse (vaginal or anal)	43	27.6
Oral-genital contact or object penetration	59	37.8
Fondling or mutual stimulation	36	23.1
Attempts/touching	10	6.4
No information	8	5.1
Totals	**156**	**100.0**

In terms of the severity of the sexual abuse, Table 1 shows that the overwhelming majority of the children experienced serious sexual contact, with 28 percent subjected to either vaginal or anal intercourse, 23 percent fondled by the offender or forced to stimultate the offender manually, and 38 percent subject to oral-genital contact or object penetration. The majority of children (69 percent) treated at the FCP were subjected to repeated assaults over a period of months and 32 percent of the children were assaulted over a period of years. The abuse was limited to a single incident in only 21 percent of the cases. The brief contacts with an exhibitionist that constitute as much as 44 percent of the childhood sexual victimization disclosed in community surveys, represented only 4 percent of the cases referred to the FCP for treatment.

Based upon the child's and parents' reports, three major strategies were used

by offenders to gain the child's compliance: (1) *manipulation*, including deceiving and bribing the child, or resorting to their authority as adults to convince the child to comply; (2) *verbal threats;* and (3) *overt aggression*, including threatening the child with a weapon, or physically overpowering or beating the child. In 32 percent of the cases, manipulation alone was used, while in 52 percent manipulation was accompanied by either aggression or threats. Sexual abuse resulted in physical injuries to the child in 23 percent of the cases, and was most serious when either intercourse occurred or when aggression was used to gain compliance. Girls, nonwhite children, and children from lower socioeconomic backgrounds were more likely to be injured. Perhaps the most striking finding is that *family members were just as likely to resort to violence as offenders who were not related to the child.*

C. *Characteristics of Offenders*

The majority of the children (74 percent) had been sexually assaulted by one offender, while 12 percent had been involved with several offenders. In 88 percent of the cases, the identity of the offender was reasonably certain. When there were multiple offenders, the initiator was identified as the primary offender for research purposes.

Almost all offenders were men (96 percent) who had some prior relationship with the child. Table 2 shows that 19 percent were natural parents while 22 percent were related. Of the total sample of offenders, 40 percent functioned in the role of parent. Nearly half lived in the same home as the victim (47 percent). Although 34 percent were nonfamily members, few (4 percent) were actual strangers. These figures strongly support repeated clinical observations that children usually are sexually abused by someone they know and often trust. Contrasts of the FCP cases with other survey data suggest that abuse by strangers may occur somewhat more frequently in the general

Table 2

Relationship of Victim With Primary Offender

Primary Offender	No.	Percent
Natural parent	30	19.2
Parental figure (not a blood relative)	32	20.5
Step-parent		(12%)
Adoptive parent		(2%)
Foster parent		(2%)
Parent's live-in partner		(5%)
Other relative	35	22.4
Uncle		(12%)
Grandfather		(3%)
Sibling		(5%)
Cousin		(3%)
Other relative		(1%)
Not a family member	51	32.7
Parent's lover		(1%)
Babysitter		(3%)
Foster sibling		(3%)
Acquaintance		(24%)
Stranger		(3%)
Other		(1%)
Unknown	8	5.1
Totals	**156**	**99.9**

Note: Due to rounding off numbers, subtotals in parenthesis do not equal numbers represented in the percent column.

population than in children referred for services.

The offenders were relatively young men, with half being under the age of 30; 29 percent were adolescents. The demographic characteristics were similar to those of the victims. Excluding students who were nearly all adolescents, 82 percent of the adult offenders were either blue-collar workers or unemployed.

The relationship between the child and the offender had some bearing on how often the sexual abuse occurred. When the offender was not a family member, the abuse was shorter in duration and occurred less frequently in the year preceding intake, suggesting that sexual assaults by acquaintances and strangers are more likely to occur as isolated instances. *The physical proximity of the offender and victim that exists when the offender is a relative or member of the child's household increases the likelihood that repeated sexual abuse will go undetected.*

The study failed to find any differences in types of abuse that could be attributed to the child's relationship with the offender. *Aggressive sexual approaches and physical injury of the child were equally likely whether the offender was a parent, a relative, or an acquaintance.* Thus, there is little reason to believe that sexual abuse of a child by a parent is less likely to involve physical harm. Some children were brutally raped and beaten by fathers and stepfathers, while others were lured into sexual activity by adult acquaintances who relied on the child's affection for them.

III. Disclosure and Reaction to the Sexual Abuse

Among the cases brought to the attention of the FCP, 55 percent were initially revealed by the child. Children who told were most likely to tell a parent or caretaker (55 percent), siblings (8 percent), school personnel (8 percent). In 17 percent of the cases, the child's initial attempt to relate the incident did not lead to help, either because the child was not believed (9 percent) or because the responsible adult took no action (8 percent).

The length of time that children kept incidents of sexual abuse secret suggests that most children are hesitant to seek help. Only 24 percent told immediately after the abuse, while 17 percent waited for more than a year. Furthermore, 39 percent of the children had not told anyone about the abuse before coming to the FCP. The primary factors underlying the reasons why children resisted reporting the sexual abuse were the fear they would lose the affection or goodwill of the offender or would be blamed for the abuse or harmed if they told. Children who experienced intercourse and those who had limited sexual experiences involving attempted activity or nontouching experiences such as exhibitionism, were especially likely to keep the abuse a secret. When the strategy for gaining the child's compliance was aggressive, the child was likely either to report the incident immediately (39 percent) or fail to tell at all (43 percent).

When the offender had manipulated the child into complying, relatively few children immediately reported the abuse (25 percent). Similarly, when a child was abused by a natural parent, more than 53 percent did not tell. Such resistance was far more rare when the offender was a parent-figure, such as a stepfather who had entered the child's life at a later time. Although 63 percent of the children in these cases waited some time before they told, relatively few continued to keep the secret (22 percent). These findings suggest that children are more likely to report the abuse when they feel little loyalty to the offender. This is supported by the observation that immediate reporting of the abuse was most frequent when the abuser was not a member of the child's family (i.e., 39 percent told immediately). These findings may be important in helping caretakers and clinicians facilitate disclosure of sexual abuses. Children need to be reassured that: (1) they will not be harmed because they tell, (2) they are not responsible for the sexual approaches of an adult, and (3) their report does not reflect disloyalty to the abuser.

A. Reactions by Mothers of the Child Abuse Victims

The reactions by the mothers of the victims fall into three major categories: (1) reassuring and protecting the child, (2) scolding or punishing the child, and (3) removing the offender from the home. Most mothers (70 percent) did not punish the child, although taking action to remove the offender from the home was contingent on whether the offender lived in the child's home and whether he refused to leave on his own accord. The mother failed to take protective action in only 18 percent of the cases.

The study indicated that the attitudes and actions of the mothers of the sexual abuse victims are shaped in part by the mother's relationship with the offender. Mothers tended to do less to protect the child when the natural father, rather than another relative or an outsider, had abused the child. It may have been especially difficult for these women to imagine that a natural father would sexually abuse his own child. However, these mothers also showed the least tendency to have negative feelings toward the child. These results can be explained, in part, by the fact that 45 percent of the cases of incest with natural fathers did not occur in intact families. A number of cases of sexual abuse that began when both parents were living together were not revealed until after a divorce or separation. Given these facts, there is less likelihood that the mother would have negative feelings toward the child.

Mothers were least protective and most angry and punitive toward the child when the abuser was not the natural father, but a stepfather or boyfriend. For these women, the new husband or boyfriend may have been providing financial resources and emotional security previously absent in the family structure. The revelation of the sexual abuse may have created a crisis for the mother as to what appropriate action she should take. Some mothers may have resolved this conflict by blaming the child.

The quality of the mother's relationship with the victimized child was also influenced by the mother's relationship with her own parents. Those who had poor relationships with their own mothers were especially likely to feel dependent on the child, while poor relationships with their fathers increased the likelihood that the mother would feel overburdened by her child's needs. Mothers whose children had been victimized by their current lovers or husbands (i.e., not the child's natural father) generally had less caring and more hostile relationships with their children than mothers whose children were victimized by someone outside the family.

This study's data challenge the image of mothers as willing accomplices in incest or other types of sexual abuse. Although some fit the stereotype and respond to the revelation of sexual abuse by either blaming the child or refusing to believe the allegations, most are able to mobilize their energies to ensure that the child will no longer be victimized, and to support the child during the difficult process of resolving the sexual abuse situation.

Assessing the reactions of the fathers of sexual abuse victims was difficult because few fathers were either available or willing to participate in treatment. In addition, less than 50 percent of the children were living with a father figure at the time they were abused. Furthermore, those fathers who were also the sexual abuse offenders often had left the home after the abuse had been disclosed. This lack of data on fathers of sexual abuse victims represents a limitation of the study.

B. Factors Associated With Emotional Distress of the Victims

The research found a modest degree of association between the amount of violence associated with the abuse and signs of emotional distress in the victimized children. Children who had suffered physical injuries during the sexual abuse were more likely to exhibit behavioral problems. Additionally, children who were induced to comply with the offender through overt aggression were more likely

to express overall hostility as well as more fears of aggressive behavior in others. There was little indication that one sexual act in particular influenced trauma, i.e., children subjected to intercourse did not suffer any greater stress than those who experienced other sexual acts.

The finding that violence was a more important influence on a child's reaction than the type of sexual abuse is consistent with the literature on rape. Threatened or actual bodily harm to the child may transform sexual behavior from odd or puzzling experiences to terrifying attacks. This study's data also failed to substantiate the hypothesis that abuse that goes on over a longer period or that begins earlier in the child's life is necessarily more harmful. *No relation was found between either the length of the abuse or the age of the child when it first began, and the effects of the experience on the child.*

One possibility for this finding is that the child's level of emotional distress when sexual abuse is first revealed may be influenced more by factors in the immediate situation, such as the furor occasioned by the revelation, than by the history of abuse. This does not necessarily mean that long-term adjustment is not influenced by a history of repeated abuse. The child who experiences longstanding sexual victimization may not appear manifestly symptomatic at intake. Nevertheless, the experience may have damaging effects on personality development; effects that will only become evident later in life.

The findings lend some support to the proposition that abuse by a parental figure is more traumatic than by other persons. Children abused by parent-figures who were not biologically related to them (e.g., stepfathers, boyfriends of mothers) exhibited the lowest self-esteem and the most severe problems with aggression and school performance. There was no indication that children victimized by natural parents were more disturbed than those who were abused by other relatives or persons outside the family. Thus, the crucial variable does not seem to be whether the offender was a father, but whether he was a substitute father. Why sexual abuse at the hands of a parent-surrogate should be more devastating for a child than incest with a father is not completely clear.

The data further indicate that a mother's expression of concern about the child and ability to take action to protect her child do not necessarily shield the child from the harmful psychological consequences of the abuse. Positive responses on the part of the mother were not systematically related to the amount of distress the child experienced. However, when a mother expressed anger toward the victimized child and punished her child for revealing the abuse, the child was likely to manifest greater behavioral disturbance. Furthermore, an angry reaction on the mother's part was associated with lower self-esteem in the child.

The research reinforces the idea that removing a sexually abused child from the home may not protect the child from psychological stress. Children removed from their homes following the sexual abuse exhibited more overall behavior problems, particularly aggression, than children who either stayed with their parents with whom they lived at the time of the abuse, or with the remainder of the family after the parent-perpetrator had been forced to leave.

Knowledge that the degree of violence in a sexual assault may be a potent influence on

children's reactions has important implications for intervention. Children who have been physically hurt or who have been threatened with bodily harm have good reason to fear that the sexual offender may still hurt them. Thus, two of the tasks of intervention with these children are to ensure that they are safe, and to decrease the likelihood that the child will be exposed to the offender, once the abuse has been revealed.

IV. Treating the Sexually Abused Child

The treatment approach used by FCP drew heavily on classic "crisis theory," which holds that crises occur in people's lives when individuals, in attempting to achieve important goals, are faced with major obstacles that cannot be surmounted through ordinary coping mechanisms. Crisis intervention theory proposes that during this period of increasing tension, the individual may be especially open to treatment that establishes new problem-solving approaches. Thus, crisis intervention may not only relieve the distress of the individual, but it may also strengthen and modify the individual's capacity to withstand future stress.

A. Crisis Theory and Treatment

In resorting to crisis theory, FCP incorporated (1) *rapid intervention* to reach families as quickly as possible after the revelation of the sexual abuse, (2) *outreach*, whereby the staff was available to meet anywhere with the families of the abused victim, (3) *focal treatment* involving up to 12 sessions of intensive treatment, and (4) *liaison with other agencies* to facilitate family interaction with these agencies. Since a major objective of the research was to gain some understanding of the efficacy of the crisis approach in dealing with child sexual abuse, FCP measured both the nature of the treatment and the extent to which variations in the treatment were attributable to the family or the sexual abuse itself. The findings are briefly described below.

Although relatively few patients were seen in the clinic within 24 hours of the initial referral (14 percent), most patients did receive an initial phone call from the clinician within 24 hours. There was no evidence that either the type of sexual abuse or the child's prior history were important factors in determining how quickly the family was engaged in treatment. Some families may not have experienced a pressing need for immediate services, particularly if they had already had contact with another agency before referral to the FCP. Such contacts may reduce the sense of urgency to get additional help, or may even heighten a family's resistance to further intervention.

In the present study, home visits occurred most often when the child had been referred by the criminal justice system and when the alleged abuse had been relatively less serious. The findings suggest that offering outreach services does not ensure that a family will accept treatment, particularly if the objective of the visits is to convince resistant families that they need help.

Home visits by the FCP staff were more useful when they involved collaboration with protective service workers who had legal leverage to insist that families seek counseling. The presence of a trained supportive clinician at the initial encounter between a family in which sexual abuse has been alleged and the official investigating agency can potentially reduce the stressfulness of the situation for the family of the victim.

Ninety percent of the cases concluded crisis work in 12 or fewer sessions, with 7 1/2 hours being the average clinical time devoted to each case. In general, the average treatment program took slightly more than 6 weeks, involving less than two sessions per week; the more serious the abuse, the more time clinicians spent with the family and child. Changes in the family constellation provoked by the disclosure of the sexual abuse influenced the type of treatment. When the victimized child had been removed from the home, sessions with the child were relatively more frequent, while sessions with the mother and family as a group were less frequent. Among those families in which there had been no change in parenting figures, mothers and couples had the most sessions while the children had the fewest individual sessions. The data suggest that families who remain intact after sexual abuse may require treatment focused more intensively on the parents and their joint responsibilities in protecting the child.

B. Referrals for Continued Services

Although crisis intervention theory generally is based on the idea that most trauma victims are able to achieve resolution of their crises with brief intervention and do not require long-term treatment, this did not prove to be the case with sexual abuse victims and their families. In the sample, 78 percent of the families required referral for additional services, with more than half of the families (56 percent) being referred for mental health services. Nearly as many (54 percent) required followup with protective services, with or without concurrent mental health services.

Recommendations for continued services were more likely when the family of the victimized child already had a history of prior problems. Thus, a program that focused on a specific problem by itself, in this case sexual abuse, might not be sufficient to produce significant changes. Prior to or during the time they were in treatment at the FCP, 65 percent of the families had some involvement with protective services and slightly more than half (52 percent) had some contact with an institution in the legal system. In all, 91 percent of the families had been involved with at least one other agency in addition to the FCP; the average family having had contact with two other agencies before FCP.

C. Evaluating Treatment Success

While the clinicians felt that 65 percent of the families showed at least moderate benefits from treatment, 35 percent had made little progress toward managing their lives without extensive outside resources. The extent to which families were able to function adequately was not systematically related to compliance with crisis techniques. Similarly, the extent to which they profited from the intervention was not related to the use of outreach or multiple sessions in a short time period. The finding that families who received more services benefited more from treatment also reinforces the idea that brief intervention may not be sufficient in cases of sexual abuse.

In a related matter, the study found that the greater the delay between the time a family was referred to the program and the time they began treatment, the less likely they were to benefit from the intervention.

These data suggest that strategies for quickly overcoming families' initial resistance to treatment are crucial if programs are to succeed in having an impact on the family.

Children who were not *physically* harmed during the course of the abuse, those who were victimized by acquaintances and strangers rather than family members, and those who came from families with no prior history of psychiatric or social services were most likely to function adequately. These findings reinforce an important point: *Crisis treatment may be helpful in cases of longstanding incest or with multiproblem families, but such brief intervention is not enough to change ingrained patterns of behavior.* Continued psychiatric treatment and access to a variety of social services is almost always necessary with such families.

The FCP experience in applying a modified crisis intervention model to the treatment of sexually abused children and their families suggests there are significant differences between the types of traumas addressed in traditional crisis work and those of child sexual abuse. These differences seriously limit the application of classic crisis techniques to the problem of sexual abuse. Because crisis theory generally presumes that prospective patients recognize that they cannot effectively cope and need outside help, the role of the treatment program is to make them aware that help is available. Although some families do seek out professional assistance, for the most part, sexual abuse cases are referred for treatment by someone else. In many instances, especially when the abuse is incestuous, clinicians must expect resistance to participating in therapy. Thus, a treatment model that emphasizes voluntary participation in services may not reach many of the families for whom sexual abuse is a serious problem, and may require collaboration with institutions and/or agencies that have legal leverage to enforce treatment recommendations.

D. The Followup Study

Data collected 1 to 2 years after the families of sexual abuse victims were referred to the FCP offer some preliminary insights into the range of interventions that families experience after the sexual abuse has been revealed as well as the changes in emotional distress that occur in the children during this period. At the conclusion of the followup study, the sample of victims, as a whole, showed a significant decrease in overall psychopathology and an increase in positive self-esteem. Seventy-five percent of the youngsters in the 4- to 13-year-old range did not exhibit significant psychopathology when compared with the general population of children in the same age group. Individualized assessment of change indicated that the majority of the children showed significant lessening of overall behavioral disturbance and improvement in self-esteem during the followup period. The data also showed that age, sex, race, and socioeconomic status did not influence improvement.

During the followup period, 51 percent of the children had experienced some change in the family structure.

Comparison of family patterns at the time the child was abused and at followup showed a decrease in two-parent families and an increase in children living away from their natural parents. Children who

had been abused by stepparents or parents' lovers were least likely to be living with the same parent figure at followup. The relatively high rate of family disruption (45 percent) when the offender was *not* part of the family is significant. Approximately 18 months after the families entered treatment *less than half the children (46 percent) were living with the same parents they had lived with when they were sexually abused.*

There was also evidence that the children who had experienced disruptions in their family environment exhibited more psychopathology at followup. Children who were living away from both parents had higher levels of emotional disturbance than those living in one- or two-parent families. Additionally, *children who were no longer living in the same household were more disturbed than those who had remained with their families after the abuse.*

Although the FCP was based on a model of brief, focused intervention, the experiences with families suggested that most (78 percent) required further services once the initial intervention was concluded. Families received relatively few services during followup; most (77 percent) having some contact with Protective Services, which was more common among nonwhite families and those from lower socioeconomic groups. These findings are consistent with repeated observations that the poor and minorities who receive health care from public facilities are more likely to be subjected to official scrutiny than families who have the resources to seek private care.

Data on the behavior of the sexually abused children in the 18-month period after revealing the sexual abuse and receiving crisis treatment suggests that 55 percent of the children did show a substantial diminution of emotional distress. Some of the distress caused by the sexual victimization and reactions to its revelation was reduced by treatment in a specialized clinic. It is noteworthy, however, that those children who improved the most were likely to have continued in therapy beyond the initial crisis intervention.

Most of the parents (78 percent) of the victimized children felt that the sexual abuse clearly had a harmful impact upon the child; 60 percent of the parents considered the sexual abuse and its revelation to be the worst event that had occurred in the family during the 3 year period preceding the abuse. Simultaneously, 67 percent felt that the abuse would cause difficulties for the child in the future. A substantial proportion of the parents felt that the revelation of the abuse caused some degree of harm for the family (43 percent) or the victimized child (36 percent). However, approximately the same number felt that the revelation had to some extent helped the child (44 percent) or the entire family (46 percent).

V. Concluding Remarks

The findings from the FCP study of child sexual abuse point out the difficulties in measuring both the effects of sexual abuse and the effects of treatment in alleviating emotional distress. It must be recognized that not all of the psychopathology a child exhibits when entering treatment is caused by the sexual abuse. Consequently, stopping the abuse and focusing treatment on the issues associated with the sexual abuse will not necessarily ensure that the child will be able to return to "normal." For many of the children seen and treated at the FCP, sexual abuse is just one among many forces that contributed to their emotional problems.

Developing effective intervention strategies for dealing with cases of child sexual abuse requires recognition of the range of experiences included in the concept of sexual abuse. The needs of a family whose child has been fondled by a neighbor are likely to be very different from those of a family in which the father has had intercourse with several children over a period of years. The types of treatment, the extent of treatment, and the degree of legal coercion used to ensure that the family receives treatment are likely to be very different in these cases. Sexual abuse treatment programs must be attuned to both the common issues and significant variations.

*U.S. G.P.O. 1988-202-045:80078