Model Treatment and Services Approaches for Professionals Working with Families of Non-Family and Family Abducted Children: Training Manual

THE WESTERN CENTER FOR CHILD PROTECTION

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Model Treatment and Services Approaches for Professionals Working with Families of Non-Family and Family Abducted Children: Training Manual

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INTRODUCTION-THE MODEL TREATMENT PROJECT

The Need

Few issues in recent years have generated as much legislative activity, media attention and public interest group activity as the problem of missing children. The U.S. Congress and almost every state legislature have passed legislation to increase the responsiveness of law enforcement to child abduction cases. The publicity of the search for missing children has become a common part of television news broadcasts and missing children photographs appear on milk cartons, grocery bags, airport/department store flyers and on the Internet. A substantial number of non-profit, public interest groups have been created to assist in searches and to promote preventative education programs as an accepted part of the education curriculum in school districts throughout the United States. The National Center for Missing and Exploited Children serves as a clearinghouse of information and assistance to families with an abducted child. State police agencies have developed specialized units, such as the Illinois State Police I-SEARCH Unit, to enhance local investigative effectiveness. The Federal Bureau of Investigation (FBI) has established a special unit which investigates child abductions along with other child related crimes.

Much of the legislative and public awareness advances have focused on recovering the child. The timeliness with which law enforcement now responds increases the likelihood that the child will be recovered for reunification. However, even in brief abductions, the child can be exposed to emotional and physical trauma. Law enforcement is not uniformly trained or equipped to respond to the immediate emotional reactions to abduction, either at the point when the child becomes missing or at the time of reunification. The intermediate and long term consequences after recovery are beyond their role and expertise.

When a child is recovered, the expectation is that the reunification will be a moment filled with relief and joy for the child and the family. The meeting often occurs in a police station or hospital. Often the police officers and detectives who have worked diligently to reunite the child and waiting family are the only people to witness the reunification. The moment rather than one of relief and joy is one of anxiety and confusion. The reunification needs of the child and family are identified in two prior projects: The Reunification of Missing Children and The Families of Missing Children Project: Psychological Consequences of Abduction. These projects also established that the impact of abduction typically spans beyond the reunification experience. Yet, to this point, there has not been the specialized

knowledge to address the unique needs of the recovered child and its family. While the psychological impact of family and non-family abduction has been examined by a few researchers and clinicians (Agopian, 1984; Forehand, Long, Zogg, & Parrish, 1989; Greif & Hegar, 1992; Hegar & Greif, 1993; Hatcher, 1981; Hatcher, Barton, & Brooks, 1992a, 1992b; Hatcher, Behrman-Lippert, Brooks & Barton, 1992; Plass, Finkelhor & Hotaling, 1996; & Terr, 1979), the literature lacks any reference to specific treatment approaches to work with the special needs of this population of children and their families.

Certainly the impact of abduction begins when a child is taken. Effective intervention starts when the child becomes missing. While the need for services with the left-behind parents and family is evident, treatment approaches specific to family needs during the missing period are lacking. Recent efforts to address the needs of left behind families have included the development of Project Hope, A Parent Support Network, funded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs. This project provides for identification of the needs of parents with family and non-family abducted children, development of a parents/family support network and training of volunteers with a missing child. Development of specific approaches for working with families with a missing child merits additional study.

In response to the special needs of recovered children and their families for treatment, the U.S. Department of Justice through the Office of Juvenile Justice and Delinquency Prevention (OJJDP) funded the **Model Treatment Services Approaches for Mental Health Professionals Working with Missing Children and Their Families**.

Model Treatment Approaches for Missing Children and their Families: Education and Training for Mental Health Professionals

The Project Goal: The goal of the Model Treatment Project is to increase knowledge of and develop effective treatment and services approaches for mental health professionals working with families of recovered children in order to minimize the psychological consequences experienced by these child victims and their families.

Model Treatment Project Manual: The Model Treatment Approaches Manual is designed to address the treatment needs of two distinct and separate populations: (1) children recovered from non-family abductions and their families, and (2) children recovered from family abductions and their families. The Model Treatment Manual is designed to provide mental health professionals with a guide to the assessment and treatment of psychological trauma associated with child abduction. The Manual is intended to assist mental health professionals in first

stabilizing family units upon recovery of missing children, and subsequently supporting these family units and the returned children in recovering from the emotional trauma of child abduction.

Use of the Manual: The Model Treatment is intended for use by mental health professionals with both limited and extensive experience in working with recovered children and their families. The manual is intended to be used as a reference resource and guide for specialized knowledge and skills related to abduction of children in order to provide effective therapeutic services to the recovered children and their families. While the scope of this project is limited to recovered children and their families, when appropriate, references are made to the needs of parents and non-missing siblings during the period the child is missing.

Two potential groups of mental health professionals may use this manual : (1) clinicians who want concise descriptions of the issues encountered in working with recovered children and their families, and interventions to assist in developing treatment plans for direct service to the clients sitting before them; and (2) clinicians/scholars who are additionally interested in the research associated with treatment issues and interventions. In anticipation of these two user groups, the initial chapters in this manual outline the issues and interventions in a direct format with minimal reference to the literature. Detailed literature reviews are presented in the appendices.

Content: The Model Treatment manual:

PART I
Understanding the Missing Child Problem

1. The Missing Child Problem and Model Treatment Development. This chapter briefly reviews the legislative/governmental response to the problem; the history and scope of the missing child problem in America; research findings on the sub-types of family and non-family abductions; research findings on the factors related to the psychological impact of family and non-family abduction; and brief summaries of the findings in The Families of Missing Children and Reunification of Missing Children Projects as they apply to both family and non-family abduction. Clinical Observation, and although limited, research (Finkelhor, Hotaling & Sedlak, 1990; Hatcher, Barton, & Brooks, 1992; Hatcher, Behrman-Lippert, Brooks & Barton, 1992), make a clear distinction between non-family and family abduction. The development, field tests and empirical measures utilized to design and evaluate the model are summarized.

2. Missing Children and their Families: the ABCX Model for Understanding Trauma Effects. This chapter presents the ABCX Model of

Family Adaptation to Stress as developed by Hamilton McCubbin of the University of Wisconsin. The ABCX Model is utilized in this Manual as a methodology to organize the complex amount of information present in child abduction cases, to assess the impact of the abduction event upon child and family and to assist in treatment planning. The use of the ABCX Model in this manual, provides a common language for mental health professionals working with families of missing children. In Sections II and III, the ABCX Model is applied by presenting detailed case histories of both non-family and family abductions. The information is then organized according to the ABCX Model.

PART II
Children Recovered From Non-Family Abduction

3. Children Recovered from Non-Family Abduction and their Families: A Model Treatment Program. Based upon research and clinical experience with children recovered from non-family abduction and their families, a Model Treatment Program (MTP) has been developed. The Model Treatment Program consists of four Stages. Stage I deals with the initial recovery of the child and the reunification with the family. Stage II describes the initial short term trauma response pattern for recovered children and their families. Stage III describes the long term trauma response pattern for recovered children and their families. Stage IV describes termination/periodic recontact for recovered children and their families.

4. Non-Family Child Abduction: Three Full Length Case Histories. In this section, the mental health professional is provided with full length case narratives that cover the pre-abduction history of the child and family, the abduction, the search and family adaptation during the search, the recovery/reunification, the initial adjustment and long term adjustment. These case narratives are designed to assist the mental health professional in making the transition from the conceptual realm to clinical practice.

5. Sample Intervention Techniques and Therapist Questions In Cases of Non-Family Abduction. Sample treatment techniques specific to abduction symptoms seen in non-family abducted children are reviewed. Therapist questions include diagnostic considerations, therapist qualifications and forensic involvement.

PART III
Children Recovered from Family Abduction

6. Children Recovered from Family Abduction and their Families: A Model Treatment Program. Based upon research and clinical experience with

children recovered from family abduction and their families, a Model Treatment Program (MTP) has been developed. The Model Treatment Program consists of four Stages. Stage I deals with the initial recovery of the child and the reunification with the family. Stage II describes the initial short term trauma response pattern for recovered children and their families, including important questions for assessment of the child and family. Stage III describes the long term trauma response pattern for recovered children and their families. Stage IV describes termination/periodic recontact for recovered children and their families.

7. Family Child Abduction: Four Full Length Case Histories. In this section, the mental health professional is provided with full length case narratives that cover the pre-abduction history of the child and family, the abduction, the search and family adaptation during the search, the recovery/reunification, the initial adjustment and long term adjustment. These case narratives are designed to assist the mental health professional in making the transition from the conceptual realm to clinical practice.

8. Sample Treatment Techniques and Therapist Questions . In this section, sample treatment techniques for issues specific to abduction related symptoms are presented. Therapist questions include child placement, diagnosis, therapist qualifications, forensic involvement and personal considerations.

PART IV
Future Needs

9. Limitations and Needs of the Models. Clinical evaluation across four samples of missing children support the utility of the model for identifying, evaluating and treating child and family needs. However the model has not been adequately tested. Development and review of the literature, expressed desires of project therapists and discussions with parents, missing children's organizations and members of other disciplines identified areas for further development including treatment for families during the missing period, treatment for families in which the victim is recovered deceased, issues for mental health professionals in the courtroom, interventions which account for ethnic and cultural diversity, and prevention.

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Appendix A: Non-Family Abduction Literature/Research Review. This appendix summarizes the literature specific to non-family abduction including child hostages, the demographics of non-family abduction, the impact of abduction on child and family, and a brief summary of the results of the *Families of Missing Children* and *Reunification of Missing Children* projects as they relate to non-family abduction.

Appendix B: Family Abduction Literature/Research Review. This appendix summarizes the literature specific to family abduction including child custody issues, the demographics of family abduction, the impact of abduction on child and family, and a summary of the *Families of Missing Children* and *Reunification of Missing Children* projects as they relate to family abduction.

Appendix C: General Trauma Review. This appendix summarizes the literature relative to adult, child and family trauma. Descriptions of trauma related symptoms, treatment strategies for child centered and family centered interventions are outlined.

Appendix D: Data Forms

Appendix E: Parental Abduction Case Summary

Appendix F: Reunification Protocol

CHAPTER ONE - THE MISSING CHILD PROBLEM

Historical Background. Child disappearance has been documented in history and literature since Greek and Roman times. Cases of parental abduction are dramatized from Euripides' Greek tragedy *Medea* to Mozart's *The Tale of the Magic Flute*. Historical records have primarily focused on the known facts of the incident, the recovery/non-recovery of the child, and the punishment assigned to the abductors. Very limited attention was given to the psychological aspects of distress or the family and child's adjustment after recovery.

In the United States, it was not until the 1700's and 1800's that child kidnapping began to be documented. One of the first accounts of non-family abduction was the kidnapping of Charlie Ross, who was abducted from Germantown, Pennsylvania in 1875. The sequential account in the *New York Times* and a subsequent book by Christian Ross reached beyond the facts of the case to document the search and coping efforts of the father. However, Charlie Ross was never found. Then, in the early twentieth century, the well known and documented baby Lindbergh kidnapping case led to the passage of new U.S. anti-kidnapping laws. Both of these cases were non-family abductions motivated by ransom/extortion efforts against the children's parents.

In the second half of the twentieth century, sexually motivated child kidnappings have dominated the media in the non-family abduction sphere. The Atlanta murder cases and the abduction and murder of Adam Walsh in the 1980's and the abduction and murder of Polly Klaas in 1993, to name a few, focused public concern on the issue of abducted and missing children. This concern not only included the adequacy of law enforcement investigations, but the psychological consequences of the event for the family of the abducted child. New federal and state legislation has been passed addressing non-family abduction and penalties for those who abduct.

Likewise, recognition of the problems associated with family abducted children has been brought to the public's attention through the efforts of individual parents, missing children's organizations, television news documentaries, magazine articles and talk show interviews. Media attention to the problems has increasingly focused on the pain associated with having a child abducted by a family member, obstacles in searching for and recovering family abducted children, and the stress and loss associated with family abduction.

Initial efforts to respond to the problem of family abduction resulted in inconsistent sets of laws and overlapping jurisdictions among states, and between the U.S. and other countries as well. Abducting parents quickly learned that such

legal inconsistencies or gaps could be used to their advantage. Even when the abducting parent and child were located, existing law could be used to continue to deny contact with the child to the left behind parent. Law enforcement agencies found it difficult to determine if parental abduction was a civil or criminal matter. At what point did the abducting parent's behavior become a criminal matter as opposed to a domestic dispute?

In response to the problems associated with both family and non-family abduction, governmental agencies, private non-profit organizations and individual researchers have focused their attention on ensuring a positive outcome.

Response of the Federal Government to the Missing Child Problem. As Table 1 demonstrates, efforts to address the problem of missing children predate the 1980's. An increase in research and program development occurred with the implementation of the 1982 Missing Children's Assistance Act (Title IV of the Juvenile Justice and Delinquency Prevention Act), under the direction of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the Office of Justice Programs, The U.S. Department of Justice. OJJDP was charged with responsibility for administering the federal Missing and Exploited Children's Program. Table 1 provides only a partial chronology of the government response to this problem and is intended to give the reader a brief outline of the types of projects and efforts that have contributed to the knowledge and development of the missing children issue.

Table 1
Finding Missing Children:
What Government and Private Efforts have been made to Recover Missing Children?

1974	Juvenile Justice and Delinquency Prevention Act (JJDPA), 42 U.S.C. 5601 *et seq.*
1980	Parental Kidnapping and Prevention Act (PKPA), 28 U.S.C. 1738A
1982	Missing Children Act, 28 U.S.C. 534(a)
1984	Hague Convention on the Civil Aspects of International Child Abduction, 51 Fed. Reg. 10503..
1985	Missing Children's Program established within the Office of Juvenile Justice and Delinquency Prevention (OJJDP)
1984	National Center for Missing and Exploited Children (NCMEC) established
1987	National Incidence Study of Missing, Abducted, Runway, and Thrownaway Children in America (NISMART) begun

1988	International Child Abduction Remedies Act, 42 U.S.C. 11601 *et seq.*
1988	Missing Children and their Families Research Project begun
1989	Reunification of Missing Children Demonstration Project initiated
1989	Missing Children Community Action Program (M-CAP) established
1990	Obstacles to Recovery and Return in Parental Abduction Project initiated
1990	National Child Search Assistance Act, 42 U.S.C. 5779, 5780.
1993	Model Treatment Project for Recovered Children and their Families begun
1993	International Parental Kidnapping Crime Act, 18 U.S.C. 1204.
1986	Start of State Missing Child Clearinghouses established throughout the U.S.
1970	First of the Private Missing Child Assistance organizations established throughout the U.S.
1995	FBI establishes special Task Force on Child Abduction investigations at Quantico, Virginia
1998	Established Project Hope-Parent Support Network

OJJDP provides support and funding assistance to the National Center for Missing and Exploited Children (NCMEC) located in Alexandria, Virginia, to a network of 43 state missing child clearinghouses and to non-profit organization development programs. Specialized assistance to Department of Defense and Bureau of Indian Affairs investigator training programs, as well as "Project Alert" (providing trained, retired law enforcement officers to local jurisdictions, upon local request), are also managed under the direction of OJJDP. OJJDP funded and coordinated the Missing and Exploited Children Comprehensive Community Action Program (M/CAP) designed to work with communities to develop a multi-agency community specific response to missing children. Project Hope, A Parent Support Network, focuses on the needs for parents and families with missing children.

In an effort to further understanding of the problem, OJJDP identified and commissioned research studies which have now been completed to address the following issues:

1. the incidence of the missing and exploited children problem,
2. law enforcement investigative practices,
3. legal obstacles to recovery and return of the child in family abduction cases,

4. child victim as witness,
5. the recovery and reunification of missing children with their families,
6. the psychological consequences of abduction for families and recovered children,
7. identifying risk factors for parental abduction.

The Definition and Incidence of Missing Children

Initial Efforts to Determine the Size of the Missing Child Problem. As the problem of missing children became a significant issue during the early and mid-1980s, efforts were made to identify the incidence rate. Victimization studies and criminal justice statistics almost neglected the issue (Finkelhor & Dziuba-Leatherman, 1994). The absence of data may have contributed to the controversy that developed when vastly divergent estimates were published about the size and extent of the problem (Best, 1988). The problem of missing children was not a focus of sustained attention, and most law enforcement data systems were not designed to track the extent of this problem. Early nationwide estimates of the number of non-family abductions ranged from a low of 67 (FBI, 1984) to a high of 50,000 by persons such as U. S. Senator Paul Simon of Illinois (Best, 1990). Estimates of the number of family abductions ranged from 25,000 to as high as 459,000-750,000 (Gelles, 1984). The National Incidence Study of Missing, Abducted, Runaway, and Thrownaway Children in America (NISMART) was designed in part to resolve the controversy and also to better understand the problem. This study, funded by the U. S. Department of Justice, clarified several of the inherently complicated issues related to missing child incidence rates.

The determination of accurate rates of incidence for missing children has been severely hampered by definition and data collection problems. Definition problems involve the different degrees of specificity used by various researchers, which results in a lack of comparability of study results between projects. Definitions are determined by whether the study has a social science or legal orientation. For example, social science research definitions of the incidence of a social problem tend to be broader than legal definitions. Legal definitions are generally descriptions of specific actions, limited to a specific jurisdiction such as an individual state. Since law enforcement incident reports are generally based on legal definitions that are jurisdiction specific, national incident data is difficult to obtain.

NISMART: An Effort to Define and Measure the Missing Child Problem. The National Incidence Study of Missing, Abducted, and Thrownaway Children in America (NISMART, Finkelhor, Hotaling, & Sedlak, 1990; Finkelhor, Hotaling & Sedlak, 1992) addressed this problem by using a two prong definition to describe the incidence of non-family abducted or family abducted, runaway,

thrownaway, lost, injured, or otherwise missing children. The definitions used in the NISMART study were *Broad Scope* and *Policy Focal.* (See Table 2).

Table 2
NISMART: "Missing Child" Definitions

The National Incidence Study of Missing, Abducted, and Thrownaway Children in America (NISMART) used a two prong definition to describe the incidence of missing children.

-*Broad Scope*: a missing child event as perceived by the family including both serious and minor episodes.

-*Policy Focal*: a missing child event as perceived by law enforcement and/or social services including only incidents of a serious nature which require immediate intervention. Policy Focal cases were thus a subset of Broad Scope cases.

Within the category of non-family abduction, the NISMART study also used two additional levels of case distinction including legal definition abductions and stereotypical kidnappings.

-*Legal Definition Abductions* : the crime of abduction as defined by state laws. This variably included short-term abduction and/or coercive movement as part of some rapes and assaults.

-*Stereotypical Kidnappings*: the more popular conception of long-term, long-distance, or fatal episodes.

Within the category of family abduction, abductions were defined as Broad Scope or Policy Focal.

-*Broad Scope family abduction*: situations in which family members took a child in violation of a custody decree/agreement, or failed to return a child following a period of visitation.

-*Policy Focal family abduction* : situations characterized by one or more of the following features-an attempt was made to conceal the taking or location of a child, a child was taken to another state, or evidence indicated that the abductor intended to keep the child or permanently change custody.

The definitions developed by NISMART have provided a substantial benefit to the study of missing children. They provide a common framework for defining the target populations being studied and the populations for which services are being developed. These definitions have also provided a framework for defining and identifying the specific factors that may be operating for different victim groups. For example, what are the dynamics and factors operating in stereotypical non-family kidnappings versus legal definition abductions? What are the characteristics distinguishing between custodial interference versus intentional concealment of family abducted children?

The estimated incidence rates for missing children during 1988 based on the definitions derived during the NISMART study are presented in Table 3 (Finkelhor, Hotaling, & Sedlak, 1990, p. vii).

Table 3
NISMART: What is the Size of the Missing Child Problem in America?

Estimated Number of Missing Children in 1988	
Family Abductions	
Broad Scope	354,100
Policy Focal	163,200
Non-Family Abductions	
Legal Definition Abduction	3,200-4,600
Stereotypical Kidnappings	200-300
Runaways	
Broad Scope	450,700
Policy Focal	133,500
Thrownaways	
Broad Scope	127,100
Policy Focal	59,200
Lost, Injured, or Otherwise Missing	
Broad Scope	438,200
Policy Focal	139,100

Subsequent analysis of NISMART data has added to understanding the problem of child abduction. Asidigan, Finkelhor & Hotaling (1995) in a study comparing stereotypical abductions and legal definition abductions identified the various motivations behind non-family abduction. Although limited by a small number of cases, missing data and low interrater reliability for some types, these researchers identified several categories of abduction in addition to those that are committed because of sexual motivations. These included:

(1) *robbery facilitation*, "in which strangers abducted children, sometimes together with adults, to obtain money or other goods" (p. 225);
(2) *hijackings*, "in which car theft was the main motive but children, sometimes together with adults, were passengers in the car" (p. 225-226);
(3) *acts of retribution*, "in which children were taken, sometimes by gang members, in revenge for misdeeds committed by the victim or someone associated with the victim, often in connection with drug dealing or some other criminal activity" (p. 226);
(4) *intimidation and terrorizing*, "in which random acts of violence, including abduction, were carried out against children for no other apparent reason than to intimidate and terrorize" (p. 226); and
(5) *dating violence*, "in which males abducted ex-girlfriends to bully them or force them back into a relationship" (p. 226).

Based on their analyses , the authors concluded the importance of looking at stereotypical abductions by strangers separate from stereotypical abductions by non-strangers. They conclude that "stereotypical abduction episodes that involve an extended period of time, long distances, and that occur in conjunctions with ransom, murder, or an intent to keep the abductee permanently-need to be treated as a distinct group of non family abductions. Although they accounted for only a small portion of all legal-definition non-family abductions, they formed a relatively cohesive group that differed from other abductions on a number of key victim, perpetrator, and episode variables. Compared to their non stereotypical abductions involved more preteen Caucasian children taken by Caucasian perpetrators for reasons other than sexual assault." (Asdigian, Finkelhor, & Hotaling, 1995, p. 228).

In addition, looking at the stereotypical abductions, they found that stereotypical abductions by non strangers, for example, family friends, baby-sitters, employers and other acquaintances, do not possess the same features of serious abductions by strangers. The victims of non-stranger stereotypical abductions were more likely to be non-Caucasian (91%) than the victims of stranger abductions (59%). In stereotypical stranger abductions, the perpetrators were almost exclusively male (95%) whereas the perpetrators in non stereotypical abductions were almost equally male (53%) and female (47%).

The additional analyses of the original NISMART data also supported a connections between legal-definition abduction and sexual assault. Nearly three quarters (71%) of legal-definition abductions involved a sexual component. In addition the legal definition abductions involving sexual assault were more likely than non sexual assault abductions to be carried out against females and teenagers; by males, young adults and lone perpetrators; and to involve physical force, weapons and lures. They were also more likely to occur in counties with low rates of violent crime. Based on the findings, the researchers recommended that prevention education about non family abduction should occur in the context of sexual assault prevention training.

Sub analysis of the NISMART data (Finkelhor, Hotaling & Asdigian, 1995) of attempted non-family abductions (ANFAs) also provided useful information about children at risk for non-family abduction and additional implications for prevention education. The data analyzed consisted of telephone interviews with the caregivers in 10,367 randomly selected households, reporting on the experiences of 20,505 children, age 17 and under. The interviews reflected a 89.2% response rate of the contacted households known to have children. Attempted non-family abductions (ANFAs) were defined as "any incident in which a non-family member tried to take, detain, or lure a child, and if the action was successful, the situation would have probably met the criteria for a completed non-family abduction." (Finkelhor, Hotaling & Asdigian, 1995, p. 944). The incidents occurred in the 12 months prior to the interview. Demographic and family interaction pattern data were collected on all households reporting any type of missing child episode studied by NISMART and a random sample of all households in which there was no missing child episode (n=491). A total of 35 ANFAs were identified.

The researchers found that in contrast to completed non-family abduction incidents, which disproportionately involved teenage girls, almost 70% of the attempted non-family abductions involved children between the ages of four and 11. The victims were almost evenly boys and girls. All of the attempted abductions were by strangers and involved the children being lured rather than forceful efforts. A third of the victims were reported to suffer psychological harm.

Further analysis attempted to explore the family and demographic factors that put these children at risk for the attempted abduction. Almost no demographic factors distinguished the ANFA children from others. Socioeconomic status, race and urban versus rural location did not distinguish between the ANFA children and others. Analysis of family interaction patterns yielded two significant group differences, caregiver history of childhood trauma and household stress. These differences however could not be explained by any differences in level of parental supervision or community of residence. Several hypotheses to explain these differences were offered including increased sensitivity by caregivers who had

experienced similar events, increased interpretation of events as abduction or abduction related events, increased memory of events because of their sensitivity, and increased vulnerability in homes with household stress because of child behavior. However, data was not available to evaluate these or other factors that might explain these markers. Based on the findings about ANFAs, the authors recommended continued prevention training that includes "stranger danger" education.

Boudreaux, Lord and Etter (2000) identified five motivations for non-family abduction: (1) a desire to possess a child (primarily infants), (2) sexual gratification, (3) financial gain such as extortion or ransom, (4) retribution (collecting on an unpaid debt or revenge) and (5) the desire to kill (Forst & Blomquist, 1991; Lanning & Burgess, 1995). Boudreaux, Lord and Dutra (1999) found patterns of characteristics depending on the age and sex of the child. For example, in a study of 550 child abduction victims, females (70%) were at higher risk than males(30%). Younger victims (ages birth to three) were more likely to be male. Females from pre-school through high-school were three more times likely to be abducted than males. In cases in which victims were abducted and murdered, teenage girls were at highest risk, followed by younger girls, younger boys and teenage boys. The variability in perpetrator motive, offense patterns and victim preference suggests the importance of not viewing child abduction in generalized terms. Prevention efforts and post recovery interventions should be based on perpetrator, offense and victim characteristics.

Analysis of the NISMART data on family abduction also provides added information. Finkelhor, Hotaling & Sedlak (1991) provide episode characteristics. The nature of incidents include child takings from the primary custodian, takings by the primary custodian, child keepings by the visiting parent, child keepings by the primary custodian and keepings that refuse the non-custodial parent from having access to the child. In terms of duration, the majority of cases are very short and quickly resolved. The very serious cases that involve concealment, removing the child from the state, keeping the child longer than a week or physical harm to the child are less frequent-making up one tenth of the cases. Missing more than a month cases are even more unusual. Further, NISMART data reflected an age range of family abducted victims from ages two to 13 with a peak for ages 2 and 3. Older teenagers accounted for few of the victims and infants also appeared to be less subject to family abduction. Not surprisingly boys and girls were abducted in roughly equal proportions.

Family Abduction: Family abductions were more likely to occur in families in which the children were not living with both parents. In the broad scope group, a quarter were living with a parent who was either remarried or in a relationship with someone other than their parent, and half were living with a single parent. Ethnicity

also did not reflect discrepancies from expectation other than with Hispanics where there were slightly fewer children abducted by family members than expected. Geographically fewer abduction took place in the Midwest and half of all abductions took place in the South.

Demographic data showed that perpetrators generally were in their thirties with three quarters of the perpetrators being under the age of 40. Three quarters were men. The risk for family abduction extended over time. Half of the broad scope family abductions took place two or more years after the divorce. Another 10% took place after four years of divorce. However the most serious cases, occurred at an incidence of 54% in the period between separation and divorce. Removal from the state occurred in 9% of the broad-scope cases and 12% of the policy-focal cases. The abductor attempted to conceal the child in one third of the broad-scope cases and over half of the policy-focal cases. Attempts to prevent telephone or written contact with the caretaker occurred in, 41% of the broad-scope episodes and 70% of the policy-focal episodes. Not accounting for duration of the episode, circumstances of the episode, whether the child's location was known or not and similar variables, 16% of the broad-scope and 17% of the policy-focal children were reported to have suffered serious mental harm.

Plass, Finkelhor & Hotaling (1996) examined the same NISMART data base to examine factors associated with duration of the missing episode and emotional trauma. Limited by the fact that only 14% of the cases examined were ongoing for more than three weeks and that the information about the case was only gathered from the left behind parent, the findings about factors that effect duration of the episode may not be applicable to longer term cases. The same limitation applies to understanding the impact of abduction on victim children. Given these limitations, they found that the longer the duration of the episode the greater the risk that the child would be emotionally traumatized. In addition they found that perpetrator behaviors that were threatening, including threats to have the abduction permanently affect custody, were related to longer duration and increased likelihood that the children would be emotionally traumatized.

These researchers found that duration and emotional trauma are more effected by the circumstances of the abduction than by the demographics of the perpetrator and left-behind parent. For example, signs for more serious outcomes in terms of duration and impact on the child were associated with the perpetrator's expressed intent and circumstances of the missing event.

Greif & Hegar, (1992) reviewed the literature examining the impact of family abduction on children. The studies generally fall into three arenas: (1) child report (Agopian, 1984; Terr, 1983; Senior, Gladstone & Nurcombe, 1982; Schetky & Haller, 1983); (2) clinical reports (Sagatun & Barrett, 1990); and (3) parental

reports (Janvier, McCormick & Donaldson, 1990; Hegar & Greif, 1991a, 1991b; Forehand, Long, Zogg & Parrish, 1989). Despite limitations inherent in the methods used, e.g. parent observation and reports in which the parent has a vested interest in either minimizing or exaggerating the impact of the abduction, several factors emerge which impact the child's functioning upon recovery. Greif & Hegar (p. 602, 1992) summarize these as "the experiences of the child during the abduction: the length of the abduction; inter parental hostility; the time since the abduction; contact with the searching parent during the abduction; and the relationship with both parents...." In general children who have been snatched by a family member are described as suffering from depression (Senior et al., 1982), extreme fear, grief and rage about parental abandonment, rejecting the abducting parent (Terr, 1983), sleep disturbance, bedwetting, fear of windows and doors and clinging behavior (Schetky & Haller, 1983).

Motivations for child abduction have also been discussed by other authors. Agopian (1981) described family abductions occurring in several contexts, with many motives. (1) Parents take children before divorce decrees because of fears of losing custody. (2) Parents take or refuse to return children after divorce because they are unhappy with custody decisions. (3) Parents go to other jurisdictions and obtain custody award decrees and then take their children to those jurisdictions. (4) Parents take children because they believe the other parent is physically or sexually abusing the child. (5) Some parents abduct as a way of hurting or retaliating against their ex-partner. (6) Extended family members such as grandparents, siblings and others become agents of the unhappy parent and take the child. (7) Extended family members feel they have a right to have custody of the child.

Hegar and Greif (1991) examined a national sample of 371 parents who had contacted child-find organizations to assist in the search for their family abducted child(ren). This sample represents respondents to 2,666 packets forwarded by the child find organizations mailed out in August 1989. Of this number 266 were returned as undeliverable. The actual return rate is difficult to determine since many parents register with more than one child-find organization and may have received duplicate packets. Based on estimates of the number of parents who register with two or more organizations, the return rate was estimated to be between 15 and 27 percent.

Two-thirds of the respondents reported only one child abducted. An equal proportion reported incomes less than $27,500 per year. Three-quarters of the children abducted in the study were six years old or younger and the modal age was two. Most parents reported they had worried about the possibility of abduction before it happened. Males abducted in 55 percent and females 45 percent of the cases. Left behind female parents were more likely to cite emotional and physical violence for the causes of the marital breakup. They were also more likely than

male left behind parents to believe the abductor acted out of anger and a desire to hurt them. Male left behind parents were more likely to believe the reason for the abduction was pressure from others to assume the child care role and problems with visitation on the part of the female abductor. Generalizability of the data is limited to those parents who contact child-find organizations in the United States and who choose to respond to a lengthy (eight page, 95 item) questionnaire. In addition there may be differences between men and women in responding to self-report measures, especially about issues of violence, both their own use of violence and violence against them.

In a subsequent study, Greif and Hegar (1994), interviewed 17 abducting parents regarding family dynamics and their motivations for abducting. Twenty-five abducting parents were contacted from the original sample of 371 left behind parents. From these, 13 agreed to participate. The others refused based on a desire to put the experience behind them, concerns about confidentiality, or were angry that the recovering parent had given out their telephone number. Another four cases were identified through missing children's organizations and personal contacts of the researchers. Generalizability should be taken with caution.

The abductors ranged from age 26 to 50 and included nine males and eight females. The children were missing for between one week and 11 years, with a mean of two years. The time since recovery varied from nine months to 11 years with a mean of six and a half years. Reasons given for the abduction were examined. Two-thirds of the abductors reported unsatisfactory contacts with professionals or the court system. In half of the twelve cases reporting unsatisfactory contacts with professionals or the courts, the abducting parent reported unhealthy situations in which they believed the child was being mistreated. In the other half, the snatching parent believed the court decision was unfair. Multiple reasons were given for some cases. These included two cases in which fathers were angry at their ex-wives; six cases in which the abducting parent reported that the other parent had previously abducted or threatened to abduct the children, one case in which a mother reported she was running from a battering relationship and two cases where mothers did not want their children to be placed in foster care.

In a sub analysis of the sample of 371 left behind parents who contacted child-find organizations, Hegar & Greif (1991c) compared domestic family abductions with international family abductions, in which a child is taken to another country. Domestic cases were those cases in which the abductor did not take the children outside of the United States. International cases were those cases in which the abductor took the child(ren) to another country. In considering the cases, the authors also examined those children taken to countries that subscribe to the Hague Convention on International Abduction in contrast to children taken to

non-subscribing countries. The Hague Convention agreement provides for children to be returned to their country of residence pre-abduction. There are however several exceptions upon which a subscribing country may choose not to return a child. (Schwerin, 1988).

Of the 371 total cases in the study, 21 percent crossed international borders out of the United States, to 27 different countries. Those parents who took their children outside of the country were roughly equally male (55%) and female (45%). Most of the children (87%) were born to married parents. Half were in the sole custody of the left-behind parent, 29% were in joint legal custody of the parents and 14% were in the legal custody of the abductor.

Several differences were found when comparing domestic abductions with international abductions. The children taken across international borders tended to be older (37% over the age of eight and only 15% under the age of two). The international family abductors were also older (35.7 years) than domestic ones (31.8). Larger sibling groups were taken abroad in comparison to the number in the sibling groups of domestic cases. The abductors also had a higher educational level than domestic abductors. People who were not born in the United States represented a higher proportion of the total study sample of abducting parents than statistically expected. Perhaps most important was the finding that the foreign born abductors were no more successful than others when abducting within the United States. However they were more successful in keeping the child from the other parent when they left the country. Most foreign born abductors took their children to their country of origin (71%). They also took their children to non-Hague Convention subscribing countries more often than American born parents. American born parents were more likely to choose English-speaking countries. These findings on destination differ somewhat from those reported by Agopian (1987) in a survey of 2292 cases of international abduction reported to the United States Department of State Office of Counsular Affairs between 1973 and 1986. In this data sample, almost half of the children were taken to Europe and another quarter to Latin and South America. However he did not differentiate between the destinations of foreign-born abductors and American born abductors. Most of these cases had occurred prior to the signing of the Hague agreement (1985)

Parents who have had their children abducted also suffer as a result of the abduction. Greif & Hegar, (1991) reported on the same sample of 371 parents. While there are variations in the degree of difficulty parents have, the data supported that almost all of the parents suffered to some degree. Parents who had not yet recovered their children obtained lower scores on measures of well-being, with lower self-esteem and a trend toward more severe depression. Female left-behind parents scored lower on measures of self-esteem, were more likely to report health problems and severe depression. Women were more likely than men to

report victimization in the relationship with the abductor. Parents who reported violence were more likely to report severe depression. Finally the length of time that the children were missing was also related to left-behind parents feeling more sad. The longer the child was missing the more sadness they reported.

The work of Greif and Hegar (1993) summarized the motivations of family abductors and the distribution of mothers versus fathers who abduct their children. Their work, obtained from responses to questionnaires suggested that family abduction is not predominately committed by one sex versus the other. Both mothers and fathers were found to be nearly equally inclined to abduct their children although for different reasons.

Their work was greatly expanded by Johnston, the American Bar Association Center on Children and the Law and the Center for the Family in Transition (1994) in their document, interview and assessment based study of abducting versus non-abducting families, which identified risk factors for abduction. They identified five risk factors which may be predictive of increased risk for family abduction by interviewing both abductors and left behind parents in high-conflict and violent couples using the family court system. The identified risk factors included: (1) belonging to an ethnic or cultural minority group that holds different values about child care arrangements after separation and divorce compared to the prevailing laws and procedures of the states' courts; (2) low socioeconomic status including low income, education, and occupational position; (3) psychological characteristics which reflect narcissistic, sociopathic personality disorders in which individuals may hold beliefs conducive to child abduction; (4) transient, unmarried relationship status in which couples were never married and had a brief, unstable relationship and the conception was unplanned; and (5) concern about child neglect, sexual abuse and family violence in which the abducting parents is attempting to rescue the children from violent, neglectful and/or criminal environments. Although the data was descriptive and collected three years after the abduction experience, identification of these factors provided an important adjunct in understanding and intervening in the dynamics of abductions.

OJJDP funded the American Bar Association Center on Children and the Law (ABA), in collaboration with the Center for the Study of Trauma at the University of California, San Francisco to examine the legal, procedural, policy and practical obstacles to the recovery and return of family abducted children. Findings from the Obstacles to the Recovery and Return of Parentally Abducted Children project identified the key legal impediments as (1) lack of knowledge of applicable law by lawyers and judges, (2) lack of compliance by judges even when knowledgeable of the applicable law, (3) lack of uniformity and specificity in the relevant laws, and (4) lack of effective enforcement procedures. Law enforcement

concerns include (1) insufficient funding for law enforcement and State missing children clearinghouses, (2) hesitance of law enforcement officers to recover a child due to liability threats, and (3) lack of involvement and experience by law enforcement. Parents reported the additional obstacles of (1) the prevailing belief that parental abduction is not a serious matter, (2) lack of financial resources to afford the expense of locating, recovering and returning abducted children, and (3) abductors succeeding with the help of third parties (Girdner & Hoff, 1994). The findings of the Obstacles Project provide insight into the frustration and challenges, during the period a child is missing, at the time of recovery and post recovery.

The Psychological Consequences of Abduction to Child and Family

Two projects, **The Families of Missing Children** and **Reunification of Missing Children and Their Families**, were funded by OJJDP in an effort to understand the consequences of family and non-family abduction on children and families, to examine how children and their families were being reunified when recovery occurred, and to develop a model for reunifying recovered children and their families. The following narrative provides an overall summary of the data as it applies to both family and non-family abduction. Detailed discussions of the results of these studies as they specifically apply to non-family and family abducted cases is presented in Appendices A (pp. 274-289) and B (pp. 319-329) respectively.

The Families of Missing Children Project: This project conducted by the Center for the Study of Trauma, University of California, San Francisco, provided the first scientific knowledge base for understanding the level of emotional distress experienced by missing children and families (Hatcher, Barton, & Brooks, 1992). This project was conducted over a three year period at multiple sites throughout the United States, involving a sample of 280 families. The families were followed with in-home interviews in a time series measurement design from approximately one month after child disappearance to eight months after child's disappearance. Three primary groups were studied: 1) child loss by non-family abduction (41 cases); 2) child loss by family abduction (104 cases); and 3) child loss by runaway status (104 cases). For comparison purposes, a separate group of families who lost a child as a result of sudden infant death syndrome (31 cases) was studied in a similar longitudinal manner.

The chronological experiences of the missing children and their families from pre-disappearance through recovery/non-recovery, the type and level of emotional distress experienced by families of missing children, the coping behavior used by families of missing children and family utilization of intervention/support services were studied. Interviews were conducted by a masters level clinician. The project assessment package included detailed structured interview items and

selected quantitative nationally normed measurement instruments including the Symptom Check List-90, Achenbach Child Behavior Check List, Family Inventory of Life Events, F-COPES, Frederick Trauma Reaction Index-Adult, and Frederick Trauma Reaction Index-Child.

To address the issue of intervention services, utilization and satisfaction were assessed across the missing child groups in each of the following categories: law enforcement services, mental health services, missing child center services, within family social support, extended family social support and community social support. For more detailed information on assessment tools and methodology see Hatcher, Barton & Brooks, 1992.

The following findings were reported:

The majority of families of missing children experience substantial psychological consequences and emotional distress as a result of child disappearance. Compared to the general population, families of missing children score in the top 20% for distress as measured by standardized psychological tests. Further, this level of emotional distress for families of missing children equals, or exceeds, the emotional distress for groups of individuals exposed to violent trauma, such as combat-related military veterans under treatment for post traumatic stress disorder symptoms, and victims of rape, assault, and other violent crimes. This finding documents the level and extent of emotional distress sustained by families of missing children. The comparison of their reactions with that of distressed combat veterans and victims of violent crime helps us to better understand the severity of the impact of child disappearance upon families.

Generally, the severity of the emotional distress for families of missing children does decrease over time. The emotional distress is naturally mitigated by factors such as the recovery of the child and family coping strategies. The passage of time does not itself reduce distress since at eight months after the date of the child's disappearance, almost one-third of these families continue to experience high levels of emotional distress. In many cases, this distress continues even after the child is recovered. Within the sample groups the most severe psychological and emotional distress was experienced by families of non-family abducted children. Families who have lost a child to non-family abduction are very severely impacted by this distress, affecting parents and remaining children over a period of many months. This finding indicates that these families, attempting to both cope with the abduction and attend to the needs of the remaining family members, function under very high stress levels.

In addition, the potential for child homicide as a consequence of non-family abduction is extremely high. One-fourth of the non-family abducted

children were recovered deceased. Families where the abducted child is recovered deceased exhibit the highest level of emotional distress. Further, this level of distress does not appear to decline over a period of many months after the recovery of the deceased child. However, the overwhelming majority of these families do not receive social service, or mental health support, and often limited extended family support. Often families, whose children are recovered deceased, have been the focus of intense public visibility and have been at the forefront of policy change in the missing child area. Yet, these families remain isolated and not served in their distress and grief.

Mental health providers need to be aware of the possibility of homicide in these cases. A recovered child often realizes the potential for a different outcome.

Another subsample of families that experience a high level of distress are families of non-family abducted infants. This is the least frequent type of non-family abduction. While the high level of distress declines after the infant's recovery, the event appears to have a very pronounced impact upon the mother. There is substantial stress and separation between new mother and new father at a universally acknowledged critical point for mother-infant bonding. While most infant abductions occur from hospital settings and/or recovered infants are immediately taken to hospital settings for medical clearance, half of these families do not receive mental health assistance. Contact and support from local/regional missing child centers drops to zero just eight months after the infant has been recovered.

The missing child movement has historically focused upon parent loss and concern. While the remaining children in the family are less visible, they are no less distressed and warrant equal attention to their needs. As a group, the brothers and sisters of missing children showed equal, or higher, levels of emotional distress than their parents. This was especially true in non-family abduction cases where the child was recovered deceased. All of the remaining children in these families were found to be initially very emotionally distressed and all of these children were still very emotionally distressed eight months later. The missing child event seems to arouse concerns and fears in brothers and sisters across the types of missing children. Yet, many parents report that a period of days or even months elapses after child disappearance before they have the energy and personal resources to fully attend to the needs of the remaining children. The remaining children themselves are very aware of the family focus upon child recovery, feel unable to do anything meaningful to assist in the search effort, and sometimes even wish to be a missing child themselves in order to gain equal attention.

Finally, the recovered children themselves experience substantial psychological consequences and emotional distress over time. At the point of recovery and reunification with the family, this distress is very high for almost all children recovered from non-family abductions, and remains high over a period of months after recovery. For the majority of children recovered from family abduction and runaway status, high levels of distress are present upon recovery and decline over time. This finding indicates that the point of recovery of the missing child and subsequent reunification with the family is a very stressful event for both recovered child and family.

The project's analysis of the experience of missing children and their families provides a new perspective on types of missing children that extends beyond the NISMART missing child incidence study. Five meaningful groups were identified. See Table 4.

Table 4
Types of Missing Children

1. Non-family abductions where the child was recovered alive
2. Non-family abductions where the child was recovered deceased
3. Non-family abductions where the child is an infant
4. Family abductions
5. Runaways

These groups emerged as the project attempted to determine if there were meaningful subgroups. Subgroups did appear within the non-family abduction category. Combining the information on all three non-family abduction subgroups had the effect of obscuring significant differences which could easily lead to false interpretations. This would then likely result in restricted understanding of non-family abduction, the behavior of the affected children and families, and the development of less effective intervention/support services.

Families in distress generally seek information and support. Because of the absence of mental health involvement during the missing period, families of missing children are most reliant upon law enforcement personnel. While families may vary in their patterns of law enforcement service use and service satisfaction, it is clear that the overwhelming burden of missing child response falls upon the law enforcement officer. This burden is not only for the investigation and hoped for child recovery, but for emotional support, criminal law

information, civil law information, victim/witness compensation information, and family court/dependency court information.

Overall, less than one-third of families of missing children rated law enforcement as highly competent during the investigation of their child's disappearance. Ratings of law enforcement competence varied by type of child disappearance. While valid and practical reasons may exist for the difficulty in child recovery in many missing child cases, the majority of families of missing children carry forward a negative impression of law enforcement competence.

Family history prior to child disappearance significantly influences the family's distress and ability to cope with that distress. Not surprisingly, prior trauma, family stress, and child physical/sexual abuse are risk factors which significantly impair the ability of the family to respond to child disappearance.

Almost four-fifths of the families of missing children do not receive mental health or counseling services. This lack of services appears to be due to: (1) an absence of clinical knowledge among mental health providers about how to understand and assist families of missing children; and (2) an absence of belief that families of missing children as a group warrant mental health services. The same pattern was true of local/regional missing child center support services. The majority of families received no services. Surprisingly, more families dealing with family abduction received initial services than those dealing with non-family abduction. Of equal importance was the finding that almost all runaway families did not receive any local/regional missing child center services.

In summary, the families of missing children want:

> **(1) a more positive relationship with law enforcement personnel assigned to their case,**
> **(2) mental health and social service personnel who understand the unique characteristics of their situation, and**
> **(3) information/support services over the length of the child's disappearance from local/regional missing child centers.**

Reunification of Missing Children and Their Families

The Reunification of Missing Children Project. In an attempt to reduce the emotional distress and psychological consequences of the abduction experience, OJJDP funded The Reunification of Missing Children. The goals of the project, also completed by the Center for the Study of Trauma, University of California Medical School, were to research the quality of the law enforcement, mental health and social service response to recovered children and their families;

to develop a model for reunifying recovered children with their families; and train multidisciplinary teams to respond to the investigative, recovery and reunification needs of these families.

The following data were derived from telephone interviews of 65 reunified families (15 stranger abduction, 30 parental abduction, and 20 runaway families). These families were identified as a subsample of reunified children (n=4,037) and their families recorded for a one year period (1987) in the data base of the National Center for Missing and Exploited Children. After verifying demographic data the interviews were constructed to be temporally focused, consistent with the McCubbin model, to include pre-abduction events/responses/attitudes, disappearance events/responses/attitudes, and post reunification events/responses/ attitudes. Five topic areas were covered for each temporally focused section:

(1) Psychological and physical symptoms
(2) Social, physical and financial stressors
(3) Cognitive systems to conclude attitudes (e.g. safety, predictability, stability) and beliefs (e.g. causality, attribution)
(4) Predominant coping styles
(5) Educational/vocational performance

The interviews were conducted by project staff educated at the doctoral level, trained in both the procedural and interpersonal requirements of such interviews, and then randomly monitored by senior project staff. 80% of the families contacted agreed to participate. Parental abduction families were the most difficult to contact and the most cautious upon contact. This may have been due to legal and custody issues that continue to confront parental abduction families for significant periods after recovery and reunification.

The location of reunification meetings between recovered children and their families vary depending on the type of abduction. For non-family abductions, the actual reunification meeting was conducted at a police station in 50% of the cases. For family abducted children, 66% of the actual reunification meetings occurred at a transportation depot such as a bus station or airport, or a site from which the parent "abducted the child back" such as a school or abducting parent home.

The reunification meetings generally were very brief for both family and non-family abducted recoveries. In non-family abductions, 33% of the meetings were less than 15 minutes, and 60% were less than 30 minutes. Parental abduction reunification meetings were also brief. Fifty percent of the meetings lasted 15 minutes or less, and 83% were 30 minutes or less.

Often the responsibility and stress of the reunfication falls on the shoulders of one parent. In families with spouses, spouses were present at only 26% of the non-family abducted reunification meetings. A spouse (in addition to the recovering parent) was present at only 25% of the family abducted reunification meetings. With regard to non-primary family members present at the non-family abducted reunification meeting, a police officer was present at 50% of the meetings, relatives present at 40% of the meetings, friends at 33% of the meetings, and media representatives were present at 20% of the meetings. For family abductions relatives were present at 30% of the meetings, a police officer was present at 25% of the meetings, and a social service child care worker was present at 20% of the meetings.

Effects of Child Disappearance and Reunification. To understand the effects of the reunification period upon families, family members were asked to evaluate the positive, neutral, or negative effects during (1) the week of the child's disappearance; (2) one to three weeks after the disappearance; (3) the week of the child's recovery; and (4) two years after the child's recovery. Ninety percent of family members experienced a severe negative impact as a result of the initial disappearance of their child. This high rate of negative impact is consistent across all three categories of missing children: stranger abduction, parental abduction, and runaway. This subjective level of distress does not change significantly in the three week period following the disappearance of the child.

During the week of child recovery and reunification, approximately 60% of the stranger abduction families and 50% of the runaway families experience significant distress, as contrasted with approximately 40% of the parental abduction families. Most significantly, two years after the recovery and reunification of the missing child with the family, approximately 40% of the parental abduction families and approximately 50% of the stranger abduction and runaway families continue to report marked negative impact from the missing child experience. It is clear that the overwhelming majority experience significant distress at the time of disappearance. Approximately 50% of the families of missing children are still in distress two years after the child has come home.

Therapy/Support Experience. This portion of the study inquired about guidance received by families of missing children prior to reunification with their child, as well as the extent to which such guidance was helpful. Almost none of the family abducted parents (86.5%) or non-family abducted parents (92%) received guidance. The very small percentage of family members who did receive guidance about reunification received the most useful information from books and friends rather than law enforcement, psychological or social service resources.

In summary, the following conclusions were noted:

1. A significant number of stranger abducted, parentally abducted, and runaway children are recovered and reunified with their families each year.

2. Families of stranger abducted, parentally abducted, and runaway children report severe negative impact beginning with the child's disappearance, extending through reunification, and continuing for at least two years after reunification.

3. Almost all families of missing children must face reunification without on site psychological or social service assistance of any kind.

4. Information or assistance for the reunification of missing children is very limited.

In response to these findings a reunfication model and training material were developed to provide reunification services to families of missing children. The model was based on a team approach designed to have multiple agencies function cooperatively and to serve the multiple needs of the child and family. The Reunfication Team Approach included law enforcement, mental health, child protective/social service, family and dependency court, victim witness and non-profit agency (depending on the community) functions. The clinical portion was developed by an expereinced clinican who had treated dozens of children and their families post reunification. Reunification issues and interventions were based on data obtained from both the Missing Childrens Project and the Reunification of Missing Children Project, and from the clinical reports of families in treatment. For additional information see Hatcher, Behrman-Lippert, Brooks & Barton, 1992.

The functions of the mental health professional included evaluating the recovered child and family, and assessing and responding to the emotional stress generated by the disappearance and the recovery. While the mental health professional was charged with making a special effort to acquire information about the psychological consequences of the missing child experience and family coping responses specific to child abduction, it was noted at the end of the Reunification Project that this information is not currently readily available.

The reunification component is included in the initial part of the model because of its importance in effectively and appropriately serving the family and child victim needs.

The Model Treatment and Services Approaches Project Design

The project was accomplished across three stages:

Stage I, Project Planning and Research/Clinical Experience Review. This Stage included review of data from the two previously referenced projects, as well as The National Incidence Study of Missing, Abducted, Runaway and Thrownaway Children (NISMART), Obstacles to Recovery and Return in Parental Abduction Project and available literature at the time. It also included review of the respective files of the Principal Investigator and Senior Psychologist each who had more than ten years of experience in the area of mental health assessment and treatment of missing children and their families.

Stage II, Model Mental Health and Family Services Development and Field Test. This phase of the project included developing, writing and field testing two models for mental health intervention and training, a consultative model and direct services model. Both will be described in the following section.

Stage III, Model Mental Health and Family Services Training Material Development. This phase of the project involved: (1) review of the data from the project field test; (2) refinement of the present treatment manual; and (3) recommendations for implementation and further research.

The Model: After the models and manuals for family and non-family abduction were written, they were field tested in two contexts: (1) the direct services clinic and (2) professional consultation to direct service providers.

The direct services field test took place at the Didi Hirsch Community Mental Health Center in Los Angeles, CA. This clinic provides direct services to a multi-cultural population in Los Angles County. Two quarter time masters level therapists, both bilingual in Spanish and English, were trained to use the model. They consulted weekly by telephone with the project director, collected demographic data on the families receiving treatment, administered nationally normed measures at the time of entry into treatment, and at the end of treatment or of the project, whichever came first, and were interviewed by the senior project psychologist at the close of the field test.

The consultation model of information and training delivery to direct service providers was field tested, utilizing a quarter time doctoral level psychologist who was housed at and worked in collaboration with the National Center for Missing and Exploited Children (NCMEC). This psychologist, who had ten years prior experience in treating child victims of sexual abuse, was trained by the project

director and senior psychologist on the specifics of the models for family and non-family abducted children. She also received weekly telephone consultation from the project director. Cases were identified by case managers at NCMEC for consideration. In order to be considered for the project, families needed to identify a local therapist in their community who had agreed to provide treatment to the recovered child(ren) and their family. This model provided consultation services to the local therapist providing direct face-to-face counseling services to the participating families, via fax, mail of printed material, and by telephone consultation with the project psychologist referenced above. The part time project psychologist also collected demographic data about the families that were receiving treatment from the treating therapist after a local therapist was identified information about the project was faxed to the local therapist. Both the local therapist and family signed agreements to participate in the project. Upon receipt of the signed forms, a packet was faxed to the therapist addressing the initial assessment and treatment issues. This was followed by a treatment manual which included information about the missing children's issues, general trauma information and specific issues for assessment and treatment for each of the abduction types (family and non-family). The project psychologist also mailed out nationally normed measures to be administered by the treating therapist at the time of entry into treatment and again at the end of treatment or of the project field test, whichever came first. Finally the therapist was interviewed by the senior project psychologist and filled out a lengthy questionnaire at the close of the field test.

The field test covered a period of eighteen months, beginning in April 1994. Demographic data was collected for each recovered child (see Appendix D). Information collected included date of disappearance, date and location of recovery, date of referral to the program, type of abduction, name of recovering parent, siblings' sex and age, agreement/decline to participate, initial assessment and treatment plan. In addition, activity forms were completed by the therapist for the direct services model and by the project psychologist for each date of contact with the family/child or treating therapist, respectively. At the time a family/therapist agreed to participate in the project, project measures were administered. These included the Achenbach Child Behavioral Checklist, Symptom Checklist (SCL-90) and Frederick Trauma Reaction Index Form C (Child). Written instructions were provided to the therapist on data collection and administration of the measures to facilitate consistent data collection and administration of the measures. The same measures were administered at the end of treatment or at the end of the project field test, whichever occurred first.

With regard to the NCMEC Consultation Model site, utilizing a quarter time consulting psychologist position, 39 cases (19 males and 20 females, age range 2-15 years) were referred for Project participation. Case consultation has been sought from 14 states, with representation from each major geographical region of

the U.S. Consultation was provided to a range of mental health professionals including psychiatrists, psychologists, clinical social workers, and marriage and family therapists. Non-participating eligible cases fell into to categories, pending and non-participating. Pending cases (n=11) were those cases in which a parent failed to follow through with treatment, failed to obtain a local therapist, was trying to obtain funding to pay for treatment or failed to return the required agreements for participation in the project. Non-participating cases (n=11) were those cases in which the therapist was reluctant to participate, the therapist was unable to obtain funding for treatment, the therapist failed to follow through with phone contacts after receiving the materials and the child received an evaluation but no follow-up treatment. The eligible cases were overwhelmingly Caucasian (n=37). The majority of the cases involved family abductions (n=35), with the children missing from one month to 8 years. Half of the eligible children from the family abduction sample were abducted by their father (n=17) and half by their mother (n=15). Four of the abductions involved taking the child to another country, the remainder stayed in the United States. Non-family abductions lasted from 1 day to three years. The majority of the non-family abductions (n=3) involved family friends or acquaintances known to the family and child.

The families of 17 children (eight males and nine females, age range 2-15 years) received services via consultation to the local treating therapist and completed the project measures. Fifteen of the children were abducted by a family member (seven males and eight females). All of the children were Caucasian. They were missing for a period of four months to eight years. Seven were abducted by their fathers and eight by their mothers. None of the children were taken outside of the United States. The two non-family abductions involved a fifteen-year-old female and a four-year-old male. Both were abducted by a family friend or acquaintance. Both involved sexual exploitation. All but three of the children treated through the project were involved in long term treatment which continued at the end of the field test portion of the project. The three children who stopped treatment terminated when they moved to another area of the country. Those three children were all from the same family.

With regard to the Didi Hirsch CMHC site, utilizing a quarter time therapist position, the caseload consisted of 10 children recovered from parental abduction (five males and five females, age range 2-16 years old). Five additional cases were eligible for treatment but did not participate. Reasons for failure to participate included child refusal to enter treatment in two cases and parental failure to follow-through in two cases. One of the additional five cases involved a non-family abduction by a person unknown to the family. The family elected not to seek treatment at the time of the project. Seven of the ten participating cases were international parental abduction cases. All of the children participating in the program were from a minority or mixed racial background. The children from the

participating families were missing for a period of one month to five years. All of the children but one continued in treatment beyond the end of the project field test.

Quantitative data analysis of the project measures was precluded by the limited sample size, unequal sample sizes between sites, and multiple variables represented in the cases. The following analyses are provided from a qualitative standpoint,.

Parental Reports About Child Distress

The following themes are characteristic of most of the children participating in the project at the time of entering treatment: (1) distressing and reoccurring dreams; (2) withdrawal and denial; (3) avoidance; (4) fear of separation from the recovering parent(s); (5) fear of reabduction; (6) lack of confidence with peers, lack of friends and poor self-image; (7) post traumatic play; (8) avoidance of reminders of the abduction; (9) appreciation of the wrongfulness of abduction; (10) startle reactions; (11) guilt over the abduction and (12) somatic symptoms.

Some children were faced with issues specific to their abduction; for example, name changes, living as the opposite sex, cultural and language barriers (especially in international abductions), lack of memory of the recovering parent, and confusion over conflicting messages from each parent.

Therapist Evaluations of the Models. Evaluations by therapists who participated in the consultative model focused on three themes:

1. **Techniques and Clinical Case Examples:** All therapists, from both the direct services context and consultation context, valued the techniques/themes chapters and clinical case examples of the draft manual. It was consistent with prior training, yet provided information on aspects of abduction cases that was counterintuitive. Content of the models was reported to be consistent with the observed impact of abduction in the treated cases. The therapists reported returning to this material as the case progressed and found it readily transferable into their assessment and interventions of the recovered child and family.

2. **Limitations of Health Care Delivery:** Recovered children and their families have not been immune to the efforts to reduce health care costs. As a result, coverage of mental health services is very limited. Second, families must have a degree of sophistication and perseverance to negotiate their local health care system in order to identify a skilled therapist-provider. Third, even when a skilled provider has been identified, it is unlikely they have treated a child abduction case before. Fourth, many abduction victims do not qualify under our current systems for crime victim assistance, although this varies from state to state. The most often

excluded cases were family abducted children who had not been victims of physical or sexual abuse.

3. **Early Intervention and Accessibility to Specialized Materials:** Therapists reported that their most crucial need for information was at the beginning of treatment. This need was twofold. First, the complexity of the recovered child's needs, the pre-abduction problems and unrelated family trauma, law enforcement and court issues were new and overwhelming. They wanted the information early in their child and family contact to become familiar with the issues to aid in assessment and case planning. Second, in other cases, the child and family appeared on the surface not to have any post recovery problems. In the absence of information about how to adequately assess child abduction cases and recognize the sometimes counterintuitive reactions, the therapist can and does miss child abduction effects. One therapist saw a child for an initial evaluation, and made the determination that the child was not impacted by the abduction. After receiving and reviewing the material the therapist recognized a number of unidentified issues in the initial evaluation, recontacted the family and engaged in a lengthy course of treatment to address the previously unrecognized impacts.

Declined Consultation and Treatment. During the field test, some families with recovered children initially expressed interest in services or consultation to their therapist but then failed to participate. There were two primary reasons:

1. **Overwhelmed by Missing/Recovery and Reunification Issues:** For some families, the recovery and reunification of the child is complex and confusing. Media attention is intense and intrusive. Friends and family often drop in without warning. The experience can result in the simple desire to shut the world out and re-establish the integrity of the separate family unit. Other times they were too overwhelmed to utilize the available resources and had difficulty following through with getting to scheduled appointments.

2. **Lack of Awareness/Knowledge about Child Abduction Cases by Local Therapists:** For other families, the challenge was to find a therapist who was willing to take their case or the inability to find a therapist they felt was qualified or who understood abduction issues. Several families initially tried to locate a therapist but eventually gave up. Financial resources were also a barrier for some families. Other times families did find therapists but would initiate treatment only to discontinue it when they felt the therapist lacked knowledge about abduction-specific issues.

The Model Treatment Project Manual

This training manual is a direct effort to provide information and serve as a guide to the mental health professional, who has already completed his/her professional training. The remainder of this manual covers the following:

Table 5
Manual Information for the Mental Health Professional

1. A model, the ABCX Model, for organizing the complex information that is encountered in abduction cases
2. Information about the subset of traumatic problems associated with abduction
3. Information about the unique and sometimes counter-intuitive issues associated with abduction
4. An illustration of the stages of treatment from the beginning crisis stage through the long term recovery stage.
5. Sample therapeutic interventions and therapist considerations

This model should be useful to the clinician at whatever stage of post-recovery intervention they become involved. The Model Treatment Programs for Family and Non-Family Abducted Children is not a proven model. It is designed to provide guidelines and direction in the (1) assessment of these children and their families and (2) the treatment needs of these children and their families. Individual needs will vary depending on the specific facts of the case. However the phases and abduction specific issues cover the range of responses which have been identified thus far.

The data and knowledge about the treatment of recovered children in specific ethnic, socio-economic and/or cultural groups is still very limited. While the models are based on clinical experience with diverse ethnic, socio-economic and cultural groups, the data in this study are too limited to address the generalization and limitations of the treatment models. The increase in divorced parents (an not married couples), custody battles, "underground hiding" of children, all should play a factor in our understanding of treatment needs. Certain

populations such as street children, may not benefit from the treatment specified in this model.

Treatment intervention in these models was offered on a weekly basis. Length of treatment varied from six months to several years. Estimates of length of treatment will vary depending on a series of variables including: length of time the child was missing, circumstances of the abduction, experiences during the missing period, pre-abduction adjustment of both the child and family, individual coping ability, family and community support, and individual and family resources.

This model should be useful to the clinician at whatever stage of post-recovery intervention they become involved. While families of missing children also need mental health attention, this model is not designed to provide approaches for working with parents or families during the missing period. Nor does it address prevention. Both of these areas are beyond the scope of this project.

CHAPTER TWO - MISSING CHILDREN AND THEIR FAMILIES: THE ABCX MODEL FOR UNDERSTANDING TRAUMA EFFECTS

This chapter is divided into three sections, Section I provides a brief discussion of the background and structure of the Double ABCX Model for understanding and organizing trauma effects. Section II provides a detailed case description of a non-family abduction. The information is then organized by using the Double ABCX model. Section III repeats the same process with a case of family abduction.

SECTION I
The ABCX Model for Understanding Trauma Effects

The ABCX Model utilized through this Treatment Manual is a methodology to organize the complex amount of information present in child abduction cases, to assess the impact of the abduction event upon child and family, and to assist in treatment planning. The use of the ABCX Model promotes effective communication by providing a common language among therapists working with families of missing children. The ABCX Model as used here is not intended as a research or treatment model, it is a clinical assessment and organizational model.

Child Abduction: Child and Family Trauma Response. The abduction of a child by a family or non-family member is an event which occurs in a highly complex social and psychological context. The act of abduction involves a minimum of three parties: a perpetrator and at least two victims, the child and the remaining parent/parents. Family systems theory would suggest that other immediate and extended family members may be profoundly affected by the abduction as well. In the case of family abduction the traumatic event is also most often imbedded in the context of a marital divorce or dissolution and may involve many agencies and institutions, such as law enforcement, the courts, schools, child care, and missing children's organizations.

The effect of multiple stressors was described by Holmes and Rahe (1967) who proposed a cumulative stress model. As any event can be associated with adjustment and requires an expenditure of physical and emotional energy to maintain homeostasis, the greater the number of adjustments required within a limited period of time, the greater the threat to homeostasis. The cumulative stress model (Holmes and Rahe, 1967) can be tested empirically and studies using the Schedule of Recent Experiences (SRE) scale have shown some predictive validity for the model. Relationships have been noted between life stress and specific health outcomes such as hypertension complications of pregnancy and birth, and between life stress and psychological adjustment. Although the adequacy of the SRE as a measure of life stress has been questioned (Sarason, Sarason, & Johnston, 1985)

the SRE continues to be a widely used measure for life stress and over 1,000 life stress studies using the SRE have been published to date.

The Double ABCX Model provides an effective means of organizing the complex amount of information in child abduction cases. This model incorporates many aspects of the trauma response experience, including: (1) temporal variables (i.e., pre- and post-trauma risk factors); (2) coping style variables (i.e., approach v. avoidance) which influence emotional and behavioral response before, during, and following trauma; and (3) family context variables also known to influence children's reactions to traumatic events.

The schema of psychological adaptation to crisis, known as the ABCX Model of Family Adaptation, was originally developed by Hill (1958), and subsequently expanded by McCubbin and Patterson (1981). Hill's original ABCX Model focused on pre-crisis variables that accounted for differences in family vulnerability to a stressor event (i.e., abduction), and whether, and to what degree, the outcome is a crisis for the family. McCubbin and Patterson's updated and expanded version is a more dynamic model that includes both pre-and post-crisis variables. This allows for a view of both family and individual efforts, over time, in adapting to crisis through the use of various resources and perceptual factors.

The addition of post-crisis variables is important in that they describe: (1) the additional life stressors and changes which may make family adaptation more difficult to achieve; (2) the critical psychological and social factors families can call upon and use in managing crisis situations; (3) the processes families engage in to achieve satisfactory resolution; and (4) the outcome of these family efforts (McCubbin & Patterson, 1981).

The Double ABCX Model has been productively employed in family war-induced crisis studies (McCubbin, Boss, Wilson, & Lester, 1980). More recently, it has been used in studies of families coping with chronically ill children (McCubbin, Nevin, Larsen, Comeau, Patterson, Cauble & Striker, 1981; Nevin, McCubbin, Comeau, Cauble, Patterson, & Schoonmaker, 1981).

In this model, which appears in Table 6:

Factor A is defined as the stressor event, the crisis to which the family has been exposed.

Factor a is defined as additional life stressors which are present in the family, but unrelated to Factor A (the stressor event).

Factor Aa is defined as the combination of the stressor event and additional unrelated stressors.

Factor B is defined as the pre-event family coping resources. This includes the behavioral responses of family members, and the collective family unit to eliminate stressors, manage the hardships of the situation, resolve intrafamilial conflicts and tensions, as well as acquire and develop social, psychological and material resources needed to facilitate family adaptation. In this model, coping refers to the family's efforts to strengthen, develop and draw upon resources from within themselves (e.g. leadership skills, role sharing, income, bonds of family unity, adaptability) and from the community (e.g. meaningful friendships, support groups, professional assistance) which can provide families with much needed information for problem-solving and confirmation that they are understood, accepted, valued, and appreciated.

Factor b is defined as the post-event coping resources. This may include new resources (individual, family, and community) which have been developed or strengthened in response to the crisis, or alterations in resources which were available to the family prior to the crisis.

Factor Bb is defined as the combination of pre-event family coping resources and post-event family coping resources.

Factor C is defined as pre-event family perceptions. This includes the way in which the family has come to perceive the predictability of crisis events, responsibility or guilt for involvement in crisis events and the family ability to effectively respond to crisis events.

Factor c is defined as post-event family perceptions. This includes new perceptions which have been developed or strengthened in response to the crisis as well as modifications of pre-crisis perceptions. Adaptive families might respond to a crisis by redefining the situation in more manageable terms, while at the same time encouraging the family unit to continue it's daily task of promoting family member social and emotional development. Maladaptive families may redefine the situation in unmanageable terms, while at the same time being unable to encourage the family unit to even maintain the stability of necessary day to day tasks.

Factor Cc is defined as the combination of pre-event family perceptions and post-event family perceptions.

Table 6
The Double ABCX Model

Factor A:	The Crisis Event
Factor a:	Family/Individual Stressors Other than the Crisis Event
Factor Aa:	Combined Interaction of the Crisis Event and Family/Individual Stressors
Factor B:	Pre-Event Crisis Meeting Resources
Factor b:	Post-Event Crisis Meeting Resources
Factor Bb:	Combined Interaction of Pre and Post-Event Resources
Factor C:	Pre-Event Perceptual Definition of the Event
Factor c:	Post-Event Perceptual Definition of the Event
Factor Cc:	Combined Interaction of Pre and Post-Event Perceptual Definitions
Factor X:	Individual/Family Experience of Stress Due to the Event
Factor x:	Intermediate and Long-Term Experiences of Stress Due to the Event
FactorXx:	Combined Immediate and Long-Term Experiences of the Event

Factors Aa, Bb, and Cc interact with each other to produce **Factor Xx** which is defined as the combination of **Factor X** (the immediate post-event stress experience of the family) and **Factor x** (the intermediate/long-term stress experience of the family). Taken together, these factors all influence the family's vulnerability. Together they influence to what extent the stressor (in this case, abduction/exploitation) will result in disruption, disorganization and/or incapacitation in the family social system (Burr, 1973). Finally, outcome is assessed by examining the variety of ways individual child victims and family members may adapt to the trauma of child disappearance over the long-term. For example, some families may continue to avoid dealing with the consequences of the trauma by minimizing the emotional impact on the child and by denying its effects on the family as a whole. Alternately, families may show relatively

healthier signs of adaptation by acknowledging the fact that they and their children have been affected, and in turn actively reach out for help from various support services.

In utilizing the ABCX Model in this project, it is assumed that the child disappearance event is a trauma that represents a substantial crisis for the family. This a priori assumption about the traumatic nature of family abduction is in keeping with the identification of a causal event in post-traumatic stress disorder. Post-traumatic stress disorder is a group of characteristic symptoms that occur following a psychologically distressing event which the person has directly experienced, witnessed or been confronted with and "involved actual or threatened death or serious injury, or threat to the physical integrity of self or others," and "the person's response involved intense fear, helplessness, or horror." "In children, this may be expressed instead by disorganized or agitated behavior," (American Psychiatric Association, 1994, p 427-428). How disruptive or disorganizing the trauma becomes for the family is determined in part by pre-abduction factors. However, in addition, coping style plays a more central role, exercising its influence prior to, during, and following abduction.

Overall, the ABCX framework provides a means of systematically identifying and describing critical variables which appear to shape the course of family adaptation to a wide variety of crises.

For the reader who is interested in research which examines the ABCX factors as they relate to missing children, See Appendix A (pp. 264-274) for non-family abductions and Appendix B (pp. 298-318) for family abductions.

SECTION II
Applying the Double ABCX Model: A Non-Family Abduction Case Example

Family Background and Characteristics. Steven Stayner was the fourth of five children born to Kay and Delbert Stayner, a working class, California couple. Kay Stayner had been raised in a Catholic boarding school but there is little available information regarding her family life prior to marriage. The family lived near her father after marriage, but he was not supportive of Kay and her family and was openly critical of Kay for having a large family.

Steven's father, Del, was a worker in a canning factory and assumed a traditional role in the household. He involved himself with projects around the house when he was not working, and became involved in the day to day domestic problems when his wife requested his help. Del was the sole breadwinner for the family and he and Kay had difficulty making ends meet. The Stayners had moved to Merced when they could no longer afford the house in which they were living.

They were able to find a more affordable house which had less space, but was adequate, and there was an elementary school a short distance away.

Seven-year-old Steven had some difficulty adjusting to the family's change of residence. He showed his unhappiness by wandering from the house without his parent's permission and by staying on the school yard to play, in defiance of his parent's instructions to come straight home after school.

Even though the family had trouble making ends meet, they were, for the most part, a close and happy family. There was some tension between the parents about how strictly to handle the discipline of the children. When the children misbehaved, they were sent to their rooms or were threatened with a spanking. Both parents believed it was important for children to obey and show respect to adults and corporal punishment was used when the parents felt they needed to reinforce a lesson or control the children's behavior.

Background of the Abductor. In the fall of 1972, Kenneth Eugene Parnell, a convicted sex offender, began work in the lodge of Yosemite National Park as a night auditor. One of the men Parnell became acquainted with on his new job was the night janitor, Ervin Murphy. Within a few weeks, the men began spending time together during their off hours and a friendship developed. During the time they spent together, Parnell began to talk about his desire for a son. Parnell had been married at the age of 17, but the marriage lasted only for a short time and Parnell did not have contact with the child born of that marriage. Parnell explained to Murphy that he wanted a child, in part, to ease his loneliness.

Parnell also reasoned that by taking a boy and raising him, he would be rescuing the boy from life in a bad family situation, similar to that which he had experienced while growing up. Parnell told Murphy that he would be a good "Daddy" for a boy, as he would indulge the child and would know how to give him a better life than most boys had growing up in their own families. Parnell revealed to Murphy that he wanted to have a son to share the Christmas holiday with, and that he intended to "pick up" a child.

Circumstances of the Abduction. Parnell tried to enlist Murphy's aid with the intended abduction and, at first, Murphy resisted becoming involved in the plan. After Parnell continued to pressure Murphy for his assistance, Murphy acquiesced and agreed to help. Parnell had devised a plan where he would drive to find a young boy who was walking alone on the street and Murphy would attempt to entice the child to get into the car with the men. The pair's first couple of attempts at abduction were unsuccessful as the boys approached by Murphy offered some resistance. Not wanting to draw attention, Murphy released them.

On December 4, 1972, seven-year-old Steven Stayner was taking his usual shortcut home from school. On the previous day, there had been conflict between Steven and his parents about his lingering on the school yard instead of coming right home after school. Steven was being careful to comply with his parent's order to come straight home from school, as he had been threatened with a spanking if he did not come directly home.

On a street corner, a short distance from his house, Steven was stopped by Murphy who gave him some religious pamphlets and asked if he wanted to make a donation to a church. Steven told Murphy that his mother might be willing to help, but that they needed to go to his house to ask her. Murphy asked Steven if he wanted a ride and he at first refused, stating that his house was only a short distance away. Murphy continued talking to Steven and again offered him a ride. Steven accepted the offer and got into the car with the two men.

Parnell drove in the direction of Steven's house, but passed the road on which the Stayner family lived. When Steven pointed out that they had passed his house, one of his captors told him that they would call his parents for permission to have him spend the night with them. Steven wanted them to take him to his house to ask his parents, but Parnell continued driving until they reached a trailer camp in an area about 20 miles from Merced. Parnell had rented a cabin in this remote location and placed newly purchased toys inside in anticipation of the arrival of an abducted child.

As Steven had been punished the night before for coming home late from school, Kay Stayner wanted to make sure Steven had learned his lesson. On the afternoon of the abduction, she took the car, planning to go past Steven's school and offer him a ride if she saw him walking toward home. She stopped to do an errand on the way and was briefly detained. When Kay didn't see Steven en route, she assumed that she would find him already at home. Upon arriving home and not finding Steven, Kay expressed her concern to her husband, as she didn't think Steven would have forgotten that he had been punished the night before for dawdling after school. Del reassured his wife that Steven probably was playing somewhere and that he would deal with Steven's behavior when Steven returned home that evening.

As Steven's siblings returned home, their mother asked them whether they had seen Steven after school. Because no one had seen Steven, the family went to look for him in the neighborhood and began asking friends if they had seen him. When it became dark and Steven was still not home, his father and brother began to search a wider area. They looked in empty lots where people discarded refrigerators and other debris. When Steven still had not been located, his parents became increasingly worried and called the local police.

The police came to the Stayner residence the same night and obtained a picture and description of Steven. They also tried to reassure the family that Steven's disappearance was not likely to be a serious matter.

Questioning of Steven's classmates revealed that he had been on the school yard after school and was seen leaving the school yard and walking toward his house. No one reported seeing Steven stopping on his way home or talking to any adults. The Stayners thought that Kay's father might have taken Steven without telling them, as he tended to be difficult in his relationships with the family, but that proved to be false.

The police began their investigation and suggested to the Stayners that a psychic be useful in locating Steven. At first, the Stayners did not believe a psychic could be of help, but they eventually followed the recommendation. The police, the Stayners, and the psychic drove around the surrounding area and the psychic reported strong feelings related to the case in an area called Cathey's Valley, about 20 miles outside of their community. The Stayners reported that Steven's grandfather lived in the immediate vicinity and had already told them Steven was not there. The psychic was not able to specifically determine Steven's whereabouts, but assured the family that she was certain he was still alive and very frightened.

In the process of conducting their investigation, the police questioned Del Stayner about his punishment of Steven. Del vehemently denied harming his son. The police asked if he would be willing to submit to a polygraph and he agreed to do so. Kay Stayner requested that Steven's grandfather also undergo a polygraph test as he had been openly hostile toward the children in the past. Kay Stayner also submitted to a polygraph test. No findings were obtained through these tests indicating knowledge of Steven's whereabouts or involvement in his disappearance.

The first few nights following the abduction Parnell, Murphy and Steven stayed in a rented cabin in Cathey's Valley, the small community where Steven's grandfather lived and where the psychic had reported strong feelings related to Steven's disappearance.

Upon arriving at the cabin, Parnell gave the toys to Steven and instructed him to play with them while Parnell stepped outside with Murphy. Parnell reminded Murphy he would be implicated in the crime and prosecuted as an accomplice if he told anyone what had transpired.

As the evening passed, Steven became increasingly anxious about disobeying his parent's instructions to come directly home after school. Parnell reassured him that his parents knew where he was and had given their permission for him to stay with Parnell and Murphy overnight. That night after showering, Steven slept in a towel because he only had the clothes he was wearing that afternoon. During their stay at the cabin, Parnell lent Steven articles of his clothing to help keep Steven warm and shared the only bed in the cabin with Steven.

Parnell elicited information from Steven about problems his family was experiencing prior to the abduction and then convinced Steven that he had called his parents and discussed the family's problems with them. Parnell told Steven that his parents could no longer afford to care for him, making it necessary for Steven to continue to stay with Parnell for a period of time. Before leaving the cabin, Parnell dyed Steven's hair so that he would not be easily recognized.

Later Parnell told Steven that his father was not too happy with him over something he had done at home. Steven confessed that he had written on the garage door. Parnell told Steven that his father thought that Steven should stay with Parnell for a while and that he did not want to talk with him because he was angry about what Steven had done. Under Parnell's care, Steven was alternately forced to eat foods he did not like, under threat of spanking, and indulged with favorite foods and special treats. Parnell continuously told Steven that he was the only person who cared about him and who would give him special toys all for himself. He gave Steven a gift of a puppy which provided Steven with a source of comfort and companionship. However, Parnell felt slighted by the affection Steven showed the puppy and commented on Steven's lack of gratitude and failure to give Parnell such affection.

Toward the end of their stay in the cabin, Parnell told Steven that he would not be going home because the court had granted him custody of Steven. Because Steven's parents could not afford to take care of Steven and that they did not want him any more, Parnell would keep Steven and provide a home for him. Parnell continued to reassure Steven he had been in contact with his parents and his actions were taken with his parent's knowledge and cooperation.

From the time of the abduction, Parnell had addressed Steven in conversation as "son", instead of using Steven's name. Now he told Steven that he was going to be called, "Dennis" and he ignored Steven's requests to be called by his real name.

While at a nearby convenience store, Parnell saw a picture of Steven which had been posted there by Steven's grandfather. Parnell became alarmed the picture

could lead to Steven's identification and made plans to leave the area as soon as possible.

Murphy and Parnell took Steven to Yosemite Valley where they had been working prior to the abduction. Parnell worked at a night job and had Murphy watch Steven or gave sleeping pills to Steven so that he would not awaken until Parnell returned.

Post-Abduction Conditions and Adaptation. After a couple of weeks, Parnell quit his job and moved with Steven to the Northern California town of Santa Rosa. Parnell enrolled Steven in school as his son and instructed him to use the name, "Dennis Gregory Parnell," instead of his real name. Parnell told Steven that he was his son now, and threatened to spank him if he ever revealed his true identity to anyone.

In Santa Rosa, Steven tried to contact his parents from a pay telephone. He didn't know his home phone number and became confused when the operator gave him instructions for obtaining the number from directory assistance. The children in the Stayner family had not been allowed to use the telephone at home, and as a young and inexperienced child, Steven became confused by the operator's instructions for obtaining a long distance number.

Steven continued to look for his family whenever he was out in public but it always led to disappointment when the person who resembled a family member turned out to actually be a stranger. Steven could not imagine why his parents did not come to get him and he had no realistic understanding of the geographical relationship between his new home and the one he had left behind.

On one occasion, Steven made an attempt to run away from his captor but returned to his home with Parnell when he realized that he did not know how to reach any secure or familiar destination. After Parnell and Steven became settled in Santa Rosa, Parnell began to sexually molest Steven by committing acts of sodomy and involving Steven in acts of oral copulation. Parnell also kept nude photographs of Steven.

Following Steven's abduction, his family tried to conduct their lives as normally as possible. His parents felt it was important for the other children in the family to be able to celebrate holidays and engage in normal activities. Christmas and birthdays were observed, and gifts were saved for Steven to open when he came home.

Del Stayner became discouraged and depressed and blamed himself for the abduction. He reasoned that Steven might not have been abducted if he had spent

more time with Steven. As tension mounted in the family, Del found he lost his temper easily. Kay never gave up hope of finding Steven alive. She found that seeing Steven's belongings in the house helped her to feel close to him, but also served as painful reminders of his absence. Del did not want anything of Steven's to be put away, but after Steven had been absent for some time, Kay realized that there was no sense in keeping his clothes, as they would no longer fit him. Over her husband's objections, Kay began to pack away the items that she knew Steven would never use again. Kay even wondered if she would be able to recognize Steven if she were to see him, as he would have changed over time.

Parnell and Steven became marginal members of the community in Santa Rosa. Parnell worked at night as a hotel bookkeeper/clerk and became a regular at a bar in town. Parnell presented himself to acquaintances as a single parent who was struggling to raise his son on his own. Steven attended school, and participated in field trips and overnight stays at the homes of school friends. He was often cared for by babysitters, as Parnell usually worked at night, and was given freedom of movement during the day.

When Steven continued to ask about his family, he was told that his father had suffered a heart attack and died, and that his mother had moved away to an apartment in an unknown location. He was told that his mother had placed all of the children in situations similar to Steven's as she could not afford to have them with her. Steven was reassured that his brothers and sisters would be calling him as soon as they were settled.

On one occasion, Steven's teacher became concerned that he seemed to be distracted in class and he was referred to a school counselor. He tried to inform the counselor of his situation by stating that Parnell was not really his father. Steven's plea was misinterpreted as the confusion of an adopted child who was curious about his biological parents. No follow up action was taken by the school to investigate or clarify Steven's statement. When Steven reached the fifth grade in school, Parnell took him to live in a Northern California coastal town. They remained in this area for the next three years, with Parnell continuing to work as a bookkeeper and/or night clerk in hotels. Steven was fairly mobile during this period as he had access to bicycles and would hitchhike from school to his residence, to movies, or the homes of friends. He was not restricted from using alcohol or cigarettes, nor was he protected from witnessing sexual acts between Parnell and women brought to their crowded residence. Steven learned to cope with the most distressing aspects of his life by tuning out the external world and withdrawing into his own fantasies. He also spent a lot of time watching television and reading comics and adventure stories.

As Steven entered adolescence, sports became very important to him. He was a member of the junior varsity football team and wanted badly to make the baseball team his freshman year in high school. Parnell belittled Steven's athletic aspirations and attempts to participate in activities appropriate for his age. If Steven placed his own interests before Parnell's, Parnell would remind him that he no longer had a family to return to and that any other options open to Steven were worse than his life with Parnell. Steven's other options were presented to him as living on the street or in juvenile hall, which Parnell described as a jail. Parnell graphically described what Steven's life would be like in a juvenile facility and contrasted that with the freedom and privileges he experienced with Parnell.

Much of the time at home, Steven was unsupervised, and there was a lack of pressure for him to perform academically. Due to the relaxed standards, lack of supervision, and the ready availability of cigarettes and liquor, the home was an attractive place for Steven's friends to spend time. Steven made excuses why friends could not be included in activities with him and Parnell, as he did not want friends to find out that his life was not normal. He especially sought to hide the sexual abuse which was part of his life with Parnell. Steven discouraged friends from spending time at his house when Parnell was there, as Parnell attempted to engage Steven's school companions in sexual acts.

On one occasion, a formal complaint of sexual molestation was made against Parnell by the parent of one of Steven's school friends. When the complaint was investigated, Parnell presented himself to the investigating officer as a minister who had moved to the community after he lost his church due to his wife's alcoholism and misconduct. He stated he was trying to raise his son based on strict religious principles and that the boy who had charged him with sexual abuse had tried to entice his son, Steven, into using drugs. Parnell stated that he had confronted the boy about using drugs and had forbidden Steven to have further contact with the boy. Parnell tried to convince the officer that the accusations were the boy's response to being rejected by Parnell because of his attempts to expose the boy's drug involvement. The allegations of the complaint against Parnell were reported as not substantiated.

In August of 1979, Parnell and Steven moved to Manchester, California, a small town near the Northern California coastline. Parnell began to talk to Steven about getting another boy and, at times, used this as a threat to Steven that he could be replaced. Parnell tried to enlist Steven's help with the abduction of another child and had Steven approach children but Steven would sabotage the attempt by "messing up" and then made excuses why he could not be available at the times Parnell suggested for making other attempts.

Six months later, using a 15 year old high school student as an accomplice, Parnell abducted a second boy, 5 year old Timmy White. Steven returned from school one day to find Timmy asleep in the home. Parnell introduced Timmy to Steven as his new brother and put Steven in charge of Timmy while he worked at night. Steven listened as Parnell told Timmy the same stories he had been told following his abduction. Steven understood that Parnell had lied about contacting his family and that there was no factual basis for Parnell's explanations of why Steven had not been reunited with his family. Steven could see that Timmy was in the same position that he had been in 7 years earlier, and he felt certain Timmy would soon be abused by Parnell in the same ways that he had been.

Although Steven had been planning to make a break with his abductor for some time, he now decided to leave as soon as possible so Timmy would not become a victim of the abuse he had experienced with Parnell. However, attempts to leave Parnell's home were delayed by heavy rains which continued for a week-and-a-half after Timmy's arrival. During this period, Steven spent as much time as he could playing with Timmy to prevent Parnell from molesting him.

Steven felt he would be able to get Timmy away from the house as Parnell commuted to work at night and routinely had a few drinks in a bar before coming home in the morning. As soon as the weather improved, Steven fled with Timmy. The two boys hitchhiked 40 miles to the town of Ukiah.

Steven found the police station and instructed Timmy to go inside while he waited at the corner (Steven feared he would be sent to juvenile hall if the police became aware of him). However, when the police noticed him, Timmy bolted from the building and ran to where Steven was waiting. Shortly thereafter, the police picked up both boys in a patrol car.

Steven was reticent about giving the police any information about himself and was especially anxious about reporting any information about Parnell who he now accepted as his "Dad." Steven had to be convinced by the police that his parents wanted him back and still loved him. At 3 a.m. the police awakened the Stayner household to tell them Steven had been found alive after 7 years, 2 months and 30 days.

Police Investigation of Steven's Abduction. During the years Steven was missing, Merced Police Lieutenant Bill Bailey had handled the investigation. However, because Parnell and his accomplice, Ervin Murphy, were just passing through Merced on the day Steven was abducted, and had no connection to Merced, there were no clues linking the men to the crime.

Massive searches were made in the central valley of California. Hundreds of leads were pursued, not just in the central valley, but throughout California and the entire U.S. Any time the body of a young boy was found in the U.S., the Merced police contacted the Stayners and asked them to assist in the identification of the remains. The Stayners were repeatedly asked to view photographs of bodies or personal articles found at the sites where bodies had been recovered.

About a year after Steven was abducted, a Bakersfield man confessed to the abduction and murder and told the police where he had buried the body. After extensive searches were conducted and no body was found, it was discovered that the man was a former mental patient. He was released without charge.

Previous History of the Abductor. After his arrest, information about Parnell began to appear in newspapers in California. Parnell's early years were marked by poverty and his father's desertion when he was five-years-old. At the age of six he moved with his mother from his birthplace in Texas to Bakersfield, California. Parnell reported that he believed that his mother had wanted him to run away so she would not have to be responsible for him.

A report from a psychiatrist who treated Parnell over a period of several years indicated Parnell had shown signs of emotional disturbance by the age of eight. On one occasion, Parnell was reported to have shone a light into his eyes to the point where he required medical attention. On another occasion he reportedly tried to pull out all of his teeth. He was also known to have attempted suicide several times.

Parnell reported to his psychiatrist that he was lured into a car and sexually molested at age 13. Subsequent to that incident, he became involved in several homosexual affairs. Parnell came to the attention of law enforcement when he faced charges of arson and car theft. He spent time in a mental hospital during adolescence. At one point, he escaped in order to visit a young boy for whom he described a liking. He was captured and returned to the hospital. Parnell was later diagnosed as a sexual psychopath.

Parnell married at the age of 17 and the couple had a daughter before separating. At the age of 19, Parnell was convicted of child kidnapping and molestation. Parnell had picked up an eight year old Bakersfield, California boy by telling him he was a police officer. Parnell then drove the boy to a canyon outside of the town where the boy lived. He assaulted the boy, drove back to town and released him. Parnell was arrested and plead guilty to pederasty and fellatio, involving the abducted child and served a prison term of 3 1/2 years.

Ten years later, Parnell was convicted of robbery and grand larceny and served six years in the Utah State Prison. He was released under a program of "conditional termination", the condition for his release being that he leave the state of Utah within 48 hours and never return.

Although Parnell was required to register as a sex offender, and to notify state authorities of any changes of address, the state of California had no record of his whereabouts for a 25 year period.

Psychological Effects Upon Steven Stayner and Stayner Family. Seventeen years after Steven's abduction and ten years after his return to his family, Kay Stayner described the Stayner family life as not back to normal. She acutely remembered her feelings during the time Steven was gone, recalling that it was worse, in many ways, than experiencing a death, as she never knew whether Steven was dead or alive.

Ten years after his reunification with his family, a newspaper account revealed that Steven was living in the central California town of Atwater, just six miles from the site of his abduction. Steven was working as a pizza delivery person. He was married and the father of two young children, a three year old daughter and a two year old son.

The story of Steven's abduction was made into a television documentary and drew public attention to Steven once again. Although Steven's story had received much attention in the California press following his flight from Parnell, the broadcast of Steven's story on network television brought Steven's story to the attention of Americans in all regions of the country.

Steven's wife had not known many of the details of the abduction or Steven's life away from his family until she saw them portrayed on television. Steven rarely talked about the time with Parnell and she asked few questions about his experience. It was hard to get Steven's attention at times and he would still answer to "Dennis" when it was used by his cousin, but she had not known the nature of the difficulties endured by her husband.

Steven felt uncomfortable with the celebrity status that accompanied public interest in his story. He stated that he longed to have the conventional life that he assumed would be his when the police assured him that his family was anxiously waiting for his return. Ten years after his return to his family and his community, Steven still had no friends and was able to trust only family members. He felt most comfortable around his children and was observed to be a gentle and caring father.

Steven stated that he learned to cope during his abduction by daydreaming, withdrawing and reading adventure fantasy books which he still enjoyed. He also developed the ability to build a psychological wall around himself that protected him from the awful reality of his life during his abduction.

Steven described trying to hide the truth of his experiences after returning to his community. He tried to be just another high school student and to blend into the general population. He disliked giving interviews and the publicity he received, as it made it hard for him to forget the things that had happened.

Steven did not undergo any therapy after returning home. He reported that he had dealt with his ordeal by talking about it, actively trying to forget, and by speaking before students at schools in the area. Steven felt that even though he was not happy about what had happened to him, he had faced it and now wanted to be able to get on with his life.

After his marriage, Steven supported his family by working as a pizza delivery person, but had hopes of finding a better job. He seemed to have difficulty reconciling the expectations his family had for him with the socially marginal life he had lived while in the company of Parnell. He aspired to continue his education in order to be able to improve his chances of obtaining a better job, but had dropped out of high school in his senior year.

Steven was disturbed by the short sentence Parnell received (3 years) and expressed a wish that his abductor would have been denied his freedom for at least as long as the 7 years Steven was kept away from his family and a normal life.

Steven Stayner died in 1989 on a highway outside of Merced, when the motorcycle he was riding collided with a car pulling onto the highway. The driver of the car left the scene of the accident without notifying authorities or rendering aid. He contacted his family from Mexico and they persuaded him to turn himself in to U.S. authorities. The driver surrendered to police at the U.S.-Mexico border and was returned to Merced on the day of Steven's funeral. He pleaded not guilty to a felony charge of hit-and-run driving and a misdemeanor charge of vehicular manslaughter. There were questions, by the officer who investigated the scene of the accident, about why he pulled his car out on to the highway. These were relayed to the press.

Steven's funeral was attended by 300 friends and family members. The Bishop officiating at the service remarked on the effect Steven's resilience had on the lives of others. The inscription of Steven's casket reads, "Coming Home."

In regard to family members, in 1999 Steven's brother was arrested and charged with abducting and murdering three women near the area that Steven was first taken after being abducted by Parnell. The impact of Steven's abduction on his brother has not been examined at this time.

Case Study: ABCX Model Outline

With this case study, the ABCX Model provides a convenient method for summarizing and organizing the essential components of the case history.

Family Crisis Event (Factor A)

- Steven punished for loitering after school
- Steven takes shortcut home from school
- Mother misses Steven on route from school
- Steven does not return as expected
- Parents assume Steven is loitering
- Steven not located in neighborhood
- Police report made
- Family searches wider area

Family Stressors Other Than the Abduction (Factor a)

- Ongoing financial problems
- Relocation to new area
- Problematic relationship with extended family
- Concern over Steven's adjustment to relocation

Pre-Abduction Family Crisis-Meeting Resources (Factor B)

- Family cohesiveness

Post-Abduction Family Crisis-Meeting Resources (Factor b)

- Immediate involvement of local police

Pre-Abduction Perceptual Definition of the Family Crisis Event (Factor C)

- Assumption that Steven was safe walking to and from school
- Fault initially attributed to Steven
- Belief that Steven failed to mind parents

Post-Abduction Perceptual Definition of the Family Crisis Event (Factor c)

- Police definition of disappearance as "not serious"
- Family members under suspicion
- Psychic's report that Steven was alive
- Attempts to "normalize" family life
- Mother's belief in Steven's eventual return
- Father's resignation to Steven's probable death

Immediate Experience of Stress Due to Abduction (Factor X)

- Parental guilt and self-blame
- Family members as possible suspects
- Limited financial resources
- Absence of clues and/or witnesses
- Emotional response to reminders of Steven's absence (i.e., belongings in home)

Intermediate and Long-Term Experience of Stress Due to Abduction (Factor x)

- Intermittent police reports of child homicide victims
- Family role in identification of child homicide remains
- Father's self-blame and depression
- Increased tension among family members
- Family changes in Steven's absence
- Profound changes in Steven during 7-year absence
- Family in public spotlight
- Knowledge of abductor as sex offender and ex-convict
- Problems in post-reunification adjustment
- Short sentence for perpetrator

CASE STUDY: NON-FAMILY ABDUCTION

ABCX Model Narrative

Non-Family Abduction Crisis Event (Factor A). The circumstances of the abduction in the Steven Stayner case illustrate a sometimes overlooked point. Even though the event of a non-family abduction tends to generate great public attention, it is an event that is embedded in the life of a family. Steven Stayner's parents had punished Steven in the hope that the punishment would help instill in Steven behaviors that would bring him home from school each day. The Stayners were trying in the best way they knew to impress on Steven the importance of obeying his parents and of coming directly home after school. Their well-meaning efforts, however, could not protect their son from an encounter with a known sex offender.

While there is some belief that children can be trained to increase their resistance to attempts at abduction, any child may fall prey to an abduction. Parents need to be protected from guilt associated with the feeling that they should somehow have been able to prevent the abduction.

In the Stayner case, Steven's mother intended to pick him up at school, but was delayed. The retelling of this detail as an important part of the event may be a manifestation of the parents guilt about not having been able to protect their child from the abduction. Details of the circumstances of the abduction which reflect the message, "If only I would have done this one thing differently, I could have prevented the abduction" are usually expressions of guilt that need to be processed with the parents so that they can acknowledge that they did not knowingly place their child in harms way, and all family members have been victimized by the event.

Family Stressors Other Than the Abduction (Factor a). The Stayner family was an economically vulnerable family which had relocated as an attempt to cope with their financial problems. The family's extended family network was a source of additional stress. There was concern on the part of Steven's parents that he was not handling the stress in the family as well as they would have wished.

Pre-abduction Family Crisis-Meeting Resources (Factor B). In spite of the family's problems and limited financial resources, the Stayners were a closely knit family with a high degree of family cohesiveness.

Post-abduction Family Crisis-Meeting Resources (Factor b). Although the local police responded immediately to the report of Steven's disappearance, the community at that time did not have any specialized resources for helping families with the immediate crisis. Since Steven's abduction and escape, a greater number of resources have been developed, primarily by prosecutors and specialized private non-profit agencies, to effectively aid families in the event that their child is involved in a stranger abduction.

Pre-abduction Perceptual Definition of the Family Crisis Event (Factor C). In a manner similar to many other parents, the Stayners were apprehensive that their child could be endangered on the journey to and from school. When Steven failed to appear at the expected time after school, his parents did not immediately make the association between Steven's absence from home and the possibility of an abduction. They were a family of modest means, not one in which a child was likely to be kidnapped for economic gain. Their first assumption, therefore, was that Steven had not learned his lesson about not playing instead of coming straight home from school.

As a family searches for an explanation for the child's absence there is a tendency to explain the event in terms of the most immediate issues operating in the family. It is difficult for a family to make the leap to thinking "the unthinkable." At some point it is necessary for parents to face the terror of thinking "the unthinkable": a stranger may have taken their child. It is important for those assisting families to know when it is in the best interest of the family to take this step, as crossing that threshold will forever change the family's sense of vulnerability. By letting families know what they can do to assist in the search for their child, professionals in contact with the family can be extremely helpful in aiding families to face a difficult reality without becoming immobilized.

Post-abduction Perceptual Definition of the Family Crisis Event (Factor c). The Stayner family's post-abduction definition of the crisis event shows how a family's perceptions are formed when there is an absence of factual information. There is a temptation for those in contact with a family in crisis to want to reassure the family by downplaying the seriousness of the event. This is especially true if the event is not as serious as other situations one typically sees in a professional role. The event should be responded to in a way that is compatible with the family's perception of the event.

While all families want reassurance that the event is not serious and can easily be remedied, giving false reassurance may prevent a family from responding in a way that will allow them to mobilize the family resources to effectively cope with the crisis. Families need to be presented with the facts in a humane, but open manner and need to be protected from false or overly pessimistic information.

Some families will attempt to "normalize" family life as a method of warding off the painful knowledge and powerful emotions associated with the disappearance of a child. While it is true that some basic family functions still need to be carried out, the family's situation is not normal. A forced attempt to make it so may only make it more difficult for family members to acknowledge the reality of the event and to be able to share their feelings with each other.

In families that have not developed ways of sharing feelings with each other, individuals may become increasingly isolated and hide their grief or ways of coping with the stress of the abduction. Some family members who seem to be strong throughout the ordeal may only cry or grieve when alone. Individuals may feel that by showing their emotions or pain, they may risk appearing weak or be seen as "pulling everyone down". This is especially true in families where emotional control is seen as an indication of strength and they feel that other members of the family are better able to control their feelings.

Immediate Experience of Stress Due to Abduction (Factor X). The level of stress generated by the abduction of a child is extreme by almost any definition. The experience of stress, however, may be mitigated by factors, such as, the coping style of the family and the family's available resources. Typically, neighbors and family members are willing to search for the child if the child is presumed to be missing or lost. A community can be galvanized around the search for a missing child and parents report feeling supported by these efforts. When there are witnesses to the child's disappearance, parents have the hope that the information provided by witnesses can be used to locate the child. Hope and the ability to take some constructive action seem to be elements which enable families to cope with the high levels of immediate stress.

Parental guilt and self-blame may increase the experience of stress. Parents need to be able to acknowledge these feelings when they occur without becoming overwhelmed or immobilized by them. Professionals working with families at the time of the crisis event can help to keep the experience of stress at a manageable level by redirecting guilt and self-blame into positive actions that can be taken to assist in locating the child. Organizations and professionals who have assisted other families facing similar situations can be especially helpful at this time.

Intermediate and Long-Term Experience of Stress Due to Abduction (Factor x). The abduction of a child from a family is an event that changes each family member individually and the family system as a whole. The long-term outcome for the family, individual family members and the child victim is determined by a number of factors including the circumstances of the abduction, family stresses other than the abduction, available crisis-meeting resources and how the abduction is perceived by the family. Children who have pre-existing emotional problems seem to have greater difficulty coping with a traumatic event and may constitute a subgroup especially vulnerable to long-term problems following an abduction. Sexually exploited children are also likely to be at increased risk.

Families are also not likely to have information about what actually occurred during the abduction until some time after the reunification. The child revealing of information about deprivation or sexual abuse can be a traumatic event for parents when they are celebrating the return of their child.

It is often not until life has regained some semblance of normality that parents begin to report difficulties the child may be having following the reunification. One reason for the delay is these difficulties are unanticipated by parents who may be led to believe that just having the child home will remove the effects of the child's experience. A second reason is that a child will begin to deal with the effects of the trauma only when he or she feels safe enough to do so.

While some of the effects of the abduction can be expected to subside over time, other effects such as a heightened sense of vulnerability and fearfulness may persist. Family members may also have very different ways of coping with the event of the abduction and unless resolved, these differences themselves may become a source of ongoing family conflict.

Summary Statements/Non-Family Abduction

1. Parents and family members feel enormously guilty about not having been able to protect the child from the abduction. They frequently review their every action on the day of the abduction, thinking about how a single different action here or there might have prevented the abduction.

2. Parents must allow themselves to think the "unthinkable", while still retaining hope, in order to be able to cope effectively with the crisis of non-family abduction.

3. The family is left with many reminders of the child. They try to cope, manage a daily routine, work with law enforcement, handle public and personal responses to the situation, and search for the child. The period a child is missing may be only a few hours, a few days or in a handful of cases many years. In some cases child victims of non-family abduction are never recovered. Intervention during the time when the child is missing should be provided to address the loss.

4. Giving false reassurance to families may prevent them from mobilizing resources needed for coping with the crisis situation.

5. Families need to acknowledge the "abnormality" of their situation and develop contacts with organizations who can put them in touch with other families who share their experience.

6. Families can be helped to keep stress at a manageable level by redirecting guilt and self blame into positive actions that are an effort to help locate the child, develop coping skills to deal with their loss and establish support systems.

7. Parents need to anticipate children may need professional help to cope with the experience of non-family abduction and to recognize all family members are victims of the trauma.

SECTION III
Applying the Double ABCX Model: A Family Abduction Case Example

Mother's History. Beth Frank was born in the Midwest to working class parents. Her family was of Western European origin and traditionally had been Protestant. She was the second of two children, a brother having been born two years before Beth. Her mother and her brother's family continue to live in the Midwestern community where she grew up. She describes herself as not being close to her brother while growing up as she felt her brother was treated as the favored child by her father.

She describes her father as authoritarian and remembers him as angry and having had difficulty relating to his wife and daughter. She describes her mother as caring, but passive and unable to solve problems effectively.

Beth attended public schools and describes herself as having been an average student who did well in the classes she liked. Her special interests were art and athletics and she excelled in these areas. In high school, she had friends from many social groups in the large urban high school she attended, but did not belong to any closely knit group. This caused her to feel like an outsider at times, but she was active in school clubs and activities and got to know many students from various socioeconomic levels. Beth belonged to a group of top art students in the school that did art work for school activities.

Beth's participation in school activities served as an escape from family tensions, as well as a way to express and develop her interests and talents. As she became older, she became more aware of the dysfunctional nature of the relationships in her family. She was most acutely aware of her father's direct and frequent expressions of anger toward her mother. Her mother's response was a submissive one. This and other problems within the family were never discussed. Beth, too, learned to placate her father in an attempt to control his anger. The family situation, however, was stable as the family structure remained intact and there was no discussion of separation or divorce.

Beth saw her mother as unable to stand up to her father and was anxious about becoming like her mother. She chose to emulate her aunt, rather than her mother. She felt that her aunt was a stronger person, who was better able to stand up for herself. This relationship remained important to Beth and she remembers having a feeling of closeness with her aunt and uncle that she did not have with her parents.

As an adolescent Beth both dated and participated in group social activities such as church and sports events. Her father had difficulty allowing her to date and

would have preferred that she not go out with boys. He was strict, vigilant and had difficulty accepting her friends or behavior that Beth considered to be appropriate for her age. There was a great deal of conflict between Beth and her father around these issues. Her mother was seen as taking a middle position in this conflict. She was more accepting of Beth's behavior and friends, but did not intercede with Beth's father on her daughter's behalf.

Following high school, Beth attended an extension program of the state university. She planned to enter teaching or human services, but only completed two years of college before terminating her education to marry a fellow student, Otto Frank.

The Courtship of Beth and Otto. Beth and Otto first met in the student lounge of the extension program they were both attending. Beth was 18 at the time and Otto was 19. Both were living at home with their parents. Beth had a male student friend who encouraged her to join the chess club of which Otto was a member. She remembers that Otto was an accomplished chess player and soccer player and that she initially found him both charming and handsome. Otto had a self-confident manner and an "Old World" quality that set him apart from the other young men at the school. On the other hand, Beth found Otto to be arrogant and aloof, but this only made him seem like a greater challenge to her. Beth responded to this challenge by arranging her schedule so that she and Otto would have some classes together. Otto's interest in Beth became more apparent after she asked him to take her to a chess club meeting. Their first formal date followed when Otto asked Beth to a school athletic event.

Late one evening, Beth and Otto returned home from a date and Beth's father threatened to expel her from the house. Otto was upset by Beth's father's reaction and tried to impress her father with the fact that he was not trying to use or take advantage of his Beth, as he was planning to marry her. Beth now believes that Otto meant the comment more to reassure her father than as a declaration of his actual intentions at that time. The confrontation with Beth's father, however, served as a marker in the couple's relationship, as the question of marriage had been brought out in the open.

Initially both sets of parents responded negatively to the couple's engagement. Beth's parents had hoped she would marry another boy whom they saw as a better "catch" for their daughter, as his family was more acculturated and prominent in the community. Beth's mother initially voiced her objections and then acquiesced to her daughter's wishes. Otto's father offered to send his son back to his country of origin, in order to get him out of the impending marriage. Otto's mother acquiesced to her husband's authority in family matters.

During the engagement period, the two families began to adjust to the situation and met socially on occasion. Otto, however, had difficulty coping with both parental pressure and the impending marriage. He arranged to take a trip to California with a close male friend and was gone for six months, returning four weeks before the wedding. Beth understood Otto's need to distance himself from his close relationship with his mother, and tried to accept the fact that he chose to spend their period of engagement at such a distance from her. Since Otto always traveled with a passport, Beth had some concerns that he might bolt and not return for the wedding. She was relieved when he returned to the Midwest and took his return as a sign of commitment to their relationship, diminishing the doubts that she had let build up during his absence. The wedding was a formal one with a full component of attendants.

The July weather was hot and humid during the honeymoon trip. Beth realized there was something wrong on this trip when she felt Otto did not seem to enjoy being alone with her. She found the hot weather oppressive and this discouraged Beth from sleeping close to her new husband. Beth reports not having been sexually experienced at the time of her marriage and she was not aware of how sexually experienced or inexperienced her new husband was. Tension from this and other issues between the couple was not resolved on the trip and Beth was left with the feeling that the marriage was not beginning on secure grounds.

After returning from their honeymoon, the couple moved in with Otto's parents for the remainder of the summer. In the fall they moved into their own apartment. Otto became a full time student at the state university that fall, while Beth worked to support them. The couple had little money and their social life was restricted to campus activities. Their social group was composed mainly of Otto's single friends, who were in favor of the use of recreational drugs. Beth was uncomfortable with this and it would remain a source of conflict between them. Beth remembers feeling lonely and socially isolated during this time, as Otto chose to spend a great deal of time on campus, complaining that he could not study in the apartment with her around.

After graduation, the couple moved to the vicinity of their respective families, where Otto began working for one of Beth's relatives. During this time Otto became closer to Beth's family and Beth came to see that her husband and her father actually held many attitudes in common. One attitude that was especially disturbing to Beth was their shared belief in the inferiority of women. She felt that this attitude had contributed to her father's abuse of her mother.

The couple had a dream of beginning a life for themselves in the West. Otto contacted a personnel recruiter for assistance in locating a position in that part of the country, but instead, was told of a good opportunity with a company in another

Midwestern community. Otto interviewed for the job, quickly made the decision to take the job and remain in the Midwest. They bought an old house and moved in with plans to remodel it. The house remodeling became the focus of their time together. They rarely went out and had few married friends. Otto began to use alcohol regularly and Beth describes shutting down emotionally to cope with the ongoing marital tension.

Transition to Parenthood. Beth became pregnant with Sean, the couple's only child, after 8 years of marriage. The pregnancy was not planned. Beth remembers having doubts about bringing a child into the world and about her ability to be a good parent. She was also not sure whether Otto would make a very good father, because he didn't seem to really like children. However, once she became pregnant, she felt that the decision had been made and there was no question of having an abortion.

Even though Beth did not feel enthusiastic about the pregnancy, she decided not to worry about it because she and Otto had a house and could financially afford to have a child. Beth broke the news of her pregnancy to her parents first. Her father was ill and she knew that he wanted very much to have a grandson. Her father's condition worsened rapidly and he died during Beth's fifth month of pregnancy. Beth spent the month following his death managing the details of his death and funeral and providing emotional support to her mother.

Beth was disappointed with Otto's response to the pregnancy. He continued to work long hours. He attended child-birth classes and the labor and delivery, but Beth had the sense that he was not really interested. Preparations for the baby were not complete when Beth went into labor. The labor progressed slowly. Otto's interest seemed to be engaged only at the time of the actual birth and then he seemed to be fascinated by the process.

Sean weighed over 8 pounds at birth and appeared to be a healthy and attractive baby. He had a molded head from the prolonged labor that was quite noticeable for a few days. He was briefly transferred to the intensive care nursery with some concerns about complications resulting from the strenuous birth, but he proved to be a healthy baby.

From the beginning, Sean was difficult to care for because he did not sleep or eat with any regularity. Since Beth was at home full-time, she provided all of Sean's care. Otto became the sole support of the family and needed to be at work every day, so Beth was always careful not to awaken him at night when the baby cried. After several weeks, Beth felt exhausted and returned to her mother's house with Sean so that her mother could help with the baby at night while she got some rest.

With the transition to motherhood, Beth coped with the couple's marital problems largely by involving herself with raising Sean. Otto worked long hours at his job (60-80 hours a week) and didn't come home until late at night. Beth had become increasingly dissatisfied with her life after Sean's birth but didn't feel there were enough reasons to justify leaving the marriage, until she discovered that Otto was having an affair with a co-worker. The discovery came when she overheard a conversation he was having on the phone late one night. Beth confronted Otto with her suspicions and he denied that he was romantically involved with the woman. She suggested that they seek counseling but Otto was not interested. His reason for refusing counseling was that Beth would not change sufficiently, and he believed that as soon as the counseling was discontinued, she would again fail to meet his expectations as a housekeeper and a lover.

Beth learned that Otto continued to contact the woman he was involved with, and she came to feel that the situation was intolerable. She talked with an attorney and decided upon a separation. She eventually was able to obtain a court order which required Otto to vacate the house. For Beth the affair served as a crisis which made it easier for her to make the decision to end her marriage to Otto.

Custody and Visitation. After the separation, Otto was seeing Sean on an informal basis, usually in the evenings while Beth was working part-time. Otto would come to the family residence where Sean and Beth continued to live and would spend the evening with Sean while Beth was at work. The arrangement seemed to work in the beginning. However, when Otto brought up the subject of joint physical custody, Beth rejected the proposal. She did not feel it was a workable arrangement. Communication between Otto and herself was not good and many of her friends talked about the difficulties of trying to work out joint custody arrangements.

In responding to his proposal for joint custody, Beth found herself questioning Otto's competence as a parent and also his motivation for wanting to spend more time with Sean in light of what she interpreted as his previous lack of interest in caring for Sean during their marriage.

Beth described several instances that she felt illustrated Otto's ineptness as a parent. When she returned home after work on the evenings that Otto was staying with Sean, she would find that their son had not been bathed or put to bed, even though it was 10 p.m. Friends reported that Otto seemed to make no attempt to control Sean's behavior, so that strangers had to control or discipline Sean when he misbehaved in public. She also believed that Otto, on occasion, did not require Sean to use a seat belt while riding in the car. And once, while making a purchase, Otto reportedly left Sean unsupervised in front of the shop.

Beth was also unhappy when she would drop Sean off at day care, expecting that he would remain there until she picked him up. Instead Otto would pick him up without notifying her and take him to his home. Beth began to suspect that Otto's attempts to spend more time with Sean were laying the groundwork for a custody battle in court and that Otto felt he was strengthening his case by spending more time with Sean. Beth began to become increasingly anxious about Otto's chances in court and/or the possibility of an abduction.

After Beth refused Otto's plan for joint custody and complained to him about his violations of their visitation arrangement, she noticed a change in Otto's behavior. He hired a custody attorney who was widely known throughout the area. When she began getting letters from his attorney, her lawyer withdrew from the case. It alarmed Beth that her attorney seemed to be intimidated by Otto's attorney. Beth had to hire another attorney in order to prepare for the upcoming court date.

When she found out that Sean had been taken to see a psychologist by Otto, Beth began to develop suspicions that Otto intended to mount a campaign to discredit her as a parent. The report from the psychologist, which was submitted to the court, said that Sean "had trouble relating to his mother." Beth was upset by the content of the report because she had never met with the psychologist. When the report was presented during the custody hearing, Beth felt compelled to agree to see the psychologist for evaluation. Upon completion of the psychologist's evaluation, a hearing was scheduled and Beth was awarded temporary sole custody.

Following the custody hearing, Otto saw Sean every Tuesday and Thursday evening and every other weekend, as well as alternating holidays. Beth describes these visitations as very difficult. When Otto returned Sean, he would have difficulty handling the transition. Sean would tell Beth that his dad said she was a bad mom, that she was sick, that the judge had made a mistake and he was supposed to be with his dad.

Sean began calling his mother "Beth" and calling Otto's girlfriend, Shirley, "Mom." He had already been instructed to call Shirley, "Mom", whenever he was with Otto for visitation. Beth felt that these maneuvers were efforts to prepare Sean for being away from her permanently. During the periods that Sean was with her without a visitation, he would calm down, but the transitions were always stormy. Twice Sean had been taken for medical care for injuries Otto claimed were inflicted by Beth. In both cases, reports were filed and the complaints were investigated, but were unsubstantiated.

Beth felt that Otto did not seem to understand how harmful all of this was for Sean. Her perception was that Otto was more concerned with destroying and controlling her than he was about hurting his own child. Beth remembers this period as a terrible time in both her life and Sean's. She began to believe that Otto was trying to break her emotionally and that the legal system would not be able to protect her or her child.

Around this time, Beth began to perceive changes in Otto's behavior. He assumed a more aggressive posture, vis-a-vis custody which generated a sense of helplessness in her. When she learned that Otto had gotten Sean a passport, she tried to get possession of it through the courts, but was unsuccessful. In response to feeling threatened by Otto's actions, Beth hired a third attorney she felt was better prepared to represent her interests in court.

Beth had previously thought of herself as someone who was very emotional and made decisions on an emotional basis. When she saw her husband acting in ways she thought were irrational in regard to Sean's custody, she began to see herself as making decisions on a rational basis. She feels that she is a person who has always managed to respond to a crisis and that this coping ability has its roots in her need to be a strong person in order to cope with the problems in her family or origin.

Circumstances of the Abduction. Sean was taken by Otto during a prearranged, extended visitation. Beth described being apprehensive prior to the visitation because she had noticed a hardening of her husband's position on the matter of custody and she had always been concerned that Otto would take Sean to Germany to raise him. A vagueness in Otto's plans for the scheduled vacation and a resistance to talking about topics that were previously discussed openly only heightened her apprehension.

When Otto did not show up with Sean at the agreed upon time, thoughts flashed through Beth's mind that he might not bring him back. Beth called Otto's parents to find out if Otto and Sean were still there. Otto's mother told her that they had not been there as expected and it immediately became clear to her that Otto had abducted Sean.

Beth called her lawyer, who advised her to file a police report. Beth made a police report and the police sent an officer to her house, where he reviewed the custody order and previous complaints made against Otto for violations of the visitation agreement. After the police left, Beth remembers feeling very alone and unable to sleep. She was awake the rest of the night. The next morning she called Otto's place of employment.

That evening Beth received a call from her mother-in-law stating that she had received a call from Otto's boss. Otto informed him in a letter that he had taken Sean and was not returning to work. Beth called her lawyer who gave her the name of a private missing child organization in her state. They provided her with information including the name of a private investigator who worked exclusively on abduction cases. The following morning, Beth met with the private investigator and began the search for Sean.

Beth continued to work with the police and informed them of the letter sent to Otto's company. During this period of initial contact with both the police and private investigator, Beth felt a combination of anger and helplessness. Otto had a 2 1/2 week head start and there was a chance that she might not see Sean again. Beth regained some confidence that Sean would be recovered due to the private investigator's record of success in other cases. The private investigator would talk with her about other cases he had investigated and kept her well informed regarding the progress of their search effort on behalf of Sean.

An unanticipated result of Sean's abduction was finding out that there were several dedicated people who went out of their way to assist her. Other parents of missing children, a day care worker, the police investigator and a private investigator were among those who went beyond the requirements of their jobs in order to assist her in the search for Sean.

However, Beth perceived federal law enforcement to be less responsive in the search. She believed that they did not place a high priority on the investigation of parental abductions and also showed some resistance to working with a private investigator. Beth's belief was bolstered when the private investigator obtained a lead that led him to believe that Otto, his girlfriend and Sean might be in Mexico. Beth and the investigator requested the assistance of the FBI case agent to obtain an address to go with a phone number they had uncovered. The agent took several months to respond. By the time the information was received, the parties had left Mexico and were traveling under assumed names.

In spite of disappointment and frustration during the search, Beth was able to function on her job and develop what resources she could to keep the search effort going. She distributed fliers, spoke before groups, appeared on television and gave media interviews.

During the time Sean was missing, Beth's financial support came from her job and money received from a prior business investment. Since her husband was still a fugitive, the court allocated part of his business investment income to Beth. In this way she was able to meet her living expenses and finance the search. She

estimated the cost of the search to be $50,000, including the bill for the services and expenses of the private investigator, which amounted to $30,000.

Beth was always able to maintain hope as new leads and resources would appear. The private investigator persisted in tracking down leads developed from phone calls made by Otto prior to the abduction and other information left behind by Otto and his girlfriend, Shirley.

Several clues uncovered during the investigation turned out to be significant. First, it was learned that Otto and Shirley had auctioned off their belongings prior to the abduction, indicating that the abduction had been thoroughly planned in advance, and that the couple could afford to move frequently, if necessary, to avoid detection. Second, before the school year ended, Shirley sent her son to be with her parents in Atlanta where the couple and Sean would soon join him. Third, the couple had moved into a hotel during the period immediately prior to the abduction.

Recovery and Reunification Events. At the time Sean was recovered, Otto, Shirley, her son, and Sean were living in Canada. Almost two years after Sean was abducted, an anonymous phone call was made to the local police department, asking to speak to the Sergeant who was assigned to investigate Sean's case. When told that the Sergeant was not in, the caller asked whether the department had an ongoing case with the name Frank. Told that they did, the caller said that Otto could be found living in Ottawa, Canada. The caller also revealed the fictitious name Otto was using and the address where he was residing with Sean.

With the information from the anonymous tip, the Royal Canadian Mounted Police (RCMP) began surveillance on the house and verified that Otto and Sean were living there. They knew from Beth that Otto's gun was not listed among the items he had sold at the auction of their belongings. They assumed that he might be armed. The RCMP then assembled a SWAT team to approach the house.

The RCMP talked to Beth on the phone just before the recovery. They asked her not to come to Canada until they could report that Otto was in custody. Beth was both frightened and elated at the news. She had concerns for Sean's safety but also feared that with delay, Otto might flee.

Late at night, the RCMP approached the house and arrested Otto and Shirley, and took the children into protective custody. A social worker was present with the team at the recovery and arranged to have the children transported together to a foster home that night. Shirley's son was released to his grandparents and left Canada.

When Beth learned that Sean had been found she contacted a friend, Carl, who had worked at Sean's day care facility and told him the news. He had been an important source of emotional support during the abduction. He again lent his support and offered to go to Canada with Beth to help in any way he could.

Beth also consulted with Sean's therapist to let him know that Sean had been found and discussed ways of approaching the reunification with Sean in order to make it as easy as possible. The therapist agreed that it would be a good idea to take along someone Sean had known before the abduction and was likely to trust. Beth had met with the therapist several times while Sean was gone to keep him apprised of the case and discuss her thoughts and concerns about preparing for a reunification.

Beth, Carl, and the private investigator flew to Canada the day after Sean was recovered. They went directly to the Social Services office to meet with the social worker who had been assigned to Sean's case. A meeting was arranged at which Beth would finally see Sean. She was very nervous and afraid of saying or doing the wrong thing.

The first meeting was held in a conference room and was attended by Sean, his social worker, Carl and the private investigator. Initially, Sean sat holding his social worker's hand and then began to talk comfortably to the men in the room. He eyed Beth warily and did not make any effort to touch her or be comforted by her. At the end of the meeting when they stood up to leave, Sean looked at his mother and told her that his father had said that she was dead. Beth calmly reaffirmed that she had been alive all along and that ended the first meeting. Beth remembers that she didn't try to touch Sean or talk to him a lot, but rather let him talk and draw pictures so that he would feel in control. Her goal for the reunification was to make it as easy for Sean as possible.

The next visit was arranged to let Sean take them sightseeing. He took them around the city on a tour bus, and then showed Beth and Carl places that were familiar to him. Sean got to be the tour guide, which gave him a sense of control in the situation. A couple of times during the outing, he would let her briefly touch him and then he would move away.

The third visit was at a restaurant and Sean let his mother put her arms around him to have a picture taken. This was the first time he actually let her get close to him. On the fourth visitation, they spent time in Beth's hotel room. By that day, Sean was comfortable enough to crawl underneath the blankets on the bed and to snuggled up against his mother, while they read books and played games. When it was time to leave, Sean didn't want to leave.

While the series of meetings allowed Beth and Sean to get used to being together again, they also were characterized by a separation at the end of each visit. In order to protect Sean, the social worker decided not to have another visitation until a decision had been made in court regarding the release of Sean to his mother's custody.

It was another five days before a hearing was scheduled and Beth was given custody and allowed to leave the country. When she saw Sean that day, he seemed happy and ready to return home. The three week stay in Canada was hard on Beth emotionally and financially, but gave her time to learn more about the facts of the abduction and to gradually begin to reestablish a parenting relationship with Sean.

Beth learned Sean and Shirley's son had been attending private school and that Otto and Shirley had both been working for a company under assumed names without Canadian work permits. They had been depositing money directly into their bank account and were paying no taxes. The car they were using was leased under a false company name and their housing was directly paid for by the company where they worked. They avoided putting anything in their names.

The motivation for the anonymous caller revealing information leading to Otto's arrest stemmed from Otto's attempts at a hostile takeover of the company where he and Shirley were employed. A director in the company reported Otto to Canadian Immigration authorities and placed the call to the police where Beth lived.

In addition to allowing Beth to gradually become Sean's caretaker again, Beth's prolonged stay in Canada also benefited Sean by giving him a chance to adjust to the changes that had taken place suddenly and unexpectedly following the arrest of his father. He had the support of a social worker he could talk with and also was able to become reacquainted with a trusted person from his former day care setting.

Upon returning to his home in the Midwest, Sean responded immediately to a picture of himself with his mother, taken before he was abducted, and to the objects which had remained untouched in his room. Beth feels that these familiar objects helped Sean to recall memories from his life before the abduction. Beth also realized that it was important not to say anything negative about Otto, Shirley, or her son. Regardless of her feelings about any of them, they had been Sean's family for nearly two years.

Beth took two additional steps to help Sean adapt to his life back in his community. First, she contacted Sean's therapist so that he would be available to see Sean right away. Beth had met with him several times during Sean's absence

and he was familiar with the details of the case. Secondly, Sean was enrolled in school, as soon as possible, in order to get Sean back into the life of a normal eight year old.

Beth was also reminded of the benefits of the extra time they spent in Canada together. The time it took to obtain permission to return to the U.S. with Sean gave her and Sean time to visit some places that were familiar to him. This gave them a shared sense of what Sean's life was like while he was living with his father in Canada. Having visited the location of the house where Sean had been staying, his school, and other sites familiar to him, made her a part of his experience there. She feels that this aided in the adjustment process which continues now that Sean is home.

Post-Abduction Adaptation. The period of adjustment following Sean's return home has been stressful at times. Beth's mother had been living with her during the period just prior to Sean's recovery. She left following Sean's return because she found it difficult to deal with Sean's aggressive behavior toward Beth. Sean also shows signs that he does not trust what people tell him. Sean frequently asks his mother if she really likes him, and still questions what she tells him. When this happens, Beth encourages Sean to call other adults to verify what she has said.

Sean also continues to make claims of having been abused by his mother. Sean believes that he was locked in a closet by his mother while living with her. Beth continues to provide Sean with evidence that these events that he claims to remember, could not have happened.

Beth would like to remain in her present community as she reports feeling safer where the police know Otto. She still feels that Otto would be capable of abducting Sean again.

In regard to her social life, Beth's social support comes mainly from individuals connected to the recovery of Sean. She continues to talk with the private investigator frequently and with the local police Sergeant on a less regular basis. Beth describes Sean as her main source of support at the present time.

Beth describes concerns about being a single parent and desire to meet someone with whom she can have a permanent relationship. During the time that Sean was gone, she wasn't emotionally available to meet anyone. Now, Beth feels that a man would be reluctant to get involved with her. She still identifies three major sources of stress in her life: (a) the psychological aftermath of the abduction still felt by Beth and Sean; (b) the reentry of Otto into her life, with the upcoming trial and anticipated ongoing custody dispute; and (c) Sean's need for services to assist with his present behavior and emotional problems.

Beth has not sought professional help for herself as she claims that she is functioning well enough. She sometimes wonders if she might experience a crisis after Otto's trial is over. She also is aware that she did not have time to recover from the stress of Sean's abduction before having to deal with his recent diagnosis of Gilles de la Tourette's Syndrome, a neurological condition marked by tics, involuntary movements, and verbal outbursts. In regard to Sean's adjustment, the aggression and behavior problems shown by Sean after his return to his mother's custody have been related to Tourette's Syndrome. He has recently been put on medication and his symptoms have shown improvement.

Beth does not believe that her life has returned to normal since Sean has been returned, and doubts that it ever will, as she anticipates that Otto will continue to fight for custody of Sean. Beth continues to be concerned about the possibility of a reabduction and doesn't feel that she can ever regain either the trust she has lost or the time that Sean was away from her.

Otto has decided to plead guilty to the charge of abducting Sean. He agreed to enter a guilty plea with a recommendation of no jail time and no prosecution of his wife. He is also requesting visitation in family court. Under the current court order, Otto will be allowed to see Sean only with the recommendation of Sean's therapist. Supervised visitation will be conducted only in the presence of Sean's therapist.

Case Study: ABCX Model Outline

With this case study, the ABCX Model provides a convenient method for summarizing and organizing the essential components of the case history.

Family Abduction Crisis Event (Factor A)

- Beth rejects joint custody
- Beth obtains temporary sole custody
- Otto violates visitation agreement
- Otto sells belongings
- Sean not returned from visitation

Family Stressors Other Than the Abduction (Factor a)
(Pre and Post-Abduction)

- Ongoing parental conflict
- Sean diagnosed as Tourette's Disorder
- Otto's affair with co-worker during marriage

Pre-abduction Family Crisis-Meeting Resources (Factor B)

- Beth's role as family crisis manager
- Adequate financial resources

Post-abduction Family Crisis-Meeting Resources (Factor b)

- Immediate access to legal help
- Referral to specialized resources
- Social support from family members
- Social & financial support from community
- Unexpected financial windfall

Perceptual Definition of Family Crisis Event (Factor C)

- Beth's fears of abduction confirmed
- Cooperation of private and police investigators

Perceptual Definition of Family Crisis Event (Factor c)

- Knowledge of other successful recoveries
- Constant discovery of new leads
- Media interest in case

Immediate Experience of Stress Due to Abduction (Factor X)

- Fear child taken from U.S.
- Sean missing for almost two years
- Concerns for Sean's welfare
- High public visibility of the case

Immediate and Long-Term Experience of Stress Due to Abduction (Factor x)

- Sean's psychological diagnosis
- Changes in parent-child relationship
- Pressure of trial on criminal abduction charges
- Anticipation of ongoing custody dispute
- Fears of reabduction

Family Abduction Case Study Model Narrative

Family Abduction Crisis Event (Factor A). As can be seen with the Frank family crisis event, Factor A, the abduction of Sean by his father, Otto, was a crisis event outside of the family's normal range of experience. After the Frank's marital separation and divorce, Beth assumed that she would continue to be Sean's primary parent and that Otto would be required to cooperate with the court ordered custody and visitation agreements. Although Otto's failure to strictly adhere to the visitation agreement was annoying and even threatening to Beth, she was unaware of Otto's extensive preparations for abducting their son. Only in hindsight was Beth able to relate isolated cues, such as Otto's move to a temporary residence, to the subsequent abduction.

Although Beth was often suspicious of Otto's motives or behaviors, she tended to interpret these in light of the past event of the couple's divorce. It was not until after Sean was taken by his father that Beth was able to perceive the overall meaning of Otto's actions. Beth then felt that her trust in Otto had been misplaced. Her emotional response was not only grief and anxiety in response to Sean's disappearance, but also a sense of betrayal and anger at the court for not protecting her and her child, and at herself for placing unwarranted trust in Otto.

Left-behind parents in a parental abduction are often judged as over-reacting to the abduction as the child is in the company of a parent. In contrast to a non-family abduction, the child in a parental abduction is usually not taken with the specific intent of exploiting or harming the child. For the left-behind parent, however, there is often a powerful emotional response with an overlay of guilt and betrayal.

Family Stressors Other than the Parental Abduction (Factor a). The Frank family had experienced moderate to high levels of stress prior to the abduction, primarily related to their problematic marital relationship and the circumstances of the separation. An additional source of stress for Beth came from difficulties with Sean's development that had been noted but not effectively addressed. There was also disagreement between the parents as to the seriousness of Sean's problems and accusations of child abuse made against Beth by her ex-husband.

Pre-abduction Family Crisis-Meeting Resources (Factor B). Although the Frank family had experienced multiple stressors prior to the abduction, they were also a family with an active style of coping. Beth was able to terminate an unsatisfactory marital relationship and considered herself to be the family crisis manager. This was a role she had played in her family of origin and continued to play during her marriage. Due to the financial resources accrued during the

marriage and the absence of other children in the family, Beth was able to devote considerable time and energy to the search for Sean.

Post-abduction Family Crisis-Meeting Resources (Factor b). Beth was fortunate to live in a community in which there was a high level of awareness of specialized resources for families of missing and abducted children.

Beth was also able to use family and community support for emotional support and participation in the actual search effort. A search effort requires considerable organization, manpower and material resources for activities such as flyer preparation and distribution, phone response and media contact. It is a challenge for most families to develop an effective search strategy while coping with the emotional impact of the abduction and meeting ongoing needs of all family members. This may be possible only with high levels of sustained family or community support.

Absent in her list of resources is access and/or utilization of mental health intervention to provide her with additional support, to deal with her feelings during an immensely difficult time while Sean was missing. In some cases, parents are unaware of treatment resources available to them. In some cases parents are financially strapped by the costs of searching for their missing child, making access to treatment difficult. In other cases, parents are reluctant to enter treatment out of fear they will lose control or their feelings are too painful to address.

Effective intervention should be flexible to adjust to the parent's current needs and affects. However at the least it should include focus on a parent's emotional losses, the uncertainty of whether her search efforts would be successful, the day to day demands of continuing her search, managing daily demands and routines of living. Experience has shown that if effective help is provided in a timely manner, it will reduce many problems that manifest themselves after the child's recovery.

Perceptual Definition of the Family Crisis Event (Factor C). In the Frank case, the abduction was an extension of a sustained parental power struggle. Beth had felt that Otto was attempting to gain control of Sean and feared that he would be willing to flee the country in order to gain this control. Beth had asked the court to retain Sean's passport as a means of protecting herself and Sean from this action. Beth had previously used the courts and legal resources effectively during the divorce and custody proceedings and viewed the abduction as a violation of her legal rights as a parent.

Post-abduction Perceptual Definition of the Crisis Event (Factor c). The perceptual definition following the crisis event was consistent with Beth's view of

herself as an effective crisis manager. This positive belief in her ability to deal effectively with the crisis was sustained by the assurances she received from the individuals and agencies involved with Sean's case that children were recovered even after long absences.

Beth had a sustained positive belief in her ability to recover her child. This stemmed in part from her knowledge of her husband's previous behavior. She knew him to be a person who engaged in high-profile activities so that he would find it difficult to live a life in hiding or anonymity. Although Beth experienced emotional lows, she was generally convinced that her personal and financial resources would allow her to persist until she would be able to locate her child.

Immediate Experience of Stress Due to the Abduction (Factor X). Although Beth's style of actively coping with crisis situations and the continued support from family and community resources allowed her to mount an effective search effort, she was not prepared for the length of time it would take to recover Sean. Beth assumed that her immediate response to Sean's abduction would bring him home quickly. The frustration and grief that a parent experiences when their child is not recovered immediately contributes greatly to the family's experience of stress. The longer the child is missing the more anniversary events there are that occur in the child's absence, such as the child's birthday or the anniversary of the date the child was taken.

The level of stress felt by the family is affected by previous sources of stress in the family. In the Frank case, Beth's anxiety was increased by her knowledge of Sean's special education needs and Otto's lack of acknowledgment of these needs, as she feared that Sean would not be placed in an educational environment that would support his continued development.

The need to gain media attention focused on her case required Beth to rapidly contact her attorney and the local police. She was immediately directed to specialized resources and because of the family's financial resources, she was able to use these resources to mount an effective media campaign. However, this required her to develop the skills necessary to become a media figure. This change from her previous role as wife and mother was a source of personal stress, as well as a strain on relationships with extended family members.

Intermediate and Long-Term Experience of Stress Due to the Abduction (Factor x). The Frank case illustrates many of the stresses faced by families experiencing a parental abduction, such as the absence of knowledge of the child's whereabouts for a period of many months or years. The emotional and financial cost of sustaining an effective search is an ongoing stress for the remaining family members. Reunification, while joyful, can be stressful for the

family and child as well, as the child has not only experienced the trauma of the abduction, but may have adapted to the new situation. The child may have also changed so that he or she seems to be a different child from the child the recovering parent remembers. Often the abducted child has been told that the left-behind parent does not want the child or is dead. For a child such as Sean who may already be psychologically vulnerable, the additional trauma of the abduction may alter the child's basic sense of trust and safety. Such children may continue to mistrust their parents for extended periods of time after reunification.

Parents also retain a fear of reabduction, in part realistic and in part as a reaction to their sense of betrayal by the other parent. It is difficult to reestablish trust between parents following reunification, as parents are likely to continue to be involved in judicial proceedings around custody, visitation and criminal charges stemming from abduction.

In the Frank case, the process of recovery from the abduction was further complicated by Sean's subsequent diagnosis with a serious mental disorder. The family was confronted with a new crisis event before its members could resolve the issues of the abduction to any degree of satisfaction. This underlines the importance of evaluating a family crisis event in light of the coping resources and style of its members. The life of the family does not end or even pause significantly with the recovery of the abducted child. The family must be able to confront any additional challenges as they arise, while simultaneously recovering from the abduction.

Summary Statements/Parental Abduction Case Study

1. Left-behind parents may only make sense in hindsight of what may have been cues that their child was at risk for abduction.

2. Left-behind parents in a parental abduction often face numerous obstacles in searching for their child/children. They may encounter jurisdictional, legal and policy barriers during their search. In some cases they may be seen as overreacting because the child is with the other parent. The emotional impact of having a missing child is immense. Intervention should start, or at the very least, be available when the child is identified as missing.

3. The parental abduction may mark an escalation of an ongoing conflict between parents or a parent's maladaptive response to a perceived loss of power or control.

4. A lack of financial and personal resources may hamper a parent's effort to recover their child, while adequate resources may result in a successful recovery.

5. The lack of therapeutic intervention for left behind parents negatively affects the parents. Left behind parents and non-abducted siblings are under served populations by mental health services. Treatment guidelines need to be established for searching parents and families.

6. Fear of reabduction and a loss of trust are common long-term responses following a parental abduction.

PART II
CHILDREN RECOVERED FROM NON-FAMILY ABDUCTION

CHAPTER THREE - CHILDREN RECOVERED FROM NON-FAMILY ABDUCTION AND THEIR FAMILIES: A MODEL TREATMENT PROGRAM

Based on research and clinical experience with children recovered from abduction and their families, a Model Treatment Program (MTP) has been developed. This model is designed to apply to several types of non-family abduction including those motivated by ransom, sexual exploitation, revenge and intimidation. It is also applicable in cases of accidental abduction and abduction that occurs during the commission of another crime. It does not apply to infant abductions. The applicability to gang motivated abductions is unknown.

The Model Treatment Program consists of four Stages. Stage I deals with the initial recovery of the child and reunification with the family. Stage II provides a short term trauma response pattern. Stage III examines the longer term trauma response pattern. Stage IV describes termination/periodic recontact for children and family members. (See Table 7.)

Table 7
Model Treatment Program Stages

Stage I:	Reunification of the Recovered Child and Family
Stage II:	Address Short Term Trauma Response Pattern-Theme Based Symptom Appearance
Stage III:	Longer Term Trauma Response Pattern for Recovered Children and their Families
Stage IV:	Termination/Periodic Recontact for Recovered Children and their Families

While the focus of this project was not specifically on working with parents and families during the missing period, clinical experience, observation and the

findings of the Families of Missing Children Project demonstrate the needs of families during the time when a non-family abducted child is missing. Prior to addressing the specific treatment needs of recovered children and their families, a brief discussion aimed at directing the clinician towards resources to assist in understanding the issues for families with missing children follows. Even in situations in which families perceive that progress is being made in the search, events such as anniversaries of the child's disappearance, birthdays and other holidays viewed as family events trigger emotional responses. Families often run into road blocks or challenges during the search that require additional energies during an already stressful time. Child search activities are extremely challenging to implement and sustain from both a financial and emotional perspective. For example, involving the media can provide an advantage for parents searching for a child. Developing this skill is essential for the searching parent. However simply suggesting, without providing guidance, that a parent contact the media could be disastrous for the searching parent and the missing child. Many resources have been developed to offer the parent needed guidance.

The Office of Juvenile Justice and Delinquency Prevention, The National Center For Missing Children, regional and local non-profit missing children's organizations and state clearinghouses for missing and abducted children have worked to establish resources for searching parents. These resources fall into four general categories: (1) abduction prevention; (2) technical written materials and programmatic resources to assist the searching parent(s); (3) information to assist the searching parents in responding to their own and other family member's emotional needs and reactions; and (4) the opportunity to talk with other parents who have missing children.

Effectively addressing abduction starts with prevention. Resources exist which are aimed at prevention (Blaine, 1999; Kraizer, 1985; Metlife, 1996-99; NCMEC, 1992; VCA, 1995; 1999) including tips for parents, safety training materials designed for children and school based abduction resistance training curriculum.

Several publications provide information and guidelines for parents/families searching for their missing children. These include descriptions of the obstacles to the recovery and return of parentally abducted children (Girdner & Hoff, 1994), the recovery and reunification of missing children (Turman, 1995), identification of risk factors for family abduction (Johnson, 1994); and prevention, search and legal issues as they relate to international abduction (Bureau of Counselor Affairs, 1997). Two publications (Hoff, Schretter & Aspell, 1994; OJJDP Report, 1998) provide suggestions on prevention and guidelines to assist parents of missing children on issues related to the search, working with law enforcement, handling

the media, working with volunteers, responding to personal and family considerations, and identifying existing resources.

Several of these publications discuss personal and family considerations and needs of the searching parent and/or searching family. They also offer suggestions on effectively dealing with and using the media, practical suggestions and checklists on what to do both short term and long term when a child is missing. They also list additional resources including publications, state clearinghouses, and specific government, private and non-profit resources. A parent support network (Project HOPE) has also been established which provides searching parents the opportunity to talk to trained parent volunteers who had/have a missing child.

STAGE I: THE REUNIFICATION OF RECOVERED CHILD WITH THE FAMILY

In this section, the following questions will be addressed:

Table 8
The Model Treatment Program
Questions to be Addressed

(a) What are the steps in reunification?
(b) Who are the reunification team members?
(c) What is mental health's and other professional's role in the reunification process?
(d) As treatment progresses, what are the conceptual categories of child/family responses?
(e) What is the short term trauma response pattern?
(f) What is the longer term trauma response pattern for the child recovered from non-family abduction and his/her family?
(g) What are the termination and post-termination needs of these families?

At this time only a handful of jurisdictions have developed or been provided the training to develop multi-agency and multi-disciplinary teams. In most cases the mental health professional or protective services worker will not be present at the reunification. In other cases, the mental health professional may have worked with the parents or other family members during the time when the child was missing. In still other cases the mental health professional may not become

involved until after the child and parent(s) have already been reunified. WHICHEVER OF THESE POSSIBILITIES IS THE CASE, THE MENTAL HEALTH PROFESSIONAL SHOULD READ THIS SECTION TO BECOME AWARE OF THE RECOVERY AND REUNIFICATION EXPERIENCE TO ENHANCE THEIR KNOWLEDGE OF THE CASE, ASSESSMENT AND INTERVENTION EFFECTIVENESS. While the team model of reunification is summarized in this section the mental health service provider should not be dissuaded from their opportunity to effectively assist these families. In the event that such a team does not exist in the mental health provider's jurisdiction, it may provide (1) sources for obtaining additional information about the case, (2) information about the types of questions the provider may want to address to the child and their family about their recovery/reunification experience and feelings, (3) and a context to understand the overall experience of abduction, recovery and reunification. It is not necessary to have a multidisciplinary team in your community to be effective with these families.

In the following discussion, the team model of reunification is summarized. The goal of the reunification team is to provide the recovered child and family with a coordinated, organized program of law enforcement, mental health, social support and victim-witness services. The most effective approaches to reunification are multi-disciplinary and multi-agency teams who work cooperatively to enhance the investigative, child protective and emotional needs of the child and family.

Law enforcement is the reunification team leader. The reasons include their role in investigating the case, locating the child and their on-going responsibilities in the case to obtain medical clearance for the child, as well as, interview the child as the primary and frequently only source about the disappearance experience and other involved individuals. See Table 9 for The Reunification of Missing Children Team Members and Functions.

TABLE 9
The Reunification of Missing Children
Team Member Functions

Law Enforcement Team Member Functions

1. insure that the recovered child receives physical and psychological evaluation and clearance
2. interview the child as the primary, and frequently the only, source of information about the disappearance circumstances, other involved individuals, and criminal violations

3. establish the limits of case information to be prepared and provided to the public.

Mental Health Provider Team Member Functions

1. evaluate the recovered child and family to assess and respond to their emotional stress generated by the disappearance and the recovery.

Child Protective/Social Service Team Member Functions

1. assist when child recovery involves one or both of the following situations: (1) the family is not immediately available for reunification with the child and a return home, (2) allegations have been made with regard to the child care adequacy of the recovering family and (3) assist in the reunification of the family and child.

Family and Dependency Court Team Member Functions

1. in some cases, assist when issues of child care adequacy and child care custody are present

Victim/Witness Agency Team Member Functions

1. assist the recovered child to obtain compensation for treatment for physical or emotional injuries associated with the disappearance, and in education/support in any subsequent criminal court proceedings.

Initial experience with the reunification of recovered children with their families has indicated the complexity of the event. Each member of the family involved in the child recovery and reunification process has an individual set of needs.

Needs of the Recovered Child. The recovered child needs to be evaluated and treated as necessary for physical injury and psychological distress related to the disappearance. The child also needs to be prepared for reunification with the family. After the reunification, the child needs access to ongoing psychological counseling and support.

Needs of the Family of the Recovered Child. The family of the recovered child needs to be informed of the recovery of the child, the circumstances of recovery and the preliminary knowledge of the child's physical and mental health. The family must determine who will go to the reunification site and who will remain at home to take care of other children in the family. As with the recovered child, the family needs to be prepared for reunification. Prior knowledge of the individual family's coping style and current level of stress will enhance the effectiveness of this preparation process. At the reunification site, the family will benefit from structure and support as the reality of child recovery sets in. Media interest may be intense. Each family will benefit from education about their options in choosing to deal, or not deal, with the media. After reunification, the family will need general guidelines about what to expect in their relationships with the recovered child. The family will also need ongoing psychological counseling and support, with modification of the general guidelines to fit their individual child's situation.

Both family and recovered child will need information and support in criminal court proceedings that may occur.

The reunification team accomplishes these goals in five steps. Table 10 outlines the steps. IN THE ABSENCE OF A REUNIFICATION TEAM, THE MENTAL HEALTH PROFESSIONAL/SOCIAL SERVICES WORKER MAY REFER TO THE INFORMATION THAT FOLLOWS AS A GUIDE TO ASSIST IN THE REUNIFICATION, ASSESSMENT AND/OR THE TREATMENT PLANNING PROCESS.

Table 10
Model Treatment Program
Phase I
Reunification of Recovered Child With The Family

Step 1:	Pre-Reunification Preparation
Step 2:	Reunification Meeting
Step 3:	Post-Reunification Family Evaluation/Assessment
Step 4:	Stabilize Family and Support Immediate Problem Solving
Step 5:	Identification of Future Goals

Step 1: Pre-Reunification Preparation

As is reflected in the reunification film "When Your Child Comes Home," an instructional tape produced for reunfication of non-family abducted children, families can vary widely in their coping response to an abduction experience. (Hatcher, Brooks and Barton, 1992). In some cases, the reunification team member may have learned facts about the abduction and left behind family or may have had direct contact with the family during the disappearance. If the law enforcement officer and/or mental health professional has the opportunity to work with a family during the disappearance, they may be able to obtain information on:

1. parental expectations of the child at reunification,
2. pre-recovery beliefs about recovery,
3. perceptions and beliefs about the abduction,
4. perceptions and beliefs about the abductor, and
5. fears and anxieties during the disappearance

For example, some parents may expect the child to be relieved and happy about the recovery or that the child will remember the parent. Others may expect the child to be frightened or perhaps even uncertain about what to expect. As the film suggests, children often fear that parents or other significant adults may be angry or blame them for the abduction. Pre-recovery contacts provide an opportunity to explore these expectations and prepare the parent for different responses. This knowledge of the family helps the law enforcement officer to anticipate family reunification reaction and manage the process. This knowledge of the family helps the mental health/social service professional to anticipate how their services may be necessary.

In other cases, the first notification about the case will be at the time of recovery and just prior to reunification and there will not be the opportunity to work with the family on these themes.

Step 2: Reunification Meeting

1. The law enforcement officer or mental health professional member of the team should tell the family to bring several items to the reunification meeting such as a child's favorite toy and photos of family members, family events or family pets (especially if the child was close to a certain pet). These items can be helpful for memory as well as provide something to discuss during the initial reunification meeting. Depending on the age of the

child, it may also be useful to take missing posters or newspaper articles to provide concrete indications to the child of efforts to find the child.

2. At the time of the reunification meeting, plans need to be made to take care of other children in the home who may not be able to attend. A neighbor, family friend or relative should be accessible who can care for the needs of other children in the home. The parent(s) should keep in contact with the caregiver to keep the other children in the family informed about the reunification and when they will return.

3. Upon recovery, media attention may be intense. While these people may have a job to do, it is important that the family's and child's needs come first. This may require coordination with other professionals involved with the reunification (e.g. law enforcement and medical personnel) to ensure the family's needs are protected. For example, arrangements may need to be made for the family to enter the reunification site through a private entrance where the media will not overwhelm an already emotionally charged parent. Instructions may also need to be given to caregivers who remain at the home with other children who cannot attend the reunification. Provisions need to be made to protect other children in the family who may still be in school or at other locations from over zealous media representatives who may try to approach them. In some cases, prior helpful media coverage of the search for the missing child may result in confusion for the parent about whether they can refuse to have live coverage of the reunification. Given the typical high level of emotions associated with the parent receiving news of recovery and the anticipated reunfication, parents may need to be reminded that they are not obligated or even advised to allow the previously helpful media to film or be present at the reunification. In other words, they may need to hear from investigators, mental health professionals or social services team members that they have permission to say no to media requests to be present.

4. Typically, reunification meetings occur in hospitals, child care facilities, or police stations. This may raise the concerns of parents about their recovered child. Most likely, the investigating officer will want to briefly meet with the family immediately prior to the reunification meeting to help them understand the need for medical clearance or other reasons that the reunification is taking place at a particular location.

5. The investigating officer will also want to meet with the family prior to reunification to provide the parent with factual information about the recovery and information about the child's condition from a nonmedical viewpoint. Medical evaluation and clearance are most likely in stranger/non-family recoveries and less likely in parental recoveries unless there are

allegations of physical or sexual abuse or neglect. In either event, it is useful for the investigating officer to issue a caution to the recovering parent and other family members to focus on welcoming the child home and to let the officer do the job of investigating and questioning the child about the abduction event.

6. In the prior discussions, various child expectations, perceptions and beliefs about the abduction event and recovering parent were identified. As a result the child may be hesitant, not remember the recovering parent(s) or be fearful, angry or confused. A reunification team member should make the parent aware of possible responses from the child and prepare them to deal with those possibilities without anger or rejecting the child. Parents should be encouraged to let the child know how happy they are that the child has been recovered and focus on welcoming the child home. In approaching the reunification meeting when two parents are involved, it is useful for one parent to take the lead in initially greeting the child.

7. Parents have often gone through considerable turmoil and distress prior to the recovery and reunification. They may feel they want to protect the child and simply return home with the child. It is often helpful and necessary for a reunification team member to remind the parent that the child may be the best source of information about the event. Investigators will need to assess what has taken place to protect the child from reabduction or to prevent abduction of another child. Parents may also need to be told or reminded about the importance of medical clearance to ensure the child's welfare. Transportation and other arrangements for the return home may also be necessary at this point.

8. When the child communicates information suggesting the possibility of abuse, established protocols for forensic interview of the child, physical/medical evaluation, etc. need to be completed. Additional investigative protocols standard for the jurisdiction such as forensic interviews, police investigation, protective services interviews, physical examination, psychological evaluation and collateral interviews should be pursued. Again, these need to be completed in a timely sequence taking into account the uniqueness of these cases and the trauma already associated with the abduction for the child.

9. Parents need to be told about what to expect on their child's first night home. With the return home, the child is most likely to be focused on being in his room and becoming reacquainted with brothers and/or sisters and other aspects of family interaction as opposed to talking about the disappearance event. The other children in the family may engage in the process of

becoming reacquainted with their recovered sibling. But some non-abducted siblings distance themselves because of their own attempts to deal with feelings about the abduction and recovery. As the day comes to an end and the children are in bed, the parents may find themselves with mixed or confused feelings. On one hand the relief of having their child recovered and returned is profound but marked by anxiety and depression. They are likely to begin to wonder how the child will adjust, what the child will experience and what the future will be. None the less, the important message is that the child and family will begin to experience the fact that things will not be the same as they were prior to the abduction.

10. The mental health professional member of the reunification team will need to schedule the first follow-up appointment within 48 hours of the reunification meeting, if possible.

Step 3: Post-Reunification Family Evaluation/Assessment

During the initial couple of meetings in the office, the focus shifts to identifying family interpersonal issues, individual issues and family issues with the outside world. In some cases the clinician may want to triage portions of the assessment to another clinician, especially in cases where there are several abducted children, several non-abducted siblings or significant family dysfunction.

Assessment of the abducted child and siblings should be conducted by a clinician trained in victim's issues and experienced in working with children. If criminal issues and future prosecution may be involved, the clinician should be experienced in areas of criminal prosecution to avoid negatively influencing future legal proceedings. The clinician should also be comfortable with providing testimony if required.

The goal of assessment is to develop an understanding of the dimensions of family/child behavior, emotion, and thoughts, to understand family coping behavior both prior to the incident and since the reunification, to understand family use of support services both prior to and after the recovery, and to address perceptions and meanings attributed to the abduction event. Siblings should not be excluded from the assessment process. As is true with victims and parents, evaluation of siblings should address their perception of the event, pre-abduction and post-abduction coping skills, response to the reunification, and the sibling's behavior, affect and cognition in regard to the abduction event. McCubbin & Figley (1983) have identified 11 criteria that distinguish functional from dysfunctional family coping styles. These criteria include family identification of a stressor. Does the family clearly understand and accept or deny the source of stress effecting them? Additional criteria include family centered versus individual

centered perceptions of the problem. The third criteria is whether the family has a solution-oriented or blamed-oriented approach to the problem. The fourth and fifth criteria look at whether tolerance for other family members is direct, unclear or indirect. The sixth criterion is whether the communication style within the family unit is open or closed. Family cohesion may be either high or low. Family roles may be either flexible, shifting or rigid. Willingness and ability to utilize resources may be high, balanced or very limited. The final two criteria are the use of violence and use of drugs within the family unit. As the assessment material unfolds, the clinician's focus shifts to the three categories identified at the beginning of this section. The therapist should be flexible in considering individual, family and/or parental needs.

1. At the individual level, the therapist is likely to find a range of internal reactions to the abduction on the part of family members. It is important that the therapist acknowledge that not every family member may have the same thoughts and feelings. Recognition of individual reactions should be communicated during family group meetings. As some family members may not feel comfortable and able to discuss their thoughts and reactions, the therapist will need to indicate that some family members may need or wish to work on individual issues. The opportunity for addressing individual concerns needs to be communicated directly to the family.

2. At the family level, the focus is more on interpersonal differences such as anxiety, depression and concerns acted out between family members.

3. Family issues with the outside world focus on external interactions such as school and peers, law enforcement and the media, Monday morning quarterbacking by relatives and friends, interventions by child protective services, etc. The families one encounters in abduction cases represent a cross-section of the general population and therefore reflect various economic, ethnic and social levels. Therefore, the incidence of severe mental illness, chronic physical illness, child sexual abuse, physical abuse, neglect, domestic violence and severe family dysfunction is likely to be present in some families. The evaluation and assessment should include attention to the presence of these factors and appropriate referrals need to be made.

Step 4: Stabilize Family and Support Immediate Problem Solving

The overall objective of this stage is to help the family stabilize and family members to define and articulate individual and family healing theories.

1. A useful focus in assisting the family to develop a sense of mastery is to have the family pick one issue and work towards mastering that goal. For

example, the goal may be for the family to communicate their experiences during the missing period so they can understand their shared and different perceptions of the event. On completing the task, the family can begin to have a sense of mastery about having shared thoughts and feelings about the event. Another possible goal could be sharing and developing a strategy for responding to second guessing or Monday morning quarterbacking by family or others outside the event. Alternatively, the family may discuss and develop a strategy for dealing with media efforts to elicit reactions from the family.

2. Parallel to the family focus of mastery is to do the same thing for each individual family member. For example, a young recovered child who was responsible for caring for and feeding the family pet prior to the abduction can be encouraged to resume that responsibility as a means of reintegrating the child into the family. An older recovered child who was a competitive swimmer before the abduction can work towards returning to those activities. Likewise, a parent who is experiencing anxiety about even brief separations from the child can develop a strategy for managing those anxieties through small, progressive steps.

Step 5: Identification of Future Goals

Utilizing knowledge about trauma and issues specific to child/family abduction, the clinician assists the family and individual family members in identifying and organizing their individual and collective behaviors and concerns. In an effort to better identify and decrease the possibility of future traumatic reaction, parents should be advised about how to respond to the child, how to respond to sibling concerns, how to address child questions, what to look for in the way of symptoms and distress signals and how to respond to child emotional responses. Alternative response patterns observed in abducted children, e.g. numbness, hyperarousal, denial, anxiety reactions, etc., should be reviewed with parents along with appropriate interpretations of the identified patterns. The same issues should be addressed for non-abducted siblings, as well as intra-familial and extra-familial behavior, interaction styles and coping behaviors. In identifying future goals and needs, families will fall into three basic patterns.

1. In the first group, the primary care-givers typically understand the issues, identify the need for intervention and desire ongoing treatment. In those cases it is appropriate for the clinician to establish a longer range treatment plan or in those cases where clinicians can not or does not wish to maintain a long term treatment relationship, refer the family on to individual and family therapists who can assist the family in addressing those needs.

2. The second group of care-givers typically have some awareness of the issues but are so overwhelmed by the traumatic experience that they simply desire respite care. In those cases, ongoing periodic contacts by phone or "check-up" sessions can be helpful to the family in maintaining a therapeutic liaison and to identify when they are ready for or require continued intervention. Periodic contacts assist the family by not playing into developing denial efforts and by making re-entry into treatment a more easy transition because of the ongoing tie to the clinician.

3. In the third group, the care-givers may not perceive the need for ongoing treatment, however, the child's symptoms do support the need for the child. As a result, the parent may resist treatment for the child. In such cases it is appropriate for the clinician to monitor the family and child. If symptomatology becomes dangerous to the child, the clinician may need to involve child welfare on the child's behalf. It is unlikely a child welfare agency will be able to take action unless the child is genuinely in danger or the agency has had an ongoing role with the child.

The key in these cases is the clinician's consistency with these families, availability to the family, and not playing into initial denial efforts by the family or individual family members. These cases differ from other cases the clinician encounters in the need to establish periodic contact with the family and an open door with the family and family members. A final consideration is whether the clinician will be the sole therapeutic contact for the family or whether the clinician shares these responsibilities with other mental health professionals. Certainly many clinicians possess the expertise in both family and child intervention necessary for working with these cases. However, the experienced clinician may determine that doing both may not be advisable due to the emotional and time demands present in these cases. In addition, providing both individual and family treatment can create difficulties in therapeutic alliances. Victim children, especially those just entering puberty and their teens, often express a need and desire for individual intervention with clear and differentiated boundaries separate from other family members. Failure to honor those requests can be detrimental to the integrity of the therapeutic alliance.

STAGE II - THE SHORT TERM TRAUMA RESPONSE PATTERN FOR RECOVERED CHILDREN AND THEIR FAMILIES

Once a child has been recovered and returned home, the short term response pattern for recovered child and family will be characterized by: A) Emotional/Behavioral Manifestations and B) Environmental Circumstances.

Table 12
Stage Two
Short Term Trauma Response Pattern Characteristics

A. Emotional/Behavioral Manifestations: The emotional and behavioral manifestations are directly related to issues in the abduction experience, for example, euphoria, hyperarousal or guilt about their behavior during the missing period.

B. Environmental Circumstances: These issues result from circumstances that occur during the missing period or result from the recovery. For example, the abduction may result in intense media coverage or require the child to testify in legal proceedings. In some cases additional, previously identified or unidentified contextual issues may be evident, e.g., mental health problems, substance abuse by a family member, poverty, divorced parents in continued conflict.

In non-family abductions, specific emotional and behavioral manifestations come up for the child and the parent. They are in direct response to the abduction experience and have specific themes and content associated with them. The following table outlines the Short Term Trauma Pattern. At the time of the initial recovery and for several days afterwards, a specific response pattern is seen consistent with that described by Rahe and Genender (1974). These are reflected in the first five responses. Each manifestation or circumstance is elaborated in the following narrative.

Table 13
Stage Two
Short Term Trauma Response Patterns

A. Emotional/Behavioral Manifestations:

1. **Brief Euphoria**
2. **Hyperarousal**
3. **Hypervigilant Recall**
4. **Compliance/Resistance**
5. **Denial and Help-Seeking**
6. **Safety/Reabduction Concerns**
7. **Child Victim Emotional Numbness**

8. **Restitution**
9. **Family Disorganization**
10. **Child Anxiety Precipitants**
11. **Family Anxiety Precipitants**
12. **Flashbacks/Reliving details of the abduction**

B. Environmental Circumstances:

1. **Media Attention**
2. **Criminal Prosecution**
3. **Family contextual issues not directly related to the abduction.**

Emotional/Behavioral Manifestations:

1. **Brief Euphoria.** The first stage is brief euphoria, lasting from minutes to less than a day. Brief euphoria is then replaced by mistrust and restraint, guided by the child's concern that the return may actually be a false event or test engineered by the abductor. Often child victims will be somewhat flat in their emotions and will be less responsive to questions as they attempt to determine whether the recovery is in fact real. Alternatively, family members characteristically are very open in their expression of emotion, as they begin to believe that child recovery has actually occurred. However, the recovered child victim will not generally shift easily to a point where he/she can share the rest of the family's relief and enthusiasm. Immediate family members may feel confused by the child victim's restraint or the loss of the child's initial positive reaction to the reunification.

Let's see how this first stage is demonstrated in non-family abduction recovery situations. In one case, a young girl who was reunited with her family was very excited about seeing her father. She was to meet him at the hospital where she had been taken for medical clearance after recovery by law enforcement. Her euphoria and enthusiasm ended abruptly when she walked down the hall to meet him. What she saw was not her usual image of a competent, capable father, but rather a man who clearly had not shaved or slept for days since her abduction. He appeared to be more emotionally drained than she had ever seen him. Suddenly, she was swept by feelings of guilt. She could actually see on his face how her abduction had affected him.

This loss of euphoria may not always be immediate, but rather delayed and stimulated by other family reactions. Another adolescent girl, recovered after a difficult, violent abduction, was very pleased to see her mother at the time of reunification. Recovered in a town away from home, the victim and family were

given rooms at a local motel. Later that evening, the girl experienced an almost overwhelming need to talk. She tried to relate the details of what had occurred to her older sister with whom she was sharing a room. Her euphoria ended when her older sister indicated that she was not interested in hearing more details about the abduction as she was tired and needed to get up early in the morning to attend to some important items in her own life.

Did this father or older sister perform less than adequately at this moment of family crisis? Should each parent insure that he/she is presentably dressed and groomed prior to child reunification? Of course not. Family members are under legitimate high levels of tension during an abduction. Their own personal stresses, both related and unrelated to the abduction, may limit their ability to be the exact person that the recovered child may wish them to be.

The important lessons for mental health and social service professionals in this first stage, and later stages, of the recovery process are to: (1) become educated about the unique characteristics of the reunification experience for both child and family, and (2) learn to assist both child and family in their post recovery expectations of each other and the limits of ordinary people to live up to those expectations.

2. Hyperarousal. The second post recovery response stage is hyperarousal. This phase usually lasts for multiple days after recovery. Both the victim and the family are over stimulated by attention from law enforcement, the media, friends and others. There is a high degree of daily unpredictability and confusion surrounding the victim and the family. During this time, both family and child victim will often talk to anyone who approaches them. It is important to assist the family and protect them from well intentioned and over-zealous well-wishers as well as from other less well intentioned individuals who may only wish to vicariously experience getting closer to someone involved in a highly publicized event. The family needs to be educated about these attention demands and the various types of individuals who make them. This education helps them to create, or to ask someone else to create a degree of insulation and protection from outside pressures. This reduction in outside pressures assists the family to better assess, monitor, and control such intrusions.

3. Hypervigilant Recall. The third post-recovery response stage is hypervigilant recall. Child victims often want to recall the details which they have so carefully stored away as part of their abduction survival strategy (Hatcher, 1981). During the missing period, victims make conscious and significant efforts at storing away information regarding the abductor's behavior, motivations, others around the abductor and the environment. When an abductor has life or death control over a victim, the only response available to the victim may be to work to

remain mentally alert, and optimistic that this alertness may help them to get out of the situation alive. For example, when two adolescent girls were abducted and imprisoned in a small room, they took careful note of environmental cues to determine the time of day. Passage of time was determined by listening to the amount of traffic on the nearby street, though they were locked in a sound insulated room without windows. In the absence of daylight, increased automobile traffic was assessed to mean daylight. No traffic meant late night. This helped to construct a sense of a 24 hour daily cycle. The girls also noted the address labels on magazines which the abductor gave them, remembering a name that were different than the one used by the abductor to refer to himself. Efforts are also made to recall specific statements made by the abductor in conversation, as well as small details of the captor's behavior. Each girl noted how the abductor switched from a violent attack on their chaperones to later being quiet, soft-spoken, and concerned about whether they were comfortable. Details about displayed weapons and abductor statements about his motivations were also memorized.

As can be seen in the above examples, the child victim may have a desire to recall the incident, and not forget, in order to assist with the investigation and to have people understand the experience. However, at the same time, recalling details can be very painful, resulting in significant emotional distress. Thus, there is a characteristic ambivalence toward this recall process.

In cases where the child's coping style during the abduction was to distance himself/herself from the experience, there may have been an effort to avoid, block, or not attend to details of the abduction. Details may come out in a more sporadic manner over time. It is not unusual in any abduction case that very significant details will come out after initial statements. This can be motivated by the fact that some material is highly emotionally charged and the victim is reluctant to divulge it at the time of recovery. The victim may also not recognize the significance of some material. It is not relayed initially because the significance of a detail was discounted. In other cases, child victims recall details as they encounter stimuli or events in their post recovery daily life which trigger memory of the details. Clinically, it may take six months or longer for all details to emerge, details whose validity are later confirmed in the law enforcement investigation.

In any event, this delayed disclosure of significant details by the child victim can produce frustration for law enforcement during the investigation, as well as for family and caregivers. The most common feeling by all three groups is that the child doesn't trust them, followed by a sense of self-failure or anger at the child. Understanding the child's viewpoint and the motivations behind delayed disclosure of event details can reduce these feelings of self-failure by caregivers, thereby reducing anger or withdrawal from the child.

4. **Compliance/Resistance.** The fourth post-recovery response stage is that of compliance/ resistance. This can occur anywhere from hours to weeks subsequent to the recovery. At the time of recovery, victims initially comply with requests. This is due to the previously referenced survival strategy developed by victims to cope during the abduction experience. Child victims often listen carefully to the requests or demands made by abductors, then comply with them in order to survive. They do this with the hope that if they comply they will not be injured and will eventually be released. This strategy continues after recovery, becoming an ongoing response to authorities who have contact with the victim. Covert as well as overt requests may be complied with by the child. This can be a particularly important factor in the child's later adjustment if the requests are made more for personal curiosity or personal gain rather than for the interest of the investigation, reunification and treatment of the family. These requests and their responses will later be recognized by the child and the family as a secondary injury to the abduction experience. As feelings of personal resourcefulness return, the child victim's resistance to requests increases. This resistance can be directed toward requests from investigators and prosecutors as well as mental health and social service professionals. In the age group of 12 and over, this can appear as direct refusal or reluctance to comply with efforts to set up appointments. In younger children, this may emerge as resistance to day to day requests made by the family members and other caregivers. Often young children will resist efforts to obtain their compliance in doing simple household chores or to complete other requested tasks.

In the mental health professional's office, these children will often act out by refusing to complete a requested drawing or a violation of basic office rules, e.g. no throwing of objects, no hitting, etc. Mental health treatment plans need to accommodate this emerging independence. With young children, recognition and interpretation of these behaviors by the therapist as understandable and predictable is the preferred treatment response. With adolescents, therapists may respond to the resistance of coming at a previously established time by setting up alternate times that take the adolescent's schedule into account. While the adolescent's scheduled event may seem unimportant to the therapist relative to coming to a treatment session, what is salient is that it is important to the adolescent. If an adolescent resists setting up any additional appointments, it is useful to allow the victim to voice their resistance at the time, while working out a compromise "check up" agreement which involves meeting or talking on the phone periodically. Adolescent victims later report that this compromise "check up" agreement showed them that the therapist did have a commitment to their welfare and would not abandon them at the first display of anger or resistance. This open-ended approach allows the victim to return to therapy at a later time when anger and resistance are less of a factor. In a minority of cases, child victims respond more readily to discussions with the therapist about being abducted and their use of the

"compliance" survival strategy. In cases in which the child can recognize compliance as a coping strategy the therapy may proceed uninterrupted.

5. **Denial and Help-Seeking.** The fifth post-recovery response stage alternates between denial and help-seeking. This, as is true with the compliance/resistance stage, can develop within days after the recovery and last from weeks to months. In this stage, the child victim covers up or negates significant internal emotional difficulties. They often will make statements such as "there is nothing wrong" or "I'm perfectly OK." Mental health professionals should be cautious about accepting such statements at face value. Such denial should be approached in a planned manner in which the denial statements are inquired about, and selectively challenged. As with the compliance/resistance stage, the child victim needs to be gently reminded to continue therapist contact by periodic follow up which keeps communication open for treatment re-entry when the suppressed feelings re-emerge.

Family counseling is essential for proper understanding of this process. Particularly with parents, child denial of problems and resistance to treatment can often be exasperating, feeding their own sense of helplessness and guilt. Parents often express a sense of not wanting to push their child into treatment or to force them to deal with emotionally painful issues. Yet, at the same time, parents are concerned about whether they should take a more forceful approach, such as requiring the child be in treatment. Extended family members, too, may not understand the significance of this reaction by the child and become angry with the victim and parents for not being more responsible and active in getting treatment.

6. **Safety/Reabduction Concerns.** Most children who have been abducted have initial concerns about safety and reabduction. This is expressed through reabduction dreams, reabduction play, sleep difficulties, and specific statements/fears about reabduction. Reabduction dreams frequently have to do with a child being taken by the abductor, a non-specific adult or a mythological character or monster.

Reabduction play involves playing out an abduction, with human or animal characters, and the child's responses to the abduction. Other forms of play may involve the development of metaphors aimed at protecting the child. One five year old child, repetitively played with a doll house, covering and reinforcing the windows with multiple levels of tissue and tape. She presented this as a protection against intruders. This child was abducted out of her home.

Other children have expressed sleep difficulties, as they are fearful of the dark, fearful of going to sleep at all, or of sleeping alone. Older, more psychologically mature children address their reabduction fears directly, speaking

openly about reabduction fears. Safety issues also may increase in general, for example, children may express concerns about their safety at school, in public or other locations.

Recovering parents also almost universally struggle with the fear of reabduction. These fears are especially pronounced in cases where the abductor has not yet been apprehended but they are also present in cases when the abductor is in custody. The parent now perceives that the "unthinkable" can and has happened and they fear the possibility it could happen again. No amount of reassurances or reasoning assuages these concerns. Only carefully thought out and implemented safety plans help. Recovering parents are sometimes hypervigilant in their efforts to protect their child from being reabducted, only to create a new set of problems for their child.

7. **Child Victim Emotional Numbness.** One of the most common themes seen in child abduction victims is a feeling of numbness. Duration is variable, typically lasting from weeks to months. In children, it may be manifested as emotional bluntness, apathy in day to day activities, denial or avoidance of the event, and lack of interest or joy in activities which were previously perceived as being fun. In teenagers, it is often manifested with apathy, denial of any intrusive or negative feelings around the abduction event, denial of thoughts about the abduction event, or a bland emotional presentation. In addressing victim numbness, it is important to assess both the family and the victim in terms of their perceptions of what the numbness means, as well as, their reaction to it.

Parents may often mistake numbness for adjustment. This is reinforced both by the child's presumed unaffected behavior as well as a child's statements of being unaffected by the abduction. With teenagers, this appears as very active, sometimes hostile insistence that their normal teenage life and activities have not, and will not, be affected by the abduction. Other parents see numbness as reason for concern. They appropriately read the numbness as an unusual response for their child. A third perception seen within families is interpretation of the numbness as expressions of emotional callousness by the child. In one case example, a mother expressed anger and resentment toward her daughter because she presumed that her daughter's lack of emotional response was due to insensitivity to the family's experience of abduction. The daughter's behavior was viewed as selfishness and a lack of caring for anyone around her. In another case, the mother made judgmental remarks regarding her daughter's apparent indifference toward other child victims during the abduction. These examples are, generally, not representative of inadequate parenting. Rather, they represent behavior that people engage in when they don't understand the behavior they are observing. The absence of an explanation for another's behavior is so uncomfortable that they guess, or project a motivation for the behavior onto the other person. The task for the mental health

professional is to assist family members in first understanding this normal response to uncertainty, and then to facilitate other possible explanations for the numbing behavior.

Child victims, like families, often misperceive numbness. Most frequently, they make statements about how unaffected they have been by the experience and how relieved they are at how well they are adjusting. These victims require periodic contact with a mental health professional, consistency and patience until their feelings and thoughts eventually emerge. Alternatively, victims experience the numbness as confusing and talk with surprise about what minimal feelings they have about the event. In a minority of cases, the victim will initially see numbness as a reason for concern. For them, it feels alien to their perception about themselves and how they typically handle difficult situations. As in the case of parents, these child victims are surprised and dismayed by their own lack of feelings. One adolescent girl talked at length about how she had always perceived herself as being a sensitive caring individual who was responsive and affected by the experiences of others. She was quite dismayed by her post-abduction lack of feeling about how her family was affected. The last type of child/adolescent victim is very responsive to psychological intervention and counseling.

8. **Restitution.** Child victims may feel the need to obtain restitution for having endured the abduction experience. This may come in the form of indulging or rewarding themselves. In some cases this may be mild. In other cases, it can be carried to more extreme levels. This can be manifested through impulsive spending, going on "earned" vacations, or not completing undesirable/demanding tasks, such as school assignments or missing work.

Another level of restitution involves the family. Upon return to the family, child victims are often very aware of the impact the abduction has had on parents and siblings. Both child and adolescent victims often blame themselves and assume responsibility for post recovery family problems and want to provide the family with restitution. This frequently occurs by withholding important information from the family such as the child's emotional distress related to the abduction. Another form of restitution to the family is to prove that they are back to normal with a quick return to school, work and other regular activities. This may be demonstrated by reluctance to tell family members about fears, anxieties or sleep difficulties. In a similar way, attempts may be made to restore family stability through giving love and attention to others, while placing their own thoughts and feelings in a secondary position. Younger children may make or give their parents small items as a way of making restitution.

Parents also try to make restitution to their recovered child. In an effort to make up for the experience or because of their own perceived inadequacy for being

unable to protect the child from abduction, they may be reluctant to make any demands on or discipline their child. Parents also shower the recovered child with extra attention, or provide trips, gifts and treats to make up for the experience. Sometimes it can be hard for a recovering parent to tell the returned child "no" or set appropriate limits and expectations, even though that may be in the child's best interest. Siblings in the family, who were not abducted often feel jealous, excluded or less important because of the special attention towards the recovered child.

9. Family Disorganization. With the abduction experience, reality is turned upside down and the family may experience varying degrees of disorganization. An event which the family never considered would happen to them has occurred, changing their sense of reality forever. Family members often approach professionals with many questions. They are unclear about what to expect of the victim and are often concerned about whether they will be able to respond to the victim's needs. There is discomfort in responding to victim statements or victim behavior because they fear saying the wrong thing. Often families have questions about whether they should ask the victim about what happened or what they should do if the victim begins to talk about the abduction experience.

Families often have difficulty mobilizing resources available to them secondary to their own trauma associated with the abduction experience. This is exacerbated by the fact that they often lack knowledge of the resources which are available to them either in terms of mental health assistance to the family, siblings, or victim as well as lack of knowledge regarding victims assistance funds or funds to help relocate when that is necessary.

Families also develop survival strategies secondary to the abduction experience. A common strategy is the effort to regain control when the recovery has occurred. This can be played out in a number of different ways. For some families control is equated with knowledge. In those families the parents may seek information from the victim or other sources about what occurred as a way of trying to understand the events and therefore gain some control over them. In other cases, families may attempt to regain control by avoiding the abduction experience and pretending that everything is back to normal. In this group of families there is often the belief that talking about the trauma will only make it worse.

In assessing the family's level of organization in coping with the abduction, it is important to understand that the current family behavior is always relative to pre-abduction family behavior. The evaluating mental health professional may see a series of symptoms of distress in both recovered child and other family members. However, the family may not perceive these symptoms, or may be missing positive opportunities which could reduce those symptoms. Part of the evaluation task is to determine whether this family lack of symptom recognition is due to: (1) the

overwhelming stress of the abduction in a previously well organized coping family, or (2) the stress of the abduction as one of a series of on-going life stress which succeeded in disorganizing the family's coping previously. Previously well organized, but now overwhelmed families will need more support in dealing with loss of self esteem over failure to cope, and questions about their ability to return to their prior level of coping. Previously disorganized, now stressed once more, families may require more structure from mental health and social service professionals over a longer period of time to assist them in responding to their child and in utilizing the resources available to them.

10. Child Victim Anxiety Perceptions. There can be a range of events that result in post-abduction anxiety or intrusive memories of the event. Sometimes, these precipitants are known to the victims, sometimes they are not. When they are not, it is helpful for the therapist to work with the victim to identify the precipitant to their anxiety. When unable to identify precipitants, victims often express feelings of being out of control, revictimized, and of being helpless. Even when precipitants are identified, there are typically feelings of frustration, anger, and failure over not being able to prevent or control these reactions.

In identifying precipitants, it is important to keep an open mind as the precipitants are as variable as the details of the abduction, including cues from all of the five senses. Tactile precipitants are involved when an abductor has touched or assaulted the victim, particularly if there was sexual contact or an effort at physically controlling the victim. Olfactory precipitants include smells that occurred during the time of the incident. For example, in one case, the abductor had a very strong, disagreeable body odor. After recovery, exposure to strong body odor became a precipitant for intrusive memories of the abductor.

Situational cues as well as contextual cues can also serve as precipitants. Well known to therapists who work with trauma victims are anniversary effects associated with significant aspects of the incident. For example, anniversary dates of the abduction or significant incidents post-abduction such as court appearances can become precipitants to intrusive memories and distress. A cue for nearly every abduction victim is media coverage of new abductions. In cases where the abduction involved sexual exploitation, news media coverage of cases of sexual exploitation will also be a sensitive issue for recovered victims.

11. Family Anxiety Precipitants. There are various causes of family anxiety after the abduction. One of the most common causes is media attention about abduction of other children. Alternatively, family members may find themselves responding to anniversary dates, verbal, visual and other sensory-motor cues which remind them of the incident. In one case, a mother experienced significant anxiety when she was faced with traveling out of town and leaving her youngest child in

the care of a baby sitter. An older child had been abducted when she left town for an overnight retreat. The mother and the father of an adolescent girl who was abducted while walking home from the store experienced anxiety each time their daughter asked to go with a friend either for a walk or other outing.

12. Flashbacks/Reliving details of the abduction. Many recovered children experience flashbacks or relive details of the abduction experience. Some children describe feeling that they are in the experience again. They seem to be especially vulnerable at night while falling asleep or when in situations that remind them of the event (see Child Anxiety Precipitants). Those children who describe these experiences at times talk about feeling haunted in a supernatural way by the memories. These symptoms often persist for months and even years as they work through various aspects of the abduction experience.

Environmental Circumstances:

1. Media Attention. A common aspect of non-family abductions is media coverage during the missing period, during the recovery and in higher profile cases, post recovery during legal or other court proceedings. In some cases writers, producers and others involved with the media may contact families for post-recovery stories or rights to books, screenplays or magazine articles. Negotiating these contacts with the media can be problematic for the family or certain family members. Often the initial contacts and assistance provided during the search process is welcomed by the family in their efforts to locate the missing child. The media coverage provides opportunities to increase the community's awareness of the missing child and provides parents and family members with a sense of maximal effort in recovering the child.

The difficulty for some abduction victims and family members is having very personal experiences, such as the reunification, aired for all to witness. In some people this creates a feeling of unwelcome public exposure during a period of great emotion and vulnerability. What felt helpful and welcome during the search becomes a vehicle for feeling that their painful experiences are being portrayed as entertainment or a soap opera for all to see. Family members may not know how to set boundaries to buffer themselves from the media limelight.

While it would be inappropriate for the therapist to act as spokesman for the family, the therapist's goal in these situations is to help the family identify resources, or a spokesperson outside the family, who can intervene on their behalf. The spokesperson should be experienced in interacting with the media and able to tactfully communicate the family's needs. It does not benefit the family to alienate the media because of poorly communicated family needs or limits. Having an

experienced intermediary can assist the family in assessing legitimate requests that they may be willing to entertain.

Resources to act as a spokesperson include the media liaison officer already assigned to the case by the investigating law enforcement agency. Depending on the specifics of the case, law enforcement agencies may include local, state or federal investigative agencies who participated in the case. Another possibility is legal counsel who has experience and an understanding of the media.

In some cases, abduction victims and/or their family may be approached, immediately or, in some cases, years after the abduction and recovery, to write a book or screenplay. While some solicitations are by legitimate professionals, families may also be approached by individuals who are less scrupulous in their intentions. One category of individuals who may exploit the family are those individuals who pose as writers or producers who are interested in talking to the victim and family. Their motivation is to hear the details first-hand and derive vicarious personal pleasure from the victim's and victim family's suffering. Their promises of a sensitive accounting of the victim's and family's experience is at best an empty promise and at worse a publication that exploits them further. Another category of individuals who may approach the family are those who fully intend to publish a book or release a film.. However, they approach the task with the intention of creating a sensationalized, and perhaps sexualized, version of the event that will be less than flattering to family members. This type of exploitation is the source of additional victimization for the child and family.

While a family and child victim may wish to consider legitimate requests, it is also important to protect them against exploitive inquiries. The family is typically not in the best position to evaluate the legitimacy of specific inquiries, either from a practical point of view or because of intervening psychological agendas that may impair the evaluative process. One alternative for the family in evaluating and managing these inquiries, and at the same time, building in a protective barrier between themselves and the individuals or companies making these inquiries is to retain the services of an agent or media attorney. As the family intermediary and representative, this person is the conduit through whom all inquiries are made. They can also request examples of prior work be produced for review. Reputable publishers or media professionals have no difficulty providing prior work samples.

When Your Child Is Missing: A Family Survival Guide (OJJDP Reports, 1998) gives helpful hints to parents about how to effectively respond to the media. The National Victim Center in Arlington, Virginia has published a Victim's Bill of Rights which provides guidelines aimed at minimizing the possibility of secondary victimization which can occur by the mishandling of a story by the media.

2. Criminal Prosecution. Prosecuting non-family abduction cases is a major developmental event in the adjustment of recovered children. Whether the abduction incident leads to prosecution, no prosecution, or an abductor cannot be identified the family members will have to deal with their feelings about the relevant court action. For example, in cases where there is an absence of an identified abductor, the non apprehended abductor is an ongoing issue for both child and family. The child will express concerns that the abductor will find them, reabduct, and revictimize them. Most parents have the desire to have somebody held responsible for violating their sense of family safety and security. In some cases where there may be an identified suspect, but evidence is inadequate to proceed with a prosecution. This is often a very difficult issue for family members as they do not understand why or how such a decision can be made in view of the crime committed against their child.

When prosecution does occur, there are seven areas which must be addressed: (1) child anticipation of testifying, (2) child reactions to court delays, (3) child pre-trial preparation, (4) child disclosure and embarrassment, (5) child fear of confronting the abductor during trial, (6) child concerns about family presence during their testimony, and (7) child concern about trial outcome. First, in looking at a child's anticipation of testifying, it is important to look at their interpretation about what that means for them. For some children, it is beneficial to role play the steps in the legal process. Testifying is perceived by them as an opportunity in which they can stand up for themselves, regaining a sense of control and self-assertion. For others, the anticipation of seeing the abductor in court and confronting him is an overwhelmingly frightening event which may be perceived as a revictimization. Another child victim interpretation of case prosecution is the child's fear that he/she will be held responsible for the abduction. In cases of sexual exploitation, children frequently express concerns that if the judge does not believe them, they will be sent to jail. It is the child's belief that someone is going to be held responsible and if the judge believes the abductor's explanation, the child will be held responsible.

The second area involves the child's anticipation of testifying and their reactions to normal court processes and delays. Children, as is true of most adults who do not work closely with the legal system, do not understand the normalcy of delays and continuances. First, it is helpful to children as well as family members to explain and diagram in writing normal steps of going through the legal process. Such explanations need to include the different types of hearings, their purpose, and who is present at the hearings. Second, it is helpful to explain that delays and continuances do not mean that there is a lack of effort or belief that an abduction occurred, but rather that these delays are a normal part of the process. A third element to examine with the child is the child's expectation of possible outcomes.

The third area which requires attention for those cases involved in the criminal law system are the victim's experiences and anticipation of the court process. The first of these is pretrial preparation. In preparing cases for the court process, child abduction prosecutors need to spend substantial time prior to trial with the child abduction victim. Abduction victims are very conscious of how they are treated by police officers and prosecutors. If the child victim feels abandoned, the flow of information and cooperation will stop, often during a key moment in pretrial events or the trial itself. The purpose of pretrial conferencing and preparation of the case should be reviewed by both the prosecutor and the mental health professional.

The fourth area involves disclosure and embarrassment. Non-family abduction cases are high profile media cases. Nothing in the family's prior life will adequately prepare them for the intensity of media efforts to "cover the story." A child may be unable to testify with the media present, especially when the case material is highly sensitive and the child has concerns about disclosure of the information to the public. While it is not possible in most cases to eliminate media coverage, it can be helpful to eliminate the presence of cameras in the courtroom for psychological reasons and to plan for the child's exit from the courtroom to avoid the media. From the point of reunification, the mental health professional needs to assist the family in becoming prepared to respond to media inquiry and involvement.

Abduction victims often have concerns about court disclosure of sexual victimization or personally demeaning abduction experiences. Young children and adolescents alike report feelings of intense embarrassment in such situations. They share concerns about being perceived as weak, vulnerable, and being subject to revictimization by others.

The fifth area for the child victim is fear of confronting the abductor in the courtroom. Often, court will be the first time that the child will have seen the abductor since the recovery. Children raise concerns on several levels including their safety, fear of the abductor, and humiliation at having to reveal the details of the abductor's behavior toward them in front of the abductor. Victims also bring up concerns about having to relive and tell the details of the incidents during the abduction. This process and anticipation of it in itself can result in significant distress and anxiety.

The sixth area is child victim concern about family presence during their testimony. Some victims wish to have their families present in the courtroom while they testify. Others have very strong feelings that they do not want their family members present to hear the details of what happened to them during the period

that they were missing. Families often have a difficult time understanding when the latter is the case. It is very important for the mental health professional to work with all family members to respect the needs of the child victim in this regard.

Finally, the seventh area is child victim concern about trial outcome. The desired outcomes for child abduction victims are often different than those of others around them. For example, extended family and friends were surprised to learn when one victim was unhappy that her abductor had received a severe sentence. They expected the victim to be happy, however, they were unaware of the dynamics behind her concerns that the abductor would come back to harm her. The dynamics involved the victim's perception that the abductor was "evil" and the belief that "evil" is immortal. She believed the abductor could return to seek revenge for the victim's part in his conviction and death sentence.

Several publications are designed to help the professional working with children (Barth and Sullivan, 1985; Bernstein et al., 1982; Gothard, 1987). Other resources are for use with or by the children themselves (Beaudry and Ketchum, 1983)

3. Family contextual issues not directly related to the abduction. Experienced mental health professionals are familiar with the issues of dual diagnosis and trauma exacerbated by the presence of environmental and contextual variables. Given the current divorce rates, some children will come from families that are no longer intact. The clinician needs to complete a thorough assessment of the child's relationship with each parent, whether from an intact family or not, the nature of their contact with the parents and the relationship between the parents. Parental blame for the abduction can place the child in the middle of a heated battle or a cold war between parents that affects their ability to openly discuss their concerns. Parental conflict may also effectively place a barrier between a child and the needed support from one or the other parent. While the entire range of possibilities cannot be addressed here, the point for the mental health professional is that family dynamic contextual issues must be evaluated and considered in developing a treatment plan.

In some cases a parent will display mental health issues that will seriously impact the treatment and treatment plan. For example in one case, the mother was so seriously depressed that she was unable to provide emotional support to the recovered child. She had turned to drugs and alcohol to self medicate her depression. Referral and separate treatment for the child's mother was indicated and made. The mother's depression impacted the child's perceptions about her mother's ability to keep her safe from reabduction. In turn she developed a series of rituals aimed at protecting herself because she did not feel she could depend on her mother. At the same time she was conflicted about revealing her mother's

impairments. The dynamics of the family prior to the abduction included the daughter protecting her mother's secret.

Parents with untreated childhood traumas may have difficulty making distinctions between their own experience and the child's experience of abduction. The child's perceptions and needs may be lost in the process.

In some cases, families are indigent. The clinician may find themselves making referrals to other agencies to assist in getting the needed services. Many families, by virtue of the abduction may qualify for State Victim Compensation/Assistance Funds. The qualifying criteria will vary from state to state. The clinician can obtain information about their State's specific criteria and requirements by contacting the agency responsible for those funds. These funds are not consistently administered by the same government entity from state to state. In the event that the clinician is not aware of the agency responsible for victim compensation in their area, several sources are suggested. In some cases local district attorney's offices have information. If your local office has a victims of crime advocate, you may want to ask for their assistance. Another source may be local/state social service agencies, or other clinicians in your state who work with crime victims. A list of State Victim Compensation/Assistance Programs can be found in the publication *Federal Resources on Missing and Exploited Children: A Directory for Law Enforcement and Other Public and Private Agencies*, compiled by the Federal Agency Task Force for Missing and Exploited Children (Revised Edition, December 1997), Office of Juvenile Justice and Delinquency Prevention.

A final environmental consideration is the child and family victim who have limited accessibility to services because of living in a remote or isolated area. In those cases cooperative efforts with other agencies to optimize face to face contact along with telephone contact may be part of the treatment plan.

STAGE III: THE LONGER TERM TRAUMA RESPONSE PATTERN

The longer term treatment issues emerge in two steps or phases. They are summarized in Table 14.

Table 14
Stage Three
Longer Term Trauma Response Steps

A. Review of Event Related Issues: Events that occurred during the abduction and as a result of the abduction are revisited in an attempt

to master the experience. The goal is to integrate the abduction experience and address unresolved questions and affect.

B. **Implement Coping Methods for Abduction Related Events and/or Assumption Violations:** This includes implementation of coping methods aimed at mastery of abduction related concerns. Violations of basic life assumptions, e.g., "the world is ordered" and "bad things don't happen to good people" are reviewed and re integrated.

The following table identifies the two types of issues that emerge for non-family abducted children and their families after recovery. As was true in the prior stage, these issues are abduction related. The specific circumstances of the abduction becomes significant in understanding and addressing the individual or family concerns.

Table 15
Stage Three
Longer Term Trauma Response Patterns

A. Review of Event Related Issues

Child:

1. **Child Victim Reorganization of the Abduction Experience**
2. **Review of Abduction Details**
3. **Recovery Events as Real Versus False**
4. **Child Victim Expectations of Family Response During Abduction**
5. **Child Victim Survival Strategies**
6. **Child Victim Evaluation of Recovery Response**
7. **Evaluation of the Child's Behavior by Others**
8. **Child Victim Anticipation of the Future**
9. **Child Victim Reactions to the Abductor**
10. **Child Victim Explanations for the Abduction**

Family:

1. **Family Reorganization of the Abduction Experience**
2. **Family Evaluation of the Recovery Response**
3. **Family Expectations of Child Recovery During Abduction**
4. **Family Survival Strategies During the Abduction**
5. **Family Anticipation of the Future**

6. Family Perceptions of the Abductor
7. Family Explanations for the Abduction

Child Victim/Family:

1. Child Victim/Family Reassessment of Abduction Behavior
2. Child Victim/Family Assessment of Damage Due to the Abduction

B. Implement Coping Methods for Abduction Related Events and/or Assumption Violations

1. Grieving the Losses
2. Child Victim Sense of Abandonment
3. Child Victims and Diminishing Support Systems
4. Child Victim/Family Feelings of Separation from Others
5. Child Safety Rules
6. Assumption Violations

Review of Event Related Issues-Child:

1. **Child Victim Reorganization of the Abduction Experience.** A parallel theme which is ongoing for both the family and the child victim is reorganization of the abduction experience. The process involves an internal review of the details of the abduction and recovery. The goal of this internal review is to understand and organize the abduction experience, as well as to place meaning on the experience. This review extends over a period of years as different elements of the experience are periodically addressed. Most often, this review is an internal process for each family member without discussion with other family members. Unless this internal review is directly brought out and addressed in treatment with clear approval for discussion and re discussion of the abduction event, family members and victims alike will be too embarrassed about their repetitive need to review the details associated with the abduction and recovery. This, then, serves only to further isolate family members from one another.

2. **Review of Abduction Details.** Careful chronological review of the details of the abduction is an essential component of the counseling process with the child. Each recovered child victim will vary by age and inclination to review case details. The mental health professional should be sensitive to these issues of verbal ability and willingness to talk, while also recognizing the ultimate importance of the abduction event details to the child victims. Victims often remember numbers of

details which are extremely salient to their emotional experience of the abduction. These details are usually of limited or no interest to law enforcement. Victims are often left with details regarding their experience which are emotionally charged but with no one to listen to them. Often these details are evidence of the individual's efforts to cope with the abduction experience, illustrating the survival strategies they utilized to get through the event. For example, one adolescent girl talked about how she did not cry throughout the abduction, as she believed that crying might jeopardize her chances for survival. She believed that crying could result in her failing to respond to one of her abductor's requests thereby angering him into harming or killing her. Likewise, she was very concerned about the specific details of how she was grabbed during the abduction and her specific response during this initial period. This was particularly salient because at the time of the abduction she was with a friend who was able to pull away and escape. These details were important to her in resolving her concerns about whether she could have done something to prevent the abduction or if she could have escaped like her friend. She also talked during treatment about her overwhelming fear during the abduction about whether she would ever see her parents or her friends again. At one point during the abduction, she mustered up the courage to ask her abductor whether she would be released at some point. The abductor responded that she would see her parents and friends again if she was cooperative. At that point, she made the decision to do whatever she was asked by the abductor with the hope of securing her safety and release. These abduction details were salient in her attempts to resolve her sense of guilt over not putting up any resistance to a subsequent sexual assault during the abduction.

In another case involving a five year old girl, the child was never able to give adequate details to identify her abductor. However, she would repeatedly bring up details in both her play and her statements which related to her ongoing fears about safety. These details included the fact that she was sleeping in her mother's bed at the time of the abduction. She repeatedly re-enacted being taken from her mother's bed where she had perceived that she was safe. She also reiterated details about being taken out of an open window from a second floor apartment. These details were important in her efforts to deal with her fears of reabduction during the night, her difficulty sleeping in a bed and her ongoing fears of the possibility that someone will come into her home and take her.

In another case which involved adolescent girls observing their adult chaperons being killed, every detail starting from the point of the first encounter with the abductor until the moment of the recovery have been committed to memory. In this case, the abductor met the girls and the adults in a business environment. The girls had a negative initial take on the individual, yet discounted their perceptions and relied upon the judgments of the adults in charge. The importance of repeated discussions during treatment of the details of the abduction

cannot be overemphasized. These discussions are not limited to the actual statements and events, but also include interpretations of those events and feelings and perceptions tied to the events/details. During treatment immediately after reunification, this review of event details will be spontaneous, but may be fragmented and out of sequence. Gradually, as the victim's anxiety reduces, the therapist should move to a chronological review of the event. The initial recounting of details may last more than one hour, and the therapist should make appropriate accommodations for the time required. In later treatment, new details and emotions will emerge in the retelling of the event.

An often overlooked area of discussion is the victim's reaction and perceptions during the recovery event. It is easy to assume that victims understand the recovery event in the same way as those who recover them, or that while abducted they believed that others were seeking their recovery. Often, neither of these beliefs are accurate. Children and adolescents frequently assume that they will not be missed and therefore no one is looking for them. They are surprised upon recovery, that a major effort was underway to search for them.

Fear of permanent separation from family and fear of dying are two areas that are often not addressed by clinician or child, directly or indirectly. Non-family abduction case histories routinely demonstrate these are fears that children have during the time they are missing. However, unless the door is opened and comfort in discussing these fears is demonstrated by the clinician, these fears are not likely to be brought out for a lengthy period of time, if ever.

3. **Recovery Event as Real Versus False.** In abductions lasting longer than 24 hours, child victims may perceive the recovery to be false, or just another attempt by the abductor to manipulate them. These victims frequently have their hopes of release disappointed during the course of the abduction. In some cases this is the result of hoped for opportunities not materializing. In other cases, abductors actively make promises of release which they don't keep. Abductors frequently lead victims to believe that they are not acting alone, but are part of a larger sexual/criminal/political network. At the time of recovery in these cases, victims may believe the recovery is yet another trick by the abductor. In one case involving a dramatic recovery with armed FBI agents storming into the house to make a recovery, the victim demanded to see proof that the agents were in fact with the FBI. She thought it possible that they were actually friends of the abductor who were scheming to trick her into accompanying them so they could murder her.

4. **Child Victim Expectations of Family Response During Abduction.** Victims also develop perceptions and expectations of what the outcome will be during the time that they are abducted. These perceptions and expectations can change during the abduction experience. It is important to assess and monitor what

those experiences/perceptions were throughout the abduction. For example, in one case, two victims talked about their initial perception of the unreality of the experience. Subsequently, they talked about their concerns that no one would miss them and that they would not be believed about their experiences when they went home. They talked about their expectations of being able to walk the long distance to their home and to go out and be with friends later the same evening. Later, one of the victims became concerned about the possibility that she would be murdered when the abductor began to talk with the other victim. She, in fact, expressed her concern that the abductor showed more interest in her co-victim. She feared that if the abductor liked the other victim better, she would become disposable.

5. **Child Victim Survival Strategies.** An important theme in the treatment of any human induced violence victim involves survival strategies and coping methods. Frequently, this is a topic which needs to be addressed by the therapist as a way of helping these child victims understand the abduction event, organize their responses, and to recognize their strategies for survival during the experience. Victims often need assistance in identifying these strategies. For example, it is often difficult for them to identify lack of resistance as being a viable coping tool aimed at surviving the ordeal. Other examples of passive survival strategies are compliance or dissociative techniques. In most cases, both active response and/or lack of response have some purpose. Understanding the purpose of the behavior or lack of behavior can be instrumental in helping victims reestablish their sense of integrity during the abduction experience.

6. **Child Victim Evaluation of Recovery Response.** Subsequent to the recovery, child victims also typically have substantial interaction with law enforcement and medical personnel. Victims frequently recall in detail those interactions, the questions and requests made of them and their responses to them. These responses either prove to be helpful to the victim in terms of their sense of support and re-empowerment, or result in secondary trauma due to the response or lack of expected responses from the professionals with whom they have contact. Likewise in older victims, the questions they are asked and the manner in which they were asked take on their own special relevance. Victims also learn about others' perceptions, for example, law enforcement's response to the incident during the time that they were missing. This information and the statements made to them will often color their perceptions of the abduction experience.

7. **Evaluation of the Child's Behavior by Others.** A common theme in non-family abductions is evaluation by others of the child behavior during the abduction, or Monday morning quarter-backing. It is typical in these cases that the child victim's responses are subjected to scrutiny by family, friends, or others who would assess themselves as responding in a more capable way. Victims often find themselves questioning the adequacy of their judgment and responses in the

situation. They feel guilty for not being able to stop the incident from occurring. At the same time, they often have an underlying sense of being revictimized by family and friends' assessments of their behavior. The details of the abduction and the unexpectedness of the event are important determinants in victim resistance to the abduction. Yet, these details are not given any weight by other individuals who are primarily concerned with guessing how they would have reacted during an abduction.

In helping victims to cope with this type of evaluative behavior by family and friends, it is helpful to have them look back on the details of the event as well as the initial element of surprise and disbelief. For example, it may be useful to ask the child victim what their response may be if somebody were to grab their arm if they were walking down the street. Their initial response is likely to be that they should somehow fight back. However, they are often able to see how unrealistic the Monday morning quarterback's responses are when they consider the possibility that the person who grabbed their arm was a friend or someone who was pulling them out of the path of a car. The circumstances of the abduction and/or the abductor's behavior may have made it quite difficult for the victim to initially determine that an event as serious as a abduction was actually happening to them.

8. Child Victim Anticipation of the Future. Another important recovery theme is anticipation of future, incident related activities such as medical procedures or court appearances. In helping the child victim, it is important to understand their perception and interpretation of these post recovery events as well as their feelings and expectations about possible outcomes. Just as family and others have perceptions of abductors, so do child victims. However, child victim perceptions of the abductor are often not the same as those around them. As stated earlier, victims pay close attention to the details of abductor behavior. In turn, they also assign intention, or purpose, to these behaviors. For example, in one case, the abductor took great care to meet the needs of his victims. He had made sure that he had food which he prepared and served to them. He had also arranged to have magazines and other materials for his victims to read. When he spoke to his victims, he would express concern by asking whether they were OK or whether there was anything else they needed. At times, he would make reassuring comments to them that they would not be hurt. The victims were also very aware of things that the abductor did not do. For example, he did not hit or speak to them in an intimidating manner. During the initial abduction, he had killed two adults demonstrating his capacity and means to kill easily. But he did not injure his captive victims. This resulted in an initial reaction by his victims of owing the abductor something for not killing them. After recovery from the abduction, the victims were faced with reconciling the co-existing characteristics of someone who was kind to them but who had murdered their adult chaperons. They also were

faced with reconciling the fact that the abductor was someone who was concerned about their needs, but who had at the same time taken them against their will.

9. Child Victim Reactions to the Abductor. Child victims frequently reference a sense of concern over what happens to the abductor. This is often very surprising to family members and friends of the victim. Victims view their experience with the abductor as close contact with primitive evil. This perception leads to victim concerns that if something bad happens to the abductor, he/she will come back to haunt the victim. This perception can be substantially reinforced if the child victim is already experiencing nightmares and intrusive images from the abduction.

Information about the abductor is an important topic area. Child victims often have variable desires to have information about the abductor. This ranges from a desire to have no information and to not have the abductor's name even mentioned, to points in time when they are receptive and actually desire having information to help them understand the abductor's behavior and motivations. Characteristically, child victims will not request a great deal of information about the abductor during the immediate post reunification counseling. Interest in such information tends to appear at one to three years post reunification. While information about the abductor should be offered to victims upon request, it should never be presumed that forcing the information on them will assist them in their resolution of the matters. Timeliness and receptiveness are key factors in terms of sharing such information.

In non-family abductions, child victims often may exhibit behavior during the initial questioning which surprise investigators or other professionals who come into contact with them. It is not uncommon for there to be some degree of emotional bluntness which develops immediately or within a short period of time after recovery. In these situations, the victim is responsive to requests and factual questions, but is affectively blank. In some cases recovered children have been described as being somewhat clinically disassociated. Interviewers may also pick up some degree of victim alliance or allegiance with the abductor. This is not the Stockholm Syndrome. Rather, the victim has developed the alliance or allegiance to the abductor as a conscious survival strategy. Child behavior during initial questioning may be due as well to role identity confusion by possible name changes and aliases. During questioning, it is important to understand what the child's perception is of who they are, who their abductor is, and what they perceive their relationship with the abductor to be. It is also important to understand their perception about their relationship to their natural parents, whether they perceive those parents as being deceased or having abandoned them, based on what the abductor has told them to gain psychological control.

Child victims frequently perceive themselves as having been an object or possession to the abductor. This often leads to consequences in terms of their perceptions of themselves in relationship to others, particularly in authority based relationships. The process of recovery from a high visibility stranger abduction characteristically produces a great deal of attention to the recovered child. During the abduction, the child was valued as a sexual object and/or as an object of possession. In the midst of the crime being committed against the child, the child, nonetheless, receives considerable attention, especially if the abductor's requests are being met. During the recovery, the child can be valued as an ex-victim. This ex-victim status can come to be the primary identity for the child. The investigative process, as well as the curiosity of family members and other adults, also focuses considerable attention on the child, especially if the child is revealing facts of the abduction. Part of this attention to the child as an ex-victim is unavoidable. The challenge is for the mental health professional to avoid inadvertently contributing to this post recovery phenomenon. Just as the recovered child is not the average child in the neighborhood, the recovered child is not the average child patient in the therapist's caseload. As a result, the recovered child will receive an additional amount of the therapist's mental and professional energy.

The goal is to recognize this as a normal process and then work constructively to manage its effects. First, the therapist accepts the initial outreach component of the reunification team, realizing that this out of the office approach is necessary in order to establish a beginning relationship with a frightened child and anxious, uncertain family. Second, the therapist accepts the short term stabilization and crisis resolution objective of the reunification team approach. Third, the therapist evaluates the individual child and family's needs in longer term counseling and therapy, assuming that role or assisting in that transition. Fourth, throughout the counseling, the therapist attends equally to the child's needs/conflicts that are non-abduction related as well as those that are abduction related.

In the same way that there may be alliance or allegiance with the abductor, there may be efforts by the recovered child to construct moral judgments about the abductor's behavior. For example, victims may give justification as to why the abductor took them, and for his treatment of them during the course of the abduction. Common statements include: "he could have killed me" and "didn't I owe him something." Likewise, there may be concerns that if the abductor is killed or imprisoned they will retaliate and thus have a type of magical control over them. This may in part be a function of what they were told. However, it may also be a function of their attempt to make sense out of the experience which they have gone through.

10. Child Victim Explanations for the Abduction. Common questions asked by abduction victims are "what if" and "why me." These questions are, of course, an effort to attempt to make rational sense out of a tragic life event. There can be many parallel responses to these questions, just as is true in other forms of trauma. The questions around "why me" may be associated with the creation of omens; child victims attempt to find ways in which they could have predicted that the events were going to occur. Such thinking often leads the victim to develop omens or magical beliefs about why the incident occurred, and what they can do to protect themselves in the future.

In the absence of other information, victims may also assign spiritual or supernatural explanations to the events. The child may also develop the belief that the incident occurred because in some way the child was bad or acted inappropriately prior to the abduction. For example, victims may develop beliefs that the incident occurred because they had an argument with a parent or sibling. In treatment, a number of questions arise around changing the circumstances of their behavior prior to the abduction in order to prevent the abduction. For example, the child victim may ask themselves "what if" they had gone directly home from school, instead of stopping to talk to a friend. Similarly, another girl walked to a corner store with her friend to get an after school treat, having received permission from her father. However, on the walk home, her friend had wanted to take different routes. The victim wanted to walk home using the same route by which they had come. She prevailed and she was abducted. Her friend was not. In counseling after recovery, she repeatedly asked herself what if she had been agreeable to taking the other route with her friend, assigning responsibility for the abduction to herself.

In some cases the child may develop an allegiance with the perpetrator to justify or normalize the experience. The bottom line in these questions is the need for self-mastery of the traumatic event.

Review of Event Related Issues-Family:

1. Family Reorganization of the Abduction Experience. Families of victims go through a parallel process of reorganization of the abduction experience. Just as the victims, family members, including parents and siblings, also find themselves reviewing the details of the abduction from their perspective. For example, parents will review: (1) the details around which their child came into contact with the abductor; (2) the initial point at which they realized that their child was missing; (3) the details of their recognition that the child was missing rather than simply returning home late; (4) initial efforts at reporting the missing child; and (5) initial law enforcement responses to their concerns. In most missing children investigations, parents and family members are likely to be viewed as potential

suspects who need to be investigated and cleared. It is important to review with the parents the process of reporting a child missing and in turn being considered or viewed as a potential suspect, in order to assess residual, unresolved feeling about these events.

Parents, as well as siblings, can often give detailed descriptions of their activities, thoughts, and experiences from hour to hour during the period when their child was gone. They give detailed descriptions about their conversations and experiences with law enforcement, the media, and support persons. For example, in a case involving a five year old child victim, the mother repeatedly referenced her experience of falling asleep on the sofa with her other child, a sick infant, then waking up to a knock on the door. She opened the door to find a police officer who asked her if she had a young child with pigtails. She vividly recalls her experience of walking into the bedroom fully expecting to see her child in her bed. However, this expectation quickly changed to feelings of confusion, panic, and fear when she saw that her child was not there, and then noticed the child's pajamas and underclothing lying at the foot of the bed. In another case, a mother talked about the details associated with learning that the police intended to tap her home phones, then having law enforcement come into her home to set up the equipment. She also talked about her feelings regarding law enforcement's decision to have canines search for her daughter, and her reactions upon walking into her daughter's bedroom so the dog could gain the child's scent. Such events are beyond normal experience. As individuals are confronted with these memories, their first efforts at mastery are to recall as much as possible about the events. The process of relating details of these events is equally as important to the therapeutic process as the releasing of pent up emotions or achieving mental insight about post recovery behavior.

2. **Family Evaluation of Recovery Response.** Just as is true for the victims, family members and siblings have reactions and perceptions as they learn about the recovery. In one case, a mother learned of her daughter's recovery over a police radio. As the officer was talking to the mother about the recovery, she overheard that her daughter had also been sexually assaulted. She was told that her daughter was being taken to the hospital for medical exam and treatment. On the way to the hospital, the mother and father drove in silence not knowing what to expect and uncertain of how to respond in the situation. In another case, a small child was recovered semi-conscious and immediately taken to a hospital. After the mother made arrangements for the care of her other children, she was driven to the hospital by a police officer. She knew that her daughter had been semi-conscious when found, but had no real idea of the extent of injuries she would find upon her arrival at the emergency room.

In still another case, the parents were notified immediately after the recovery had occurred. On their drive to the hospital, they had no idea of what to expect as their child had been gone for several days. As parents and siblings talked, one of the siblings asked: "But what about me?" The parents found themselves angry, perceiving the statement as being cold and selfish. The question set the stage for the sibling to feel discounted and undervalued. Further, it set the stage for the parents to vent unfocused anxiety over what they would find upon reunification. The same family had the experience of having news reporters speed past them in a rush to get to the hospital, before the parents themselves could find out their daughter's status. Thus the details of the recovery became important items in the reunification adjustment and counseling process for the family.

Authority response to the abduction is particularly important for the family and siblings as they are more directly involved with the law enforcement agency response to the missing child. In one case, the parents talked about their sense of the initial dismissal of their concerns when they were asked whether their child had run away. This dismissal was followed by the parents making numerous phone calls, seeking to collect information on their own regarding their daughter's disappearance. Law enforcement finally became reinvolved when the father broke into the office of the acting school where his daughter had last been seen. Shortly thereafter, a senior law enforcement officer became involved in the case, and the response changed immediately. The area law enforcement agencies in the case quickly became organized into a task force and developed a collaborative investigation along with the FBI. After the recovery of their daughter, this family was left with confidence that the best efforts possible had been made to find their daughter along with the other missing children. Not every family is left with such a positive evaluation of law enforcement efforts. Other families may experience frustration and anger with the level of response. This is especially true in longer term abductions extending over many months. Negative attitudes toward law enforcement response may be exacerbated by the fact that families are often evaluated as suspects in the initial phases of investigation. Because of the nature of the investigation, families cannot be told of all of the efforts being made by law enforcement. As less and less information is forthcoming, family members become increasingly frustrated. Family experience of these events strongly influences their sense or their ability to reestablish control of their lives after child recovery. While delayed recovery may result in a focus of anger and frustration toward the police, mental health professionals also need to appreciate the impact of law enforcement's response to the family's concern about the attention given to the investigation and progress of the investigation. Similar to the importance of details of the abduction period for the victim, the details during the missing period are a vital part of the treatment process for the family members. The details will need to be discussed again and again.

3. **Family Expectations of Child Recovery During Abduction.** Families develop perceptions and expectations of post recovery outcome while their children are missing. As is true with the victim, these perceptions and expectations of outcome may change over time. An important component in the treatment of the family and the siblings is to review the expectations of outcome both during the initial period while the child was missing and in later periods. In one case, the mother had the perception that her child would be found and had not entertained any possibility that her child could be injured or even killed until law enforcement made the decision to involve search dogs. Only when she took the officers and dogs to her daughter's room did she consider the possibility of her daughter's death.

As important as the expectations of recovery events are the family member's feelings about these expectations. For example, the expectation that a child could have been murdered may not even be discussed or brought up voluntarily because of the parent or sibling guilt about having even had that perception. Checking out family member's opinions about the abduction outcome expectations of other family members can uncover significant family dynamics. In one case, a mother began to wish for her child to be dead because of her concern about what the child was experiencing on an ongoing basis if she were alive. The father was both confused and resentful as to how his wife of many years could even have such a thought. In another case a sibling became resentful towards optimistic members of the family because of the sense that they could not address or talk about their fears about the death of the missing child without hurting the optimistic family member's feelings.

4. **Family Survival Strategies During the Abduction.** The parents and siblings of abducted children develop survival strategies to deal with the stress of the missing child. As is true with the victim, these survival strategies may be proactive or they may be decisions to remain passive and not respond at all. Each response has a purpose and a meaning to the family member who employs it. It is important to understand that purpose and meaning from that family member's perspective. Some family members develop a survival strategy of giving a great deal of energy and support to other family members. The strategy of other members may be to respond by withdrawing or not expressing feelings, not wanting to burden family members with their emotional needs. Still other family members may take an active role in attempting to gain information about the missing child's disappearance, or take on the role of being watchdog to insure that the case is not forgotten by investigating agencies. All of the above described coping strategies may co-exist within the same family.

Family members may develop resentments toward other family members for their response or apparent lack of response, attributing different motivations to the

behavior than may actually be intended. For example, the individual in the family who chooses not to burden the other members of the family with their feelings may be seen as callous, indifferent, or uncaring for the missing child. The family member who assumes the watchdog role over investigative professionals may be perceived as a threat to the investigation if they become too demanding.

Family members also have to respond to Monday morning quarterback evaluations of their behavior by extended family and friends. In some cases they are direct targets of such evaluations when they may overhear the comments of others. In other cases, they must also deal with seeing another family member victim put under scrutiny by others who do not fully understand the situation. Often family members struggle with wanting to protect vulnerable family members from such intrusive evaluation versus the recognition that sooner or later such unpleasant events are unavoidable.

5. Family Anticipation of the Future. After recovery, families, too, anticipate future abduction related activities. This may include medical tests, court appearances, or media demands for interviews. This anticipation involves concerns about the impact of these incidents on the victim as well as concerns about the outcomes of those future incident related activities.

6. Family Perceptions of the Abductor. In regard to perceptions of the abductor, family members develop their own set of beliefs based upon their own information and experiences during the abducted period, combined with information received from the victim and from the professionals involved in the case. As indicated earlier, these family member perceptions are often different than those of the victim. However, family members are frequently not aware that their perceptions differ from those of the victim as the victim's attitudes toward the abductor are often complex and confusing. In one case, a family member was highly religious, holding the belief that the best way to deal with an event was to forgive the person who had harmed you. Any response short of that was not acceptable. The child victim interpreted this message as meaning that she was not good if she did not forgive the abductor. At the same time the child found herself unable to do so because of her intense fear of the abductor.

Family members also have varying desires for information about the abductor. In some cases, family members desire information in the hopes that this will help them understand why the incident occurred. With this information they hope to be able to more effectively protect their their children from reabduction. In other cases, family members have a desire to deny the abductor's history or existence in the hope that in so doing the trauma will subside. Their belief is that talking about and thinking about the incident will only exacerbate their trauma.

Still other family members find themselves fluctuating between a desire for information and a desire to avoid information about the abductor.

7. **Family Expectations for the Abduction.** In the same way that victims ask themselves questions about "what if" and "why me," family members have similar concerns. Parents find themselves asking why they had to be in a situation where their child was abducted. Their questions and efforts to understand why their child was abducted produce similar results as seen in victims. These results include omens about how the abduction could have been predicted, as well as in some cases, supernatural or spiritual explanations for the abduction. Similarly family members find themselves asking numerous questions about changes in their behavior which may have made a difference either in preventing the abduction from occurring or in the investigative process of the abduction. For example, one family had specific rules about the children not walking to a corner store by themselves. The family rule was that a child needed to be accompanied by another child of at least equal age. Indeed that rule had been followed on the day of the abduction. Nonetheless, the father could not stop asking himself "what if" questions about allowing his daughter to go with her friend.

Review of Event Related Issues-Child Victim/Family:

1. **Child Victim/Family Reassessment of Abduction Behavior.** Victims and family go through a parallel process of underlying questions and feelings involving reassessment of one's behavior during the abduction period. The family struggles with questions around self-blame, guilt, helplessness, and vulnerability. There is a tendency on their part to rehearse their responses as they occurred during the time of the abduction. For example, family members may ask themselves if there was anything they could have done that could have prevented the abduction. In one case, a young brother who was present when his sisters were abducted focused the next ten years of his life upon trying to make up for this to his mother. Family members feel guilty that they were not able to prevent the abduction or were not able to do more in the process of finding the victim. Family members raise questions about helplessness, as they see the child victim going through reorganizing the abduction experience and feel helpless in assisting them in this process. Families feel vulnerable in that they have now been a victim of abduction and now fear reabduction.

After recovery, the child victim also goes through a series of questions and feelings in the process of reassessing their behavior during the abduction period. Victims may ask themselves questions such as "what did I do?" They often ask whether escape, prevention or prediction were possible and will review again in detail the events leading up to the abduction as well as their behavior during the abducted period. Victims also ask themselves questions about "how did I behave

during the abducted period?" Many of them also raise questions and concerns about their sense of vulnerability to abduction.

The second part of the underlying questions and feelings for the family is an assessment of their reactions and adjustment to the incident. Different family members may have different feelings concurrently. These feelings typically center around resentment over continued attention and disruption of the abduction event. Siblings and parents may find themselves wanting the abduction event not to play such a large role in their life. For example, for years after a highly visible stranger abduction, child victims and their families will be approached by news media or other groups for follow up interviews, and possibly even movie rights. Family members may find themselves angry over their continued identity to others as victims, and resentful of this disruption in their lives while another family member sees the offer as an opportunity to tell their story and prevent another child from being abducted. Another perception has to do with resentment versus acceptance over the discussion of abduction events. In some families, victims may choose not to discuss the details of the events. In fact, they may actively avoid direct discussion of details, despite questions and encouragement to do so by other family members. Even though they may be addressing these issues with therapists or friends outside of the family, some victims do not wish to address this within the family. Their reasons vary from a desire for privacy to concerns about their experiences being minimized. Family members may respond to this decision by the victim either with acceptance, mild resentment, or frequent protest. Family members may encounter a similar range of feelings over the victims' need to continue to discuss the abduction events when family members no longer wish to hear about it. Just as a lack of discussion can cause these reactions so does the continued need to discuss events. Victims may find themselves alternating between feelings of anger over family reluctance to discuss the event to feeling resentment over the family desires to discuss the event. In families where there are no questions regarding the event, child victims have expressed the sense of abandonment over the lack of discussion.

2. Child Victim/Family Assessment of Trauma Due to Abduction. Another phase of treatment addresses the psychological trauma caused by the event. Both family and child victims go through this process, but it is often a silent, unshared process between them. Family members may respond to such an assessment by the mental health professional with a recognition of their own impacts, or complete denial of the impact. Just as victims often go through periods of denial regarding the abduction, family members may similarly deny the impact of the event upon themselves and interactions within the family. As is typical in any new trauma, family members and victims find themselves assessing prior traumas. In one case, a father whose daughter was abducted while she was walking home from a store found himself reassessing a prior trauma from his childhood when his five year old

brother and mother were brutally attacked in the home. As a result his brother died and his mother was seriously injured. A primary focus of treatment became a re-evaluation of the meaning of the prior trauma and how it was influencing the father's post child abduction behavior.

Family members also make interpretations of abduction impact on the child victim. Most frequently, families underestimate or overestimate the abduction impact on the child victim. The family may go through a much delayed assessment of sibling needs. This is a very neglected group by the family and treating mental health professionals. It is clear that siblings are affected by the abduction of their brother or sister. However, when the sibling attempts to gain some attention, it may be misinterpreted as jealousy or lack of empathy for others. For the therapist, a means of limiting such misinterpretation is to assist the family in looking at the sibling needs during the initial post recovery counseling period.

Child victims similarly go through an assessment of the damage due to the abduction. Victims often are very aware of and carefully evaluate the impact of the abduction upon parents and siblings. Victim attitude about family impact encompass both guilt and anger. In some cases, child victims have talked about their sense of responsibility for what the family was going through and made the decision to spare the family of addressing their needs by minimizing their feelings. In other cases, victims have actually resented the family impact. This is the case when the victim feels that attention to siblings or parents will result in a minimization of their own experience.

Victims also go through an assessment of the personal impact of the abduction upon themselves. In some cases, this leads to feeling overwhelmed by the impact. Some victims have stated that the abduction experience has "made me question myself wall to wall." They have lost trust in their perceptions, and their ways of looking at the world. This is accompanied by anxiety and other post-traumatic stress symptoms. Other victims approach the assessment of the impact with ambivalence. They may find themselves in approach-avoidance situations as the issue comes up. Other victims eventually address the issues in a stepwise progression addressing those issues which they find most salient or the most comfortable to deal with initially and progressing through more difficult issues sequentially. Child victims express feelings of burn out in regard to working on the abduction related issues. At times, they will say that they are tired of thinking about their concerns and will elect to take a break from doing so. It is probable that one will see more than one of these requests for a break from the issues during counseling with any one victim.

Implement Coping Methods for Abduction Related Events and/or Assumption Violations:

1. **Grieving the Losses.** A common theme for child, siblings and parents is reviewing and grieving the losses. The biggest loss is the sense that things will never be the same as prior to the abduction. They describe themselves as different and family members as different because of the unique experience of abduction. It isn't a normal experience that they have in common with neighbors, classmates or friends, such as a child's first day at school, a first date, or scoring the winning point in a sporting event. It is distinct and different and makes them feel different, if not at times separate and apart from everyone else. Because of the shattered assumptions about safety and their own empowerment to predict and manage the world, their perspective cannot help but be changed. Abducted children and parents also speak of "seeing the world differently than other people". Whether they actually do or not, children and teenagers eventually talk about how they perceive things differently than their peers. They often describe themselves as more mature or more serious than their peers. Sometimes they see themselves as being more thoughtful and aware in their approach to and understanding of relationships. Globally this loss comes down to a statement about losing a sense of innocence in viewing the world.

2. **Child Victim Sense of Abandonment.** Child victim sense of abandonment comes with the perception of shrinking support systems and embarrassment over continued abduction concerns. After recovery, child victims initially receive substantial support from family and peers. They will often make comments that they have people to talk to about their experiences, relating this to not needing to be involved in treatment. However, as time progresses, victims may find themselves uncomfortable continuing to discuss their feelings with these same individuals. Whether accurate or inaccurate, they perceive their various support systems as being tired of hearing them talk about their experiences and feelings around the incident. In fact, child victims will often make comments that others will tell them to forget about it or to get on with their life. Yet they find themselves with ongoing concerns, anxieties, and distress symptoms related to the incident. This reinforces their sense of embarrassment over their continued concerns. They quickly accept that they should be able to have coped with these concerns and should have moved beyond them. They very much wish that they could indeed do just that, sensing that they have failed. Child victims may receive feedback that their counseling or therapy must not be helping them, since they still have ongoing symptoms. It is important for the therapist to recognize these feelings, so that the child victim does not prematurely withdraw from treatment due to a sense of failure. Typically, these issues develop from six to nine months after the recovery. They are especially likely to become prominent around the one year anniversary of the abduction.

3. **Child Victims and Diminishing Support Systems.** Victims cope with diminishing support systems in one of a couple of ways. They may tend to withdraw and isolate, feeling that they have somehow failed and need to deal with their concerns within themselves; or, they may seek to expand their support systems. The latter is certainly the more advantageous and functional response. For example, they may be encouraged to reach out to other crime victims either through victims assistance groups or other community agencies. Victims have pursued support through an occupation which they perceive as being supportive of their feelings, and providing an opportunity for self mastery. Still others take an active role in educating others on a victim experience. This education can be through consultation with writers who may write material regarding their case or through direct teaching within the community.

4. **Child Victim/Family Feelings of Separation from Others.** With recovered children, a recurrent feeling is that of not fitting in with other children and not being like their peers. This typically arises when they realize that the topics their peers talk about or are concerned about are not what they worry about. They find their peer's thoughts and worries to be relatively trivial, contributing to their sense of no longer fitting in the same way that they did pre-abduction.

Child victims as well as parents may find themselves having mixed feelings about public acknowledgment of their experience. For example, for victims there may be an ambivalence between wanting to be viewed as normal and being like every other child, versus wanting others to recognize the impact of such an experience on their life. In the therapy room, this may be seen with the child victim alternating between feeling angry with others at their bringing up the abduction and feeling angry by other's apparent lack of recognition fof the changes this event has made in their life.

In cases where sexual exploitation is part of the reason for the abduction, there will be concerns about those experiences and how they are integrated into the child's post recovery life. The victim may find themselves dealing with the sense that sexual contact is frightening. Associated with the sexuality may be guilt, sense of embarrassment, and betrayal. Movies and newspaper articles about rape can take on special importance and become intrusive reminders of their own sexual abuse.

5. **Child Safety Plans.** Surprisingly many families do not formulate or re-establish child safety rules as part of the healing process. As discussed earlier, possible explanations for this parent behavior may be: (1) belief that the family safety rules are fully adequate before the abduction, (2) belief that no family safety rules can prevent an abduction, (3) the need to deny that better family safety rules could have prevented the abduction, (4) the belief that abduction or child crime

will not strike the family twice, (5) confusion/immobilization after the abduction, or (6) a combination of the above explanations. Whatever the reason, an important component of the treatment intervention is a review of the family perspective on child safety rules and when appropriate, establish and implement rules and guidelines.

6. Assumption Violations. These are child and family responses to violations of basic life assumptions. The basic assumptions violated in a non-family abduction fall into four categories: (1) assumptions about people in general, (2) assumptions about a meaningful order about how the world works, (3) assumptions about personal integrity and vulnerability and (4) assumptions about the integrity and competence of significant other persons.

The assumptions that fall into the first two categories have been discussed by Janoff-Bulman (1992). In her book, *Shattered Assumptions*, she divides life assumptions into those core beliefs about the external world, ourselves and the interaction between the two. She describes how most people believe the world is a good place and that people are generally "good, kind, caring and helpful" (p. 6). People generally assume that events are generally positive with more positive outcomes than negative ones. It can be argued that this belief is based on our general experience that things that happen to most people most of the time are good. People are typically optimistic about their own future. Further, people believe that misfortune is not random or without meaning. We generally ascribe to the cultural belief that things are just and happen for a reason. Typically we look to this justice as being personally or family based justice. Most of us have a difficult time looking at the possibility that we do not have control over all the events in our life and that things can happen even though we were not negligent or didn't do something to cause the event. Our very economic system is based on the belief of rewards and punishment. Therefore, our assumptions about our personal fate is one of "security, trust and invulnerability" (Janoff-Bulman, p 18). We believe in our own integrity and virtue which makes us worthy and protects us from negative random acts. Therefore the final assumption is that "because I am a good, competent, careful person, nothing bad can happen to me."

To extend these assumptions, most of us have a difficult time truly understanding or coming to terms with violence which evolves from human design. While nature based destruction may be difficult to deal with, we can accept it as a natural act or an act of God. Destruction precipitated by intentional or planned human design goes against our beliefs about the world. Human designed violence or destruction is preventable and unnecessary. It is destruction without reason.

So, in general, our assumptions are that: (1) people in general are good, kind and caring and will not intentionally or arbitrarily try to hurt us. (2) The world is

just and ordered and things do not happen to people at random unless they have been somehow negligent or bad. (3) Because I am a good competent, careful person, nothing bad will happen to me. (4) I can count on those people closest to me to not harm me, to have my best interests in mind and to watch out for my welfare. Furthermore, children have a basic trust in authority (adults). They believe that authority is right and will not harm them. Thus, children are typically vulnerable to the demands or coercion of an adult, whether stranger or familiar.

Non-family abduction violates both parent assumptions and child assumptions about the world. Both children and adults find that the basic assumptions they lived by and made decisions by no longer apply or work. At the very least they do not trust their prior assumptions as valid. For some people the questioning is immediate. For others the immediate response is denial or numbness and the questioning begins later. Whenever the questions begin, the challenge is the same. Both child and adult reassess their assumptions and beliefs about the world, about people and relationships. Then they must rebuild the assumptions that will guide their beliefs about how the world works and their personal capability to deal with the world. This is a critical process in trauma recovery because it dictates how individuals will interact with people and their environments, possibly for the remainder of their lives. For example, some individuals may determine that the world is dangerous and people cannot be trusted. Behaviorally this may translate into the person becoming phobic, isolative, depressed , anxious, or hostile. These feelings then become the seeds from which trauma related coping styles develop. For example, hostility can be used to create a protective barrier by keeping people at a distance.

Another variation of re-worked assumptions may be that the world is hostile and dangerous and that individuals are helpless to protect themselves against it. In this scenario victims may develop what has been referred to as a "victim" attitude in which they expect to be revictimized or accept any revictimization as a part of life. This is not to say they create or welcome the revictimization. Rather, they could simply be more vulnerable to victimization and have more difficulty leaving a situation in which they are being victimized.

While discussion of all the variations in how assumptions may be re-worked is not practical, another version which merits discussion is the assumption that people cannot be trusted. This can develop whether the abductor was known or not known to the abduction victim. This assumption leads vicitms to not being able to trust significant persons or relationships in their life. Although they are able to initially establish a bond or have the appearance of engaging in trusting relationships, they inevitably began to question or test the other's sincerity. Through their questioning or testing, they inevitably push others away. When the

other person pulls away it further reinforces their belief or assumption that others cannot be trusted.

Certainly this process is not solely dependent on the abduction process. This is where understanding the other stressors and life experiences of the parent, sibling or abducted child is essential to the clinician's work. As referenced earlier, a suggested format for conceptualizing and organizing these various contributors is the double-ABCX model discussed in Chapter Two. In fact, any individual family member may already have reworked their assumptions based on a prior loss, trauma or life experience. The patient and therapist may be working with the abduction as a reinforcement of a prior life assumption.

Working with individuals who are reassessing their assumptions is a process rather than a state. Often the clinician will recognize the process in the individual who begins to discuss their belief about the trustworthiness of people. Sometimes the process is characterized by expressions of disappointment about people or humankind in general. For example, they may state they are disappointed that there are people in the world who can hurt others without remorse. Or the process may be characterized by statements about how they don't understand how a person could hurt someone else. These expressions of "disappointment" or "having a hard time understanding" are indications that the process of reassessing assumptions is fluid and still ongoing.

Other indications that a person is engaging in the process of reassessing assumptions are questions like "why did this happen to me" or "what is the meaning or purpose of this event for me." There may also be self assessments in which the victims looks at their responsibility or guilt. As Janoff-Bulman states this is not necessarily a negative process. Guilt can be assumed at two levels, internalized self loathing which is damaging or assessing ones actions in order to re-establish a sense of control over one's life. The latter may lead to a renewed sense of empowerment.

For the clinician it is important to recognize that: (1) rebuilding assumptions is a process which takes time. (2) The process of rebuilding assumptions cannot be rushed or arbitrarily decided. Individuals must take into account past experiences and questions about people and the world before they can truly rebuild an assumption. (3) As long as the person has not clearly defined an assumption and is still in the process of rebuilding, the clinician has the opportunity to assist the process of building healthy assumptions that will allow the person to optimally function in the world. (4) It is improbable that most people can go through an abduction experience without making some adjustments to prior pre-abduction assumptions.

Perhaps the larger challenge occurs when the parent, sibling or child comes in years after the abduction incident, not because of concerns related to the abduction but rather because of interpersonal difficulties or mood related symptoms based on their rebuilt assumptions. In those cases it is necessary to determine the current life assumptions and the experience base of those assumptions. Therapy can then proceed to examine how those assumptions impact their interpersonal relations and mood. Other life experiences may be identified that could allow the person to approach the world with a somewhat modified framework.

PHASE IV- TERMINATION/PERIODIC RECONTACT FOR CHILDREN RECOVERED FROM FAMILY ABDUCTION AND THEIR FAMILIES

The amount and length of treatment required will clearly vary from case to case, depending on a series of variables including the abduction experience, other stressors, individual coping abilities, and psychological mindedness. Recovered children and family members will vary in how salient the various defined themes will be for them, when these themes will emerge and their resources (whether developmental or psychological) for coping with and working through these issues. From a developmental perspective, child victims may have progressed as far as possible for their age and developmental capabilities in resolving issues. In fact, some issues may not emerge until a later developmental milestone is obtained. In other circumstances, issues may emerge or re-emerge after a trigger event. For example, for a recovering parent it may be when the child moves to another level of independence and there are demands on the parent to relinquish some parental control, which in turn precipitates anxiety or depressive symptoms. For a child it may be when he begins to date or with the arrival of his first child. There are endless developmental and situational precipitants that may result in the return to treatment.

In general, the best policy is an open door policy for the victim and the family to return to treatment for intermittent periods when the need arises. These intermittent recontacts may be very brief, for example, one to four sessions. Circumstances often develop where a therapist is leaving the area or the victim and/or family leave the area. When possible the therapist should provide referrals for follow-up contact if the family remains in the area and the therapist is no longer available. In cases where the family or victim are relocating to another area, the therapist may want to provide resources that may be helpful in identifying potential therapists. Some possible resources may be Victims Witness, often located in the local district attorney's office, and/or local or state professional associations. These may include state psychological associations or state licensed social worker associations.

CHAPTER FOUR - NON-FAMILY CHILD ABDUCTION: THREE FULL LENGTH CASE HISTORIES

The three specific case studies are employed to illustrate the process involved in reunification and post recovery treatment. In doing this, the ABCX model is utilized to organize the complexity of pre-disappearance, disappearance, and post disappearance components of the child and family's experience. Use of the ABCX model is not essential to the understanding and treatment of the recovered child and the family. It serves only as one method of organizing case information. As such, the experienced mental health professional may choose to use another model to organize and conceptualize their cases. For example, using a brief therapy model for immediate symptom treatment may put less emphasis on the pre-disappearance data and long term treatment issues and focus on current symptoms and symptom relief.

The issues and themes unique and specific to non-family abduction are incorporated into the case descriptions. The dynamics and victims of non-family abduction fall on a continuum. This has been documented in the NISMART data and sub-analysis of the data (Asdigian, Finkelhor & Hotaling, 1995; Finkelhor, Hotaling & Asidigian, 1995; Finkelhor, Hotaling & Sedalk, 1992; Hatcher, Behrman-Lippert, Brooks & Barton, 1992; Hatcher, Brooks & Barton, 1992). Victims include infants, abducted from hospitals or their homes by individuals motivated by the desire to have an immediate family. Pre-school, school age children, and teenagers, both male and female are taken. Teenagers are often taken for purposes of sexual exploitation. Other motivations include accidental kidnappings in the course of a crime, ransom kidnappings, hijackings, acts of retribution, and intimidation and terror. In some cases, individuals familiar to the family have taken children with the stated intent of raising the children as their own. In some cases these individuals view themselves as removing the child from a bad parent and in other cases, these individuals have established, at least in their own mind, an attachment to the child. For example, the latter may occur when a baby sitter or acquaintance of the family perceives a special bond between themselves and a child, real or fantasized, which is threatened by separation or interference by a concerned parent.

The socio-economic, ethnic and cultural backgrounds of the infants, children and teenagers who are taken is as diverse as their ages. Children from inner cities are abducted as are children from small rural areas. These children come from homes with happily married parents and single parents. There is no one profile of the children who have been taken.

In some cases the victim is missing over a long period of time, such as in the case of Steven Stayner, who was under the control of his abductor for seven years. In other cases children are abducted, assaulted and released. Unfortunately some perpetrators kill children after exploiting them.

The following case reviews do not reflect the continuum of motives or victims. A review of the specific issues related to infant abduction: the dynamics, epidemiology and safeguards can be obtained from the National Center for Missing and Exploited Children (Rabun, J, 1993). Different ethnic/cultural experiences and beliefs overlay specific issues, needs, coping strategies. Intervention strategies that may be experienced as helpful in some cases, may be perceived as threatening or even offensive in others. Ethnic and culturally sensitive assessments and interventions are required. Specialized treatment considerations are now being developed and researched for different ethnic and cultural backgrounds (Akhtar & Kramer, 1998; Foster, Moskowitz &Javier, 1996;). This research is generalized and not specific to child abduction. Unfortunately this project and the data from this sample is not adequate to make such delineation and recommendations. The reader is encouraged to access the developing literature in this area depending on their specific case needs.

The following cases provide summaries aimed at assisting the mental health professional in assessing, organizing and understanding the needs of abducted children and their families over time.

Case Study Questions

1. How does an actual case look using the ABCX Model?
2. What kinds of information can be generated using the ABCX Model to organize and conceptualize a case?
3. What are the unique issues/themes observed in non-family abductions?
4. How do these issues/themes manifest across different developmental stages?

CASE #1

The Abduction Crisis Event (Factor A). The first non-family abduction case involved two victims. The event began with an audition for a teen video on

high school dropouts to be held at a Northeastern theater arts school at which both of the victims were students. The audition was to take place at the end of the day after a regularly scheduled class. Since the girls were not in the same class, they did not know one another. The audition involved each of the girls being asked to walk as well as read lines from a script. Both girls recall that it was their first opportunity to audition for a job. They were concerned about their performance, paying little attention to the man who had come to the theater arts school for the auditions.

Almost immediately Susan, the younger of the two girls, was selected and notified that she had been chosen. The other girl initially received word that she had not been selected, at which point her mother made the decision to spend a night away from home at a Christian retreat. After the mother had left for the retreat, Mary received a phone call from the theater arts school director telling her that she indeed had gotten the job and that they would be leaving early Saturday morning. She was told that she would need to bring along a change of clothes, which included a pair of shorts and shirt. Mary and Susan were equally excited about the opportunity to do their first job. Mary was taken to her director's home where they were to meet and leave for the job. Unknown to the parents, the school director had decided to take along one of her 55 year old friends as an additional chaperone.

Meanwhile, Mary's sister, Kathryn, was spending the day at home. Kathryn was baby-sitting her infant sister and had decided to enjoy the day at home since it was her eighteenth birthday. It was expected that Mary would be returning from her video shoot sometime during the early afternoon. Her mother anticipated returning at approximately the same time. When the mother returned, Kathryn told her mother about the job that Mary had gotten, how she had been dropped off at the school, and was expected to return any moment.

As the afternoon wore on, Mary's mother became increasingly concerned over her daughter's failure to return. It was unlike her daughter to be late. Typically if she was going to be late, she would be responsible about calling to let her parents know. The stepfather had left town to attend a baseball game after dropping off his step-daughter. As he prepared to make the return drive home, he called his wife to let her know his plans. He was confronted by a tearful, scared mother whose first comment was to ask him where her daughter was.

By this point, it was approximately 10:00 o'clock at night. The stepfather instructed the mother to phone the authorities and hospitals. She attempted to call the theater arts school with no response. She called three local police agencies. The initial response was a suggestion that perhaps her daughter had run away. She also called three local hospitals to check whether there could have been an accident and

her daughter could have been transported for medical care. Her daughter was not listed as being at any of the hospitals.

Mary's family was not aware of the name of the other adolescent girl who was to be the second model. They were also unaware that the theater arts director had taken a friend to accompany her. As the night continued, Mary's sister began her own personal search. She drove around looking for any sign of her sister or the school director's vehicle. The father made phone calls trying to gain any information he could. He called the theater arts school secretary, a former friend of the family, who had worked at the theater arts school for a period of time. Eventually, out of desperation, the stepfather broke into the theater art director's office for clues about where they may have gone.

An off duty police command officer came into the department. Scanning the patrol activity reports out of habit, the command officer noted the missing child reports and the police units at the family residence. Sensing a potentially serious situation, this officer assumed command of the situation, mobilizing a full response. The officer was also instrumental in initiating an interagency task force, composed of all local law enforcement agencies as well as the FBI. Still frustrated with the lack of information and the lack of leads, the stepfather and other relatives continued in their search for information regarding Mary. Mary's uncle found the chaperon's car in a community approximately 60 miles away from the family home. This was also the community where it had been said that the video shoot was to occur.

Meanwhile the FBI and collaborative agencies had set up two command posts, one in the family home. In the home they screened incoming telephone calls, and questioned the family extensively. They established media releases seeking information from the public, submitted the case for review by the Behavioral Sciences Unit of the FBI, and carefully screened incoming leads and other data as it became available.

Family Stressors Other than the Abduction (Factor a). These stressors included the divorce between Mary's natural parents when she was just an infant. Although the natural parents lived approximately 3000 miles apart, there was good cooperation between them regarding their daughters. Their daughters regularly visited over extended holidays and summer vacations. The mother had remarried after approximately six years of being single. There was a new baby from that marriage. Kathryn, Mary's older sister, found the adjustment to a step family to be difficult. She remained close to her natural father, and found that her mother's new marriage meant that her mother no longer devoted as much attention as Kathryn desired to Mary and herself. These issues had not been resolved at the time of the abduction.

The Pre-Abduction Family Crisis-Meeting Resources (Factor B). Mary's step-father was a successful professional in the community. The family had financial resources allowing the parents and children to pursue their interests, including Mary's interests in acting. A problem focused coping style was present within Mary's family. When there was a problem, the parents would typically sit down, identify the problem, identify available resources, and develop plans for a response. However, they also encountered some issues where it appeared that there were no easy solutions including the ongoing relationship struggles between Kathryn and the family and differences on what consituted making good choices about use of family financial resources. These tended to be an ongoing irritation within the family that were not discussed directly.

Mary's mother had strong Christian beliefs, often relying on her faith in times of crisis as a method of coping. This had served her well earlier in life when Mary's grandmother was in a bad car accident that left her partially disabled. The family's extended social support was very strong. The mother had come from a large family and she had maintained contacts with her siblings. The extended family routinely relied upon one another during times of crisis.

The family also had a strong support system with many friends, both the parents' friendships with other adults, as well as the girls' friendships with their peers. Despite the stresses described, the immediate family was a cohesive family in which caring for one another and communication was valued. The mother and her two daughters had particularly established a close bond prior to her second marriage. For six years the mother spent a great deal of time with her daughters, focusing her primary energy during non-work hours on their interests. Now, despite the stepfamily adjustment issues, the overall attitude was one of acceptance and family strength.

Post-Abduction Family Crisis-Meeting Resources (Factor b). These included professional liaisons and contacts from the stepfather's business that gave them the knowledge to push forward even though their concerns were initially minimized by law enforcement as a runaway. Within 12 hours of the initial contact, there was an interagency task force which included several local law enforcement agencies with active FBI participation. The law enforcement agencies had a coordinated plan for utilization of media assistance in finding the girls by quick publication of their pictures as well as those of their chaperons.

Fortunately for this family, there were also immediate funds accessible to deal with the incident at hand. The extended family, friends and neighbors actively offered assistance with the search, baby sitting and moral support.

The Pre-Abduction Perceptual Definition of the Family Crisis Event (Factor C). Mary and her parents pre-abduction perceptions rested on the assumption of trust in the theater director's expertise and judgment. The theater director had over 30 years experience as an instructor, with several students going on to become nationally recognized performers. She had been a long time resident of the community and had a reputation of being experienced. In addition, the family had the perception of Mary, their daughter, as a responsible, trustworthy individual who had always followed the rules of the house. During the initial hours of the abduction, the family had the immediate perception that there was a problem because of Mary's degree of responsibility. It was highly unusual behavior for her not to notify the family if she was going to be late coming home. There were also no conflicts or antagonisms between Mary and other family members prior to her leaving. The video job was perceived as a positive opportunity which family members supported.

Based on police involvement and the knowledge that four persons were missing, there was a police assumption of foul play. At the point in which it became apparent that there was foul play or criminal activity involved, the mother's belief that her child was still safe prevailed. This was reinforced by her reliance on prayer and belief that her child would be kept safe. However, as the abduction continued and the decision was made to use canines to search for her missing daughter, the mother began to have doubts as to Mary's safety. It was at that point that she began preparing herself for the worst of either not finding her daughter at all or finding her deceased. The stepfather attempted on an ongoing basis to be a source of support and strength to Mary's mother and Kathryn. Despite the fact that there were no sound leads, the parents retained hope based on their observations of the continued energy and cooperation between law enforcement agencies until the time of recovery.

The Immediate Experiences of Stress Due to the Abduction (Factor X). This included parental guilt on the part of both parents. The mother felt guilty for the fact that she had been absent, had gone to the retreat and was unaware of the video job. The father felt guilty over the lack of specific information about his stepdaughter's photo shoot, it's location and the other individuals involved. As is often true in these cases, the mother had the belief that the course of events would have been changed if she had been home. The initial absence of clues and/or witnesses to the abduction or information regarding the chaperons and girls whereabouts left the family in a void and contributed significantly to their distress during the missing period.

Once the recovery had occurred, the parents experienced obvious relief, however, they struggled with concerns about how to appropriately respond to Mary. They were left with questions about whether to take Mary in for treatment

with a mental health professional. They had numerous questions about what to expect in her behavior. They also had many questions about how they would know if she was experiencing substantial distress and were worried about how to respond to those signs of distress.

Likewise, they themselves were experiencing stress associated with their daughter's abduction experiences. They knew at the time of recovery, of the chaperons' murders and of physical injury to their daughter. They were also aware just after the recovery that there were concerns about the abductor murdering the girls. Law enforcement's decision to act quickly and use a swat team during the recovery was based on those concerns. They knew that their daughter had gone through experiences which would be difficult for anyone to recount let alone resolve. Yet, at the same time, they felt helpless about how to best respond to Mary's needs.

They observed a few of Mary's peers, who were only acquaintances, claim on television to be best friends with their daughter. These peers wanted to benefit from the limelight and attention associated with the case. They knew she would be vulnerable to others who may want to exploit her for their own gain. In addition, friends and family questioned the parents' actions and decisions, both leading up to the abduction and since the recovery.

The Intermediate and Long Term Experience of Stress Due to the Abduction (Factor x). The stress experience was extensive despite the family's and victim's good coping skills. There was a national tabloid newspaper article with pictures of the girls. The headlines and text gave a sensationalized accounting of the abduction and suggested the girls were sex slaves. Mary's mother experienced ongoing feelings of guilt, depression, and a sense of failure for not having been present at the time of the abduction. She also had thoughts that she might have been able to prevent the abduction. The family remained in the public spotlight for a period of time with each new court hearing. With every hearing and development in the criminal case discussions about the abduction re-emerged. The media always wanted to photograph the girls. Each time they appeared to testify, requests to not publicize photographs or videotape of the girls had to be reasserted. Likewise, knowledge of the abductor as a murderer and a sex offender added to the distress of the family, particularly for the parents who were plagued with thoughts about their daughter being exposed to such an individual.

Mary also experienced problems in post-reunification adjustment. On the surface, she appeared to be doing fine. She was outgoing, immediately participated in school drill team tryouts. She quickly returned to school and engaged in her normal activities. However, the family was also aware of the ongoing distress that she was experiencing. For example, she was fearful and uncomfortable at night

time. These fears were associated with post-traumatic dreams, difficulty sleeping, and flashbacks of the abduction. There were manifestations of newly acquired anxieties that they had not seen prior to the abduction. She had intermittent sensations that her theater arts director was present in a ghostly form. The sense of her murdered director's presence was very frightening. She had memories of her abductor. His distinct presence, his efforts to change and disguise his appearance, his unusual body odor, his words and tone of speech were etched in her mind. So were the memories of her chaperons' deaths, the words they exchanged with the abductor, the instructor's plea with the abductor to spare the girls' lives, the sounds of the assault when the perpetrator killed them and the silence that followed.

Despite the recognition of these difficulties, Mary continued to be adamant in her belief that she did not need to participate in treatment. She could address any of her concerns in the context of her family or friendships. However, at the same time, the family also felt concerned that their responses to her anxieties were inadequate. In addition, there was no refuge from the abductions and murders. Court appearances were recurrent with full media coverage. With each court date, they could anticipate meetings with the prosecutor and others in which the experiences needed to be re-told. Each time, these meetings were accompanied by intrusive memories of the abduction and other post-traumatic symptoms of distress. Actual court appearances were difficult. Mary was required to face the perpetrator, reveal the details of how the abduction occurred, describe the murders and talk about the sexual assaults that occurred during the missing period.

Nearly a year and a half after the actual abduction, post-traumatic symptoms of distress continued to be exacerbated. In addition to abduction anniversary events, there were new developmental challenges. For example, Mary had begun dating, she was increasingly concerned about how boys may respond to her, given her history of abduction. There was also the constant intrusiveness of stimuli which made her feel uncomfortable. Certain words and phrases, and a person's build, hair color or styles of movement that were similar to the abductor's all reminded her of the event. There were daytime flashbacks about the murders, nightmares in which the murders were replayed. The family was contacted by sensation seekers including little known movie directors. They wished to make a movie about the event, but were unconcerned about the actual events as they had occurred. They wanted to create a sensationalized account. In addition, Mary's mother began to experience additional post-trauma symptoms of distress.

Both mother and daughter found themselves increasingly anxious in response to daily family events. For example, the mother was faced with going on vacation without her children which reminded her of the abduction, raising concerns about what may happen while she was gone. She was beginning to develop an omen that her absence would lead to another devastating event for one

of her children. There was anxiety about allowing Mary to go on a class trip without parental supervision. She wanted to allow Mary to be a regular teenager with normal experiences but she feared making a bad or somehow irresponsible decision. With treatment from her own therapist, she decided to let Mary go on the trip.

Overall Mary found the trip to be a positive experience, feeling competent to care for herself. However she also experienced two incidents involving death and near death while traveling. In Paris, she saw a young man, who was standing near her on the upper platform of the Eifel Tower, commit suicide by jumping to his death. While in Spain, she attended a bullfight where one of the bullfighters was severely gored. When she returned home and resumed high school, classroom assignments began to stimulate anxiety. Reading books such as "The Tale of Two Cities" with references about violence caused flashbacks.

There was another non-family abduction in the community. Learning about newly abducted children through posters and billboards made Mary more vigilant about safety and stirred up old feelings. Family members had similar experiences when new, although unrelated, abductions within the community occurred.

For Mary issues developed around fear that the abductor would have magical evil powers over her, returning for retaliation after he had been given a capital punishment sentence for the murders. The abductor's references to having accomplices also came to mind. This raised questions of whether the abductor might use such accomplices for retaliation against her and Susan. Mary also experienced increased sensitivities to family responses to her efforts to talk about the abduction. Mary was particularly unhappy about reassurances which were offered too quickly without fully listening to her concerns. Socially she felt somewhat alienated from her peers because her world perspective, attitudes and personal worries were different than those of her friends.

CASE #2

The Abduction Crisis Event (Factor A). The second case examines the experience of a five year old black American victim, Tenisha, who was abducted out of her family home. Tenisha was at home with her mother and infant brother. Earlier that evening, her ten year old brother had written his mother a note requesting to stay at a friend's house and had done so. The maternal grandfather was visiting the home and had gone out for the evening. The mother and child had watched a movie on TV when the child fell asleep. The mother's male companion moved the child onto the mother's bed and left for work. Tenisha's mother had fallen asleep on the sofa where she was caring for her sick one year old child.

At approximately 3:00 a.m. the police knocked on her door and inquired whether she had a daughter with pigtails. She stated that she did and that her daughter was in bed. She and the police went into the bedroom to find that Tenisha was missing. Her panties and pajama bottoms were lying on the end of the bed intertwined with each other. In the next room, they found the window open with the screen removed from the window. The mother was taken to the hospital emergency room by the detectives.

A half hour earlier, when Tenisha was found, she was semi-conscious and unresponsive. She was bruised with dry blood on her face and between her legs. Her hair was matted with leaves, dirt and twigs. In the emergency room, the child remained semi-conscious. She screamed and cried when efforts were made to examine her. She would open her eyes to stimulation and seemed to be awake, but would not respond to any questions. No intelligible speech was evident. Emergency room doctors noted abrasions on her forehead and neck. Lacerations of the vaginal vault were extensive. After neurological evaluation and clearance, Tenisha was taken to surgery.

Family Stressors Other than the Abduction (Factor a). The mother had severe medical problems including kidney disease which had given her difficulties for some time. Tenisha's mother was eight months pregnant. Her father was absent from the home due to his employment out of the home for approximately eight months per year. Tenisha's father was absent at the time of the abduction, stationed half-way around the world. Her mother was on probation for illegally obtaining a prescription. These concerns were further raised by reports of the mother's repeated efforts to get drugs from various hospital personnel while her daughter was hospitalized. These concerns were apparently given support when the mother gave birth a month after the abduction and drugs were found in both the mother and infant's blood. The family had limited financial resources. At the time of the abduction, the mother did not have a car and transportation was difficult. The mother and father were also mutually involved in extra marital relationships when the father was out of town. The children had knowledge of these relationships.

Pre-Abduction Family Crisis-Meeting Resources (Factor B). This included extended family support. At the time of the abduction, this appeared to be an asset as the family was present and supportive of Tenisha and her mother. However, with time, this proved to be somewhat problematic. While still in the hospital, the extended family reportedly criticized the mother for not being more aggressive about trying to learn who the abductor had been. During their visits with Tenisha, extended family members questioned her about who had taken her from her mother's bedroom. Some of this questioning was done with suggestive and leading questions. The extended family clearly cared and wanted to help, but they were frustrated with the lack of immediate information from the law enforcement

investigation. They were accustomed to immediate answers and did not trust they would receive them.

Various members of the maternal extended family had also moved in and out of the family home at various times prior to the abduction. Boundaries about parental roles were unclear. The mother's coping style tended to be emotion based. Drug use and limited financial resources had been an ongoing problem for some time. The parental marital relationship appeared to be strained. The parents were married when the mother was 17 years of age. The father's work schedule was such that he was away from home for approximately eight months out of the year which diminished the amount of first hand parenting support he could offer. Relationships with other men were a way for the mother to deal with the father's extended absences. The mother also reported that she had a prior stranger molest when she was approximately the same age as her daughter. She stated that she had not received any treatment or assistance regarding her early childhood experience. It still frightened her when she thought about it. She now feared Tenisha would face the same struggles.

The Post-Abduction Family Crisis-Meeting Resources (Factor b). This included immediate police response. As soon as Tenisha was found by a passersby who heard her moans, the police were contacted. The extended family responded immediately to the mother's requests, but with the limitations outlined previously. There was community support from social service agencies, business and private individuals who set up emergency relief funds to assist in the relocation of the family to a new home, transportation to and from doctors' and other appointments, and to cover other expenses.

The mother gave birth to her fourth child approximately a month after the incident. After it was learned that there were drugs in her own and her infant's blood, the mother was placed under county child protective services supervision. This supervision provided mental health therapeutic services for family members, as well as public nurse health support and financial support for additional services. With support and assistance from those around her, the mother was able to contact an attorney who was willing to serve as a guardian ad lidum and file a lawsuit on Tenisha's behalf.

The Pre-Abduction Perceptual Definition of the Family Crisis Event (Factor C). The pre-abduction perceptual definition was grounded in the family's decision to move to the community where the abduction occurred. The family believed that the community where they had previously resided was unsafe because of the high incidence of crime. It was also the location where the mother had been raped as a small child. Mother and father had moved to the new community with the assumption that it would be a safer area to raise children. In addition the

parents had taken special precautions by moving into an apartment with 24 hour security.

The mother also expressed a strong assumption of safety within the confines of her own home/apartment. From her growing up experiences, nothing bad happened when inside her parent's home. From her perspective and prior living experiences, bad things only happened outside of the protective walls of home. She shared a common assumption of most Americans, that she and her children were safe within their own home.

The Post-Abduction Perceptual Definition of the Family Crisis Event (Factor c). This definition included initial police suspicion of family member involvement. As is frequently the case in stranger abduction, a thorough investigation required that law enforcement look at the possibility of family member participation. During the initial time that Tenisha was in the hospital, the identity of the abductor was unknown. Tenisha, along with her mother, expressed fear that the assailant would return. Tensiha insisted the curtains in her third floor hospital room remain drawn.

The extended family was highly emotional, wanting the mother to question the child to get answers about the abductor. When the mother heeded law enforcement's request that she not question her daughter, they questioned Tenisha themselves. As a result of these questions Tenisha gave a description of an abductor which was suggested by one of the family members. The child conceded to the name offered to her by a family member. When the mother learned the suspect's identity, she was quite distraught because the named suspect had visited Tenisha in the hospital subsequent to the abduction. Later that person would be cleared by forensic DNA lab tests. Despite the forensic DNA lab results exonerating the suspect, the family continued to believe the identified assailant was responsible. There were no new leads based on the child's description.

The Immediate Experience of Stress Due to the Abduction (Factor X). This included parental shock and disbelief. The mother was distressed over the many questions toward her from family members, as well as law enforcement officers, about her parenting. This distress increased during the initial period following the disappearance, as there were neither any witnesses to the abduction nor suspects. Due to the child's degree of fear, as well as the fact that the abductor was still at large, the mother made the decision to relocate to another apartment. While this was a functional response to her own and Tenisha's anxiety, the move created additional stress for the family due to limited financial resources and the time demands involved. Tenisha's older brother also had to adjust to moving to a new school and making new friends.

A major confusion and stress for Tenisha, as well as the rest of the family, was the mother's decision to separate from the father. This occurred as the father returned home and just after the child's release from the hospital. The mother decided on the separation as a function of her own anger with the father for not being present to offer support when the abduction had occurred. She was also angry with him for not honoring her request that Tensiha not be questioned by him about the incident. With the relocation and highly emotion-based coping styles within the family, there were increased tensions among family and extended family members. The support offered by the extended family was diminishing.

Tenisha was hospitalized for a six-day period after the abduction. Initially she appeared very quiet and withdrawn. Subsequently, she became a very busy child who had a difficult time maintaining attention to one activity. She shifted from one task to another as if to keep herself too busy to think about the incident. There were large mood swings, from tears to anger to aggression towards her mother and medical staff. During medical intervention, she would hit, bite, and spit at her mother and the nurses. She fought sleep and verbalized her fear of falling asleep. There were periods of regression with Tenisha acting on an infant's level. She feared going home, wanting to live in the hospital. Her degree of fear made a return to the old apartment untenable.

Intermediate and Long Term Experiences of Stress Due to the Abduction (Factor x). The intermediate and long term stress experiences were exacerbated when the only suspect was cleared by forensic DNA lab results. There was also increased family instability contributed to by the mother and father's separation and the mother being involved in a relationship outside of the marriage. The mother was medically hospitalized repeatedly for her kidney problems as well as other medical concerns. She required surgery, stating at one point she had been diagnosed as having cancer. During that time, there were threats of being evicted from their apartment, with the children being sent to live with various relatives and family friends. Tensiha was not brought in for scheduled psychotherapy outpatient appointments on a regular basis.

Tenisha also demonstrated ongoing difficulties. Tenisha's mother sought to have her admitted into a psychiatric facility for approximately a week and a half because of the child's aggressive behavior and severe mood swings. The mother felt unable to respond to Tenisha's needs after the birth of her infant son. Tenisha had ongoing difficulty and symptomatology including avoidance of play with male children, including her brother, nightmares, bedwetting and an inability to sleep in her own bed. She had gone through periods of being very clingy. She exhibited an increasingly short attention span which became problematic in the school environment. She verbalized fear for her safety and fear of the dark. At times, Tenisha demonstrated a preoccupation with themes of death and blood. At one time

when her mother was giving her a bath, Tenisha asked her mom if she was going to hurt her in her vaginal area. On another occasion when her mother was bathing her, she raised concerns that her mother needed to wash her genital area better because Tenisha believed that there was still dirt inside of her. This was approximately nine months after the abduction.

Post-traumatic play was prevalent. Tensiha made references during her play to the apartment from which she had been abducted as the "ugly" house. Contact with police, hospital care, making a home safe from intruders, caretaking and parenting were all repetitive themes within her play. With the mother and father's separation and the father's frequent traveling, Tenisha had identified her mother's boyfriend as her stepfather. There were also the stresses of depositions related to the civil lawsuit. Eventually the parents reconciled. However, there were ongoing stresses of legal difficulties in addition to the abduction, father's absence from the home due to career and ongoing extramarital relationships.

CASE #3

The Abduction Crisis Event (Factor A). A third case involves the abduction of a single 13 year-old female victim, Michelle. Michelle had taken the bus home from school as was typical. Her father had already returned from work. Her mother was expected to return in approximately an hour and a half. She had asked her father if she could walk to the corner store with a girlfriend. The store was about a mile away. The parents had previously agreed that Michelle could walk to the store as long as she was in the company of a friend or adult. Her father gave Michelle permission to go. Michelle enjoyed the walk to the store and talking to her friend about her day. On this particular spring day Michelle and her friend walked to the store, purchased their favorite candy and drinks, then began their walk home. While the Michelle wanted to walk back the same way they had come, her friend wanted to return by a different route. After a brief discussion, the two decided to return the same way they had walked to the store.

As they began their walk home, Michelle and her friend noticed movement in a van which was parked on the side of the street, but thought nothing of it. As they walked past the van, Michelle saw two hands coming out of the door. Suddenly, a man grabbed Michelle and her friend by the hair. He pulled Michelle into the van. Her friend was able to break away. As the van sped off, her friend memorized the license plate number, immediately ran to a nearby house where the resident had also witnessed the abduction. Together they notified the police. The police were also given Michelle's parents names and address. The police, along with her friend, drove to the family home to inform them of what had occurred. As the police officer and Michelle's friend approached the door, Michelle's mother questioned "what did she do now?" As the police explained what had occurred,

they heard a voice on the police radio announce that Michelle had been recovered. She had been sexually assaulted, and was being taken to a local medical center.

Michelle's parents silently drove to the hospital, each thinking of their concerns about how their daughter would be, feeling lost as to what they would find upon arrival at the hospital. When they arrived at the hospital they could not find Michelle. It took nearly 15 minutes to find her with their anxieties increasing by the minute.

As a result of the investigative interviews, pictures of the abductor were televised. However, the abductor was still at large. That evening after returning from the hospital, the family learned of a shoot out between the abductor and police from the local late night television news. They were told that the abductor had been killed and felt some sense of relief that they were safe. However, later they were contacted by the police who indicated that the earlier report was not true, the abductor was still at large. The news left Michelle and her family concerned about their safety, questioning whether the abductor would attempt to come to their home. He still had Michelle's coat and house key in his van. That evening the father slept with a shotgun nearby. At approximately noon the second day, they learned that the abductor had committed suicide.

Family Stressors Other than the Abduction (Factor a). These appeared to be limited. The parents were quiet individuals who worked hard. They shared responsibility for the children and had generally provided well for their family. Despite a move several years earlier, both Michelle and her older sister had made a good adjustment to the change in residence. Both children had done well in school earning A's and B's and had developed several close friendships. Both children were generally responsible and responded to parental requests and limits. However, family members described themselves as not discussing "personal things." Each of them described limited communication among family members.

Pre-Abduction Family Crisis-Meeting Resources (Factor B). Prior to the abduction the family approach to problems generally involved individualized, focused coping but with little communication. Despite the lack of communication, the family appeared to be quite cohesive and to view the family unit as safe and dependable. The parental marital relationship was quite stable, as had been the financial resources.

Post-Abduction Family Crisis-Meeting Resources (Factor b). This involved immediate and collaborative police involvement with several law enforcement agencies. The family was also provided with immediate crisis intervention and mental health referrals as well as the opportunity to meet with hospital social services personnel. Follow up therapy appointments were

immediately set up for Michelle and her family with the assistance of crisis intervention workers.

The Pre-Abduction Perceptual Definition of the Family Crisis Event (Factor C). The pre-abduction perceptual definitions of the abduction were affected by the father's experience at the age of eight of having his three year old brother murdered and the attempted murder of his mother. While the father was at school, a 50 year old man feigned car problems and had approached his parents' home. Subsequently, the man nearly beat his mother to death and murdered his little brother. Another brother, who was less than a year old, was in a crib and slept through the incident. His family of origin's mission during the subsequent years was to keep the assailant in prison. The family felt defeated when the assailant was paroled some 18 years after the murder.

Other pre-abduction perceptions were based on the family's assumption that the area where they lived was relatively safe. It was on the outskirts of a mid-sized southern city but was at the same time semi-rural. The parents had also previously discussed and decided that Michelle would be safe if she went on her walks to the store with another person. This had become an agreed upon rule between the parents which had been enforced the day of the abduction. They viewed Michelle as a responsible teenager who routinely responded to the family rules and limits.

The Post-Abduction Perceptual Definition of the Family Crisis Event (Factor c). This was initially based on mother's perception that one of her daughters was in trouble as she saw the police approach the door. However, she was immediately notified by the police of the abduction and recovery. There was knowledge that Michelle had been sexually assaulted during the abduction almost as soon as they learned she was abducted.

There was also knowledge that the perpetrator had a prior history of abduction and sexual assault. In fact, he had been released from prison just six months earlier after serving a lengthy prison term for a similar incident. The family concerns for their potential safety increased when they learned that the assailant had been in a shoot-out with the police and was still at large. There were concerns that the assailant would return to the house and try to harm Michelle or the family. Upon learning that the assailant had committed suicide, the parents expressed relief that their daughter would not have to go through lengthy legal proceedings and that the threat of danger was over.

Michelle's mother in particular expressed a sense that the abductor could have done a great deal more to her daughter. She believed that there must be some good in the abductor that he had let Michelle go and not hurt her additionally. Michelle's father also described feeling thankful that the abductor did not do more

to his daughter than he did. He commented that he remembered all of the things that his mother went through with his brother's murder and her own near murder, and was relieved that their daughter would not have to go through the legal process.

With the knowledge that the assailant had a prior criminal history and was on parole, Michelle's father expressed his anger that "if prisons rehabilitated, this would not have happened." Overall, the family perceived the response of police and crisis intervention positively. They had mixed reactions, however, about media coverage. It was difficult for their daughter to return to school. The number of details given and high visibility of the case given the shoot-out, man-hunt, and suicide made it possible for almost everyone to identify Michelle and the family.

The Immediate Experiences of Stress Due to the Abduction (Factor X). This stress involved Michelle's fear of being killed during the incident. There was also the immediate fear of the assailant returning, as well as the father's childhood flashbacks. Father, mother and Michelle had numerous unspoken thoughts about what the assailant could have done. These thoughts were clouded by the fact that the parents did not know the details about what occurred directly from Michelle. Their knowledge was based on statements made to them by investigating law enforcement officers which were sketchy. While the parents wanted to be supportive, they were also uncomfortable breaking the family rule of not discussing "personal things" and were uncertain how to respond to their daughter's needs. The father also re-experienced feelings of helplessness which he referred to as "being like my father felt with my mom."

Both parents, particularly the mother, had experienced a great deal of anxiety about allowing Michelle to go out of the home. In the days after the abduction, Michelle had difficulty sleeping with recurrent nightmares about the abduction. Until it was learned the abductor had committed suicide, she was concerned about her safety. Initially, she appeared to be adjusting well. However, when she faced returning to school, she was unable to stay. Michelle became tearful and tired. She was upset with all the attention and questions that were directed toward her. At that point, Michelle would lay in her room, curled up, and withdraw from the family.

Intermediate and Long Term Experiences of Stress Due to the Abduction (Factor x). Intermediate and long term experiences of stress included Michelle's concerns about others' knowledge of the sexual assault. It was a high profile media case and others knew that she had been the victim. She was concerned about how males would react to her, given the media attention to the assault.

In the meantime, Michelle's father had repeated flashbacks of his own experience as a child, learning of his brother's murder and his mother's injuries. He talked at length about these concerns in therapy. Yet, he would not mention them at home. His family was surprised to learn in the therapeutic process that he was experiencing significant distress in relationship to these memories.

Subsequently, Michelle encountered substantial second guessing about her behavior from peers at school. She repeatedly heard comments of how her peers would have responded differently in the same situation. Her initial response was a sense of guilt and failure in that she believed she should have been able to do something to prevent the abduction from occurring. Michelle also began to develop omens. These came up as a result of her many questions about "why bad things happen to her" as well as her ongoing concerns about safety when she was walking outside. As a result she attempted to develop a strategy by which she could have predicted that the abduction and assault were going to happen. This was curtailed by immediate discussion of her concerns in therapy. At the same time, her father was having nightmares around his sense of helplessness about protecting his daughter. He began to think, in the same manner as his daughter, about childhood omens that predicted his brother's death.

Given the many feelings around the abduction that each of the parents were experiencing and the lack of communication around their concerns, tension began to develop between the parents. There were arguments about financial decisions as well as career changes. The abduction occurred approximately two years prior to this writing, and the family continues to utilize mental health services.

CHAPTER FIVE - SAMPLE TREATMENT TECHNIQUES AND THERAPIST QUESTIONS IN CASES OF NON-FAMILY ABDUCTION

In this chapter, two areas will be addressed: (1) sample treatment techniques and (2) therapist questions. Table 16 outlines the issues addressed in each.

Table 16
Therapist Questions and Sample Treatment Techniques

A. Sample Treatment Techniques

1. Symptom Specific Interventions

B. Therapist Questions:

1. Child Placement

2. Diagnostic Issues

3. Therapist Background and Experience

Sample Treatment Techniques:

Following are a few possible interventions for commonly occurring symptoms and issues in family abductions. The experienced clinician will have a number of additional techniques that can be applied. This is intended only as a sample of the type of interventions that may be implemented.

Non-family abducted victim children and their families are most likely to complain of symptoms in the areas of (1) fear and anxiety, (2) sleep disturbance and nightmares, (3) withdrawal/depression, and (4) somatic complaints. Sometimes these symptoms are generalized and in other cases they are attached to specific issues. For example, in one case, a child was more anxious overall. She had difficulty being separated from her mother, difficulty concentrating at school due to safety concerns and generally felt anxious much of the time. In another case, a child was having difficulty sleeping because she continued to have images of her abductor in her dreams.

Fear and anxiety. These symptoms are generally associated with specific fear of reabduction and intrusive thoughts about the abduction. In the case of the

five year old female abducted by an unidentified non-family member from her bedroom, the child never felt safe whether at home, with her mother or away from home at school, with friends, at a restaurant or at a park. She feared that at any time another abductor could take her. Reassurances were an empty promise for her. She required specific interventions to reduce her anxiety symptoms. Four useful interventions include: (1) defining and re-establishing family safety rules, (2) concrete implementation of the rules and defined safety rules, (3) teaching mastery skills, (4) teaching relaxation skills and (5) educating the parents, and to the extent appropriate, the victim child and siblings.

Defining and re-establishing family safety rules is a four step process: (1) Work with the family in establishing what their current safety rules are, e.g., establish secret code words when someone other than the parent comes to pick up the child; ensure the parent has information about who the child is with including address and phone number; have the child call when the child returns from school; and teach the child appropriate responses if someone other than the parent or their designee tries to pick the child up. The clinician will find that some families have no defined or clear-cut safety rules. (2) Have the child, sibling and parents define specific safety concerns that have developed as a result of the abduction. (3) Develop written safety rules based on past rules and current specific concerns. When a family has no defined rules, have family members write safety rules. A helpful resource in this process may be the publication, *My 8 Rules for Safety* (written in 23 languages), published and distributed by the National Center for Missing and Exploited Children (1992). Many local and regional missing children's organizations also have developed safety and prevention tips. Several organizations such as Vanished Children's Alliance in San Jose, California and the State of California, Govenor's Office of Criminal Justice Planning, Children's Branch, Sacaramento, California have published coloring books which give safety and abduction prevention tips for children. Some of these books are published in Spanish as well as English. (4) Review and write the rules for each family member.

Another powerful technique in dealing with fear and anxiety is actual, concrete implementation of a safety plan. Safety plans differs from safety rules. While safety rules define rules and expected behaviors on the part of family members, safety plans are specific plans to address specific fears on the part of the child or family. For example, the child who was abducted from her bedroom had generalized fears including the fear that she may be re-abducted on the school yard. A safety plan may be to develop a strategy for the child to go to a playground teacher or principal if they feel uncomfortable or see a stranger near the school yard. In turn, the teacher or principal will assume responsibility for taking the child indoors to a safe location, check out the stranger and call the parent. Concrete implementation of the plan includes having a meeting of the parents and child with the playground teacher and principal to outline the child's fears, develop a safety

plan and obtain agreement from school personnel in front of the child to follow the plan. This concrete follow-through with the child's participation can be reassuring to the child that people are aware of their fears, know the plan and have committed to follow the plan. Questions about whether others are aware and committed can be alleviated. Sometimes however, periodic follow up and review may be necessary by the parent to re-establish the child's belief in other's commitment to their safety.

Teaching mastery skills involves identifying a skill that will help the child feel safe and teaching and practicing that skill to mastery. One example of this type of skill is teaching the child how to dial for help either by calling home or dialing 911. This works best when the exercise is concrete and not just discussed. While away from home the child should actually call home from pay and private phones. Optimally, the child will reach another family member or an answering machine on the other end to reassure them that they can call home. To extend the exercise, the child should leave a message if they reached the answering machine so that the child understands the parent will get the message. Another skill, is to teach a child how to call the operator to make a collect call. These skills can be practiced on family outings. Once these skills have been mastered the exercise can be expanded to teach the child how to leave the telephone number from where they are making the call, to practice making a call to 911 by having the child dial the number on an actual disconnected phone, and role play a conversation.

Relaxation training for parent and child can be helpful in dealing with anxiety symptoms. Trained clinicians can assist children or parents in applying these skills to specific anxiety generating incidents.

The previously discussed five year old also feared being reabducted in her home. Those fears were especially prevalent at night. The safety plan in this case was to add new locks to the outside doors and wooden rods in the sliding windows at night so that they could not be opened. Concrete implementation included having the parents install the locks and the wooden rods with the child's help. An important consideration for this child was her fear that someone could enter her house from any floor. This fear existed because she was indeed abducted from a second story bedroom with a balcony. It was necessary for the parents to include all windows and levels of the house to alleviate her fears. In some cases the child may benefit from being part of the parent's nightly routine of locking doors and windows.

Educating parents about what to expect from a recovered child is also helpful in alleviating anxiety among recovering parents. Providing them with knowledge, realistic expectations about their child's behavior and the tools to observe their child's behavior is often reassuring. In the same way, for those parents who just want to go home and assume everything will be just like it was

before the abduction, education provides them with a framework to be more appropriately attuned to the child's behavior.

Sleep disturbance and nightmares. Sleep disturbance is typically a result of specific fears, intrusive thoughts about the abduction at bedtime or nightmares about the abduction experience. Sometimes the already discussed techniques can be helpful in reducing sleep disturbance. Additional interventions may include: (1) reframing the outcome of the dream; (2) using concrete props to alleviate fear and (3) practicing mastery skills. Reframing or changing the outcome of a dream involves having the child tell the dream in as much detail as possible and then having the adult or caregiver talk with the child to reframe the dream in which the outcome is favorable or the child obtains mastery over the feared interaction.

Use of concrete props would include having a night light or intercom added to the room if one is not already present, providing the child with a whistle to call the parents, bolting windows, etc. Mastery skills may include having the child participate in a search of the room before going to bed to reassure the child of his/her safety.

Sometimes dreams are more troublesome to resolve because of the nature of the abduction and the outcome. This is especially true where the child experienced some type of injury at the hands of the abductor or witnessed the abductor injure or kill another person. In these cases the dreams may be a replay of actual events during the abduction that were hurtful. Because of the violence associated with the dreams, some children are reluctant to describe or reveal the content of their dreams. In those cases it may be helpful to identify some way in which the child victim was successful in being stronger than the perpetrator or the survival skill that allowed him/her to weather the specific trauma and be recovered. These dreams are more difficult and may require trying several alternative strategies.

Withdrawal and Depression. Immobilization in responding to demands, decreased interest in normal activities, the inability to identify or utilize resources, difficulty concentrating, and tearfulness may be some of the manifestations of depression seen in family members in non-family abductions. Four useful strategies in symptom based treatment are: (1) identifying and organizing resources; (2) direct detailed discussion by the family of the abduction event; (3) establishing and implementing a family/individual healing model; (4) reviewing the successful survival strategies implemented during the missing event.

Because of the disorganizing and traumatic elements of non-family abductions, families often have difficulty mobilizing resources. This is exacerbated by the fact that they often lack knowledge and awareness of the resources that are available to them, for example, victims assistance funds, funds to assist in

relocation, public health services and so on. Identifying resources and helping them implement a plan can help the family members feel more empowered. The steps include (1) have the family list available resources including services, family, friends, and local and national victim organizations. (2) Have the family identify which of those resources would be helpful at this time in resolving a problem. (3) Have the family establish one specific behavior/goal they want to accomplish within a clear timeline. For example, the goal may be to call a particularly supportive friend and talk to them about the abduction experience on the phone. (4) After that goal is accomplished, have the family member set a second simple goal, for example, calling victim witness services and setting up an appointment time. Step by step goal setting and achievement can be helpful in getting the momentum started and not further overwhelming the family. The key is to get the affected family member to become active in resolving the problem. However, that activity must be broken down into manageable steps.

Direct discussion about the abduction told in a family format, with each family member contributing, provides an opportunity to practice communicating about the experience. The therapeutic environment provides an opportunity to have this discussion which may otherwise be too overwhelming for the family. Creating the opportunity for dialogue between family members about the traumatic experience is another way to reinforce mastery when done in a planned and careful manner. This may meet with some resistance from the family or individual members. Sometimes this resistance can be overcome by giving a clear and concise explanation of why the discussion is important. Some families are concerned that discussing the abduction will be traumatic. This resistance can be reduced by having family members have the initial discussions in dyads, for example, abducted child and mother or non-abducted sibling and victim child or non-abducted sibling and parent. Start with the dyads that have the greatest chance of success.

Family and individual healing models focus on assisting the family and individual family members develop a sense of mastery by picking one issue and working towards mastering that goal. This focus helps in mobilizing individual family members in problem solving behavior. For example, a goal may be to develop a strategy for responding to Monday morning quarterbacking, or second guessing by extended family and people outside the family. For example, in one family, family members repeated a standard response that everyone did a very good job with the information available at the time of the abduction. The family members also agreed to share any Monday-morning quarterbacking comments they received so they could collectively examine them. Alternatively, the family may discuss and develop a strategy for dealing with media efforts to elicit reactions from the family. One family decided to have local law enforcement who assisted in

the investigation and recovery be the intermediary between themselves and the media.

Parallel to the family focus of mastery is individual mastery for each family member. For example, a child who was responsible for taking out the garbage before the abduction can be re-integrated into the family by being encouraged to reassume responsibility for that chore. Likewise an older child who was active in a youth group or sport prior to the abduction would be supported in resuming those activities.

Reviewing successful survival strategies promotes in older child victims, teen victims, and family members an appreciation and recognition of personal behavior which positively effected their survival. Survival strategies are those decisions and behaviors the individual makes during the missing period aimed at survival. Although some active efforts, like escape from the abductor, are obvious survival strategies, passive behavior and compliance are also successful survival strategies. Survival is being recovered alive, even in cases where a sexual assault has occurred. For example, in prior case examples, the survival strategy of the abducted teens was the decision to remain calm and listen carefully to the abductor. They decided that they would not do anything to alarm him or cause him to react violently towards them. Another strategy is to be compliant with the abductor in order to not challenge his authority, to obtain release. A third strategy is to take careful mental note of all details so they can assist in apprehending the abductor post recovery. Another less obvious survival strategy is the ongoing belief and trust that they will survive the abduction. Victims and family members often feel helpless and defeated simply in the face of being abducted which can lead to withdrawal and depression. Supporting their recognition of the behavior, which promoted their survival in the abduction situation, helps them to identify their personal effectiveness and feel less helpless.

Somatic concerns. Many of the same approaches that are helpful in addressing prior symptoms are also effective in reducing or alleviating somatic complaints. However, careful note should also be taken of unusual complaints. For example, for a child who has been strangled during the missing period, ongoing complaints of neck pain should be referred for medical clearance to insure there are no physical contributions. A related assessment consideration is whether the somatic symptoms are general complaints or relate specifically to part of the abduction experience. While relaxation and other general techniques may be helpful in reducing general somatic concerns, they are less likely to be effective with incident specific complaints. In the later case, interventions specific to the concern may be indicated.

Treatment Resistance. While a few families will not be able to make the commitment to treatment, a number of children and families will realize over time the impact of the experience and desire ongoing treatment. The initial reluctance to enter treatment is not a surprise since one of the common post recovery patterns is an effort to return to normal and return to the daily routine. This in part derives from the desire to walk away from the experience unscathed, to minimize the effects, and to regain some sense of control and mastery in their lives. Whatever the reason, many children and families enter treatment months after the recovery to obtain symptom relief and/or to talk about the life assumptions that were challenged and violated during the abduction.

For example, in the case examples of the two young women abducted with their chaperones, both were reluctant to continue treatment after a brief series of initial sessions. One of the girls continued to have symptoms but minimized or denied their impact. Eventually she began to engage in high risk behavior which put her into potentially dangerous situations. She continued to minimize and deny her feelings and reactions to the abduction until her mother insisted she return to treatment. Treatment was again brief and symptom related. For the other girl, the symptoms gradually became more pronounced and more difficult to hide from her parents. She felt guilty for the stress the abduction had put on her family and had sought to protect her parents from additional distress by hiding her concerns from them. She also had hoped that denying her symptoms would eventually make them go away. She eventually voluntarily returned to treatment for symptom relief and then continued, addressing longer term issues about violated life assumptions.

Some children and their families may be embarrassed by the return of symptoms and perceive that they have failed because they "should be better" with the previously prescribed number of sessions. The clinician will need to examine these perceptions and must be prepared to convey the message that: "nothing is wrong with the short term model of reunification but the need for longer term treatment doesn't mean they have failed."

Coping Styles. Cognitive coping styles fall along continuums. Those dimensions most useful in understanding the response to abduction are approach vs. avoidance and internalization vs. externalization. Clinicians may include other continuums they have found useful for conceptualization and intervention. Identifying the individual style of the recovering parent, sibling or child victim will give the clinician some guidance in understanding the individual response to the trauma. Individual differences in perception of an abduction event and response to the event have been observed in cases where more than one child has been taken. Differences can also exist between individual family members.

Differences in individual coping styles are salient at two levels. The first is at the family dynamic level. Different family members will interpret and cope with the event differently, depending on their styles. Family intervention at some point in treatment is typically necessary to work with the family on accepting their different perceptions and coping styles. Family intervention also needs to address conflicts, resentments and misunderstandings that develop because of these different coping styles.

The second level at which understanding the specific individual coping style is important is to plan individual intervention. The individual coping style assists the clinician in understanding what resources and limitations the individual will have in addressing the specific abduction related issues. Another perspective is that it assists in identifying what types of interventions will work and those that will not. For example, the internalizer is likely to have more difficulty with Monday-morning quarterbacking than the externalizer. Both internalizers and externalizers will have to come to the point of identifying and appreciating their survival skills in effecting their recovery. However, the process each goes through to arrive at that point will look very different. The clinician will also have to be more astute to these issues because the internalizer is less likely to express his/her struggles and concerns.

In the case of the approach versus avoidance issues, avoiders will have a more difficult time continuing in treatment. At times their avoidance of the issues makes it difficult for them to see the need for treatment. At other points, when their avoidance is too severely challenged in the therapeutic process, they may try to escape to relieve the tension they experience. In keeping with the avoidance they will have a difficult time expressing the reasons behind their decision to leave treatment directly.

Other related dimensions that emerge are minimizing (a form of avoidance) versus catastrophizing (a form of approach) the abduction. Some people will compartmentalize the event and wall it off from the rest of their existence while others will try to integrate it by giving it meaning or identifying what lesson is to be learned from the experience.

Working with cognitive styles can be very tedious and demanding. It is often difficult for people to see the limitations of their styles or to approach a problem from another perspective. However, attacking a person's coping mechanisms prior to providing them with alternatives can leave them helpless to deal with or defend against the painful affects associated with the trauma of being abducted or having one's loved one abducted.

Therapist Questions:

1. **Child Placement.** Return of a non-family abducted child to the searching parents should not be the automatic assumption. While most non-family abducted children are returned to the parents, it is not always in the child's best interest to do so. This occurs in the following circumstance:

The recovering parent(s) cannot provide an adequate environment or parenting for the child; or, the parent has a documented history of abuse towards the child. In some cases, the searching parent may have not provided adequate care for the child pre-abduction or exhibits significant problems that interfere with parenting, for example severe substance or alcohol abuse, severe mental illness, abusive behavior toward the child and the absence of an inadequate residence.

2. **Diagnostic Issues.** The clinical evaluation of the abducted child and family members must also consider appropriate diagnosis. As documented in the literature, trauma may lead to a variety of diagnostic syndromes including depressive disorders, anxiety disorders, adjustment disorders, attachment disorders and so on. Some children and adults may develop a series of symptoms that do not meet DSM-IV (American Psychiatric Association, 1994) criterion for a diagnosis. Others may not have experienced the abduction as traumatic. Accurate diagnosis is essential for case formulation and implementation of a treatment plan.

One diagnosis that has been overused in the area of trauma treatment is Post Traumatic Stress Disorder (PTSD). While PTSD may be an appropriate diagnosis in some cases, it is not always the correct diagnosis and should not be used as a diagnosis of convenience. Failure to thoroughly evaluate may lead to misdiagnosis and consequently inadequate treatment. Some children and their families may come to treatment with dual diagnoses. Some conditions may have developed even prior to the abduction and remained untreated. For example, some children have an undiagnosed learning disability or attention deficit disorder in addition to the issues due to the abduction. Other children may have developed phobias as a result of the abduction. Likewise a parent may have an undiagnosed depression that would require evaluation by a medical doctor for possible use of psychotropic medication in addition to treating the problems associated with the abduction. The important message for the clinician is to thoroughly and carefully evaluate each individual case.

3. **Therapist Background and Experience:**

While many mental health professionals have the basic clinical knowledge and training to provide treatment to a variety of clinical populations, the following offer some practical guidelines.

1. Background in understanding and treating trauma. Background, training and experience in treating trauma victims is a prerequisite for working with abducted children. Background and experience can be obtained through reading the literature, such as the texts written on treatment of trauma by James (1989), Herman (1992) and Janoff-Bulman(1992). The inexperienced clinician can also attend continuing education courses, and arrange for supervision and case centered consultation from experienced clinicians in the field.

2. Knowledge about the specifics of non-family abduction. A great deal of printed material about non-family abduction is available as previously referenced in this document. It is imperative that mental health service providers who have not had prior contact with families of missing and recovered children access this material to familiarize themselves with the specific logistical and emotional challenges and disappointments facing searching and recovering parents. Popular novels also illustrate the experiences of these families (Spiering, 1995; Walsh, 1997).

3. Background and familiarity with developmental issues. The mental health professional should also have experience in treating children and /or adolescents and knowledge of the developmental issues and limitations of the age group they are treating. This knowledge is necessary to provide appropriate interventions for the developmental level of the child.

4. Readiness to Deal With Complex Issues. Non-family abductions are often multifaceted cases. Multiple members of these families often require treatment post recovery. The perceptions and needs of the various family members also may differ. It is often useful for the clinician to have more than one mental health professional working with the family.

5. Evaluation of the Potential Influence of the Clinician's Personal Issues. Non-family abductions can tug on the mental health professionals personal issues, either from childhood or from their current family status. As is true in treating other forms of child exploitation, the responsible clinician must evaluate and be aware of his/her own biases and vulnerabilities in making the decision of whether to accept a case for treatment or refer it on. An issue which merits specific mention is the pull clinicians may feel to "rescue" the child. Such responses do not assist the child in achieving the mastery needed to progress in treatment.

6. Forensic Involvement. Because of pending criminal and/or civil court actions, the mental health professional is often called upon to provide an evaluation of the child, or testify in legal proceedings. For the treating clinician, it is important to define the differences between clinical and forensic evaluation, and the difference in the treating versus evaluation role. In cases where forensic evaluation is needed, it should be completed by an independent professional, other than the therapist, who specializes in forensic evaluation. However, this does not mean that the treating clinician may not still be called into the courtroom to give testimony as the treating professional.

Non-family abductions are complex cases, and require careful consideration by the clinician of both their qualifications and ability to intervene in such cases.

PART III
CHILDREN RECOVERED FROM FAMILY ABDUCTION

CHAPTER SIX - CHILDREN RECOVERED FROM FAMILY ABDUCTION AND THEIR FAMILIES: A MODEL TREATMENT PROGRAM

Based upon research and clinical experience with children recovered from abduction and their families, a Model Treatment Program (MTP) has been developed. The Model Treatment Program consists of special assessment considerations and four Stages. Stage I deals with the initial recovery of the child and reunification with the family. Special assessment considerations precedes Stage II to facilitate planning for short term and long term treatment planning. Stage II provides a short term trauma response pattern. Stage III examines the longer term trauma response pattern. Stage IV describes termination/periodic recontact for children and family members. (See Table 7.)

Table 7
Model Treatment Program Stages

Stage I:	Reunification of the Recovered Child and Family
Stage II:	Address Short Term Trauma Response Pattern-Theme Based Symptom Appearance
Stage III:	Longer Term Trauma Response Pattern for Recovered Children and their Families
Stage IV:	Termination/Periodic Recontact for Recovered Children and their Families

STAGE I: THE REUNIFICATION OF RECOVERED CHILD WITH THE FAMILY

In an effort to not duplicate material, the reader is referred to Chapter Three, pages 79 to 89 to review recovery and reunification. This section addresses: (1) issues and resources for searching parents; (2) pre-reunification preparation for the parent and professional; (3) the reunification meeting; (4) post-reunification family evaluation and assessment; (5) family stabilization and immediate problem solving and (6) identification of future goals. Many of the same steps and considerations

are important both in family and non-family abduction and are generalizable to both types of reunifications. The special considerations in cases of family case reunification follow as they apply for each step and should be read after review of the information referenced in Chapter 3.

Step 1: Pre-Reunification Preparation

As in non-family abduction information, from both parents and children,is important to anticipate reunification expectations, beliefs and fears. This information includes:

1. parental expectations of the child at reunification,
2. pre-recovery beliefs about recovery,
3. perceptions and beliefs about the abduction,
4. perceptions and beliefs about the abductor, and
5. fears and anxieties during the disappearance.

Pre-reunification preparations also must consider whether the child will be given the opportunity to say good-bye to the abducting parent. When possible, recoveries should be made to minimize the trauma to the child, for example, the child may be recovered while at school or in a child care facility while the parent is at work. Recovery of the child apart from the abductor reduces trauma to the child by not seeing the abducting parent arrested or being taken into custody. It also minimizes the danger to the child of problems during the actual recovery. In these cases, the reunification team members will need to assess the potential benefits and risks to that specific child in arranging the opportunity to say good-bye to the abducting parent. Some of the considerations will be the abducting parent's attitude to having such a meeting. For example, is the abducting parent capable of conveying an appropriate attitude to the recovered child or will the abducting parent increase the child's concerns by threatening to reabduct or come for the child at a later time. Some abducting parents may appropriately say good-bye while others may raise the concerns of the child about being reunified with the left-behind parent. In the instance that the child is recovered at home or at a public location, such as at a customs facility at a point of entry back into the country, an assessment may need to be made on location. Factors that may assist in the assessment are facts known about the abductor, potential danger to the child and the abductor's behavior at the time of the recovery. If it is not possible to say good-bye at the time of the recovery, a brief meeting between the child at a later time may also be helpful to the child in dealing with post-reunification issues.

The meeting between the child and abducting parent in which they say good-bye should be supervised by a reunification team member. The meeting should be

planned and discussed with the abducting parent to minimize trauma to the child. It should also be brief. If the abducting parent is unwilling to cooperate in choreographing the meeting, the meeting should not take place.

It is also helpful to plan for recovering possessions important to the child. For example, some children may be attached to a particular toy, stuffed animal, photo or other item. When possible, consideration should be given on making arrangements to obtain those items from where the child and abducting parent have been residing. This may mean obtaining permission and the cooperation of the abducting parent to retrieve those items.

Step 2: Reunification Meeting

The first ten considerations in conducting a reunification are discussed in Chapter Three, pages 83 to 86. Additional considerations in family cases include:

1. For parental abductions when there are allegations of abuse against the recovering parent, the reunification team member from county Child Protective Services or the Department of Children's Services will need to be notified because of the need: (1) to investigate the validity of abuse or neglect allegations and in some cases (2) to place the child in a child care facility or alternative home. Appendix A: PARENTAL ABDUCTION CASE SUMMARY can be used to record actions taken and actions to be anticipated in a particular case. Given the trauma already associated with abduction, these cases need to be given priority and investigated in a timely manner to reduce further trauma due to lengthy separations from appropriate caregivers. The child, recovering parent and abducting parent each need to be interviewed. When the child communicates information suggesting the possibility of abuse, established protocols for forensic interview of the child, physical/medical evaluation, etc. need to be completed. If the child communicates allegations of abuse, the need for emergency services should be assessed and placement made if appropriate. If emergency measures are implemented, a detention hearing will need to follow. Additional investigative protocols standard for the jurisdiction such as forensic interviews, police investigation, protective services interviews, physical examination, psychological evaluation and collateral interviews should be pursued. Again, these need to be completed in a timely sequence taking into account the uniqueness of these cases and the trauma already associated with the abduction for the child.

2. In the case that the allegations are determined to be unfounded, the decision can be made to return the child to the appropriate home and to make referrals to facilitate the child's adjustment. In cases where the allegations are

determined to be unsubstantiated, visitation may be appropriate along with the return to the appropriate home. If allegations are substantiated, the child may be returned to the non-offending parent's home or the child may be placed in foster care. In the later case, supervised visitations may be recommended depending on the child's best interest. Similarly, parallel interviews with the recovering and abducting parent will need to be completed. In either case, whether the allegations are against the abducting or recovering parent, should allegations be substantiated, family court hearings and review for possible criminal proceedings need to be conducted. In the case of allegations against the recovering parent, the decision may be made for the child to remain in protective foster care with or without supervised visitation, returned to the home or a services plan may be designed to address the problems within the family (e.g., counseling, parenting classes, drug/alcohol treatment, homemaking, etc.). Continued review hearings about the case and child's and parent's progress follow. Similar decisions need to be made in substantiated allegations against the abducting parent.

3. The mental health professional member of the reunification team will need to schedule the first follow-up appointment within 48 hours of the reunification meeting, if possible.

4. The law enforcement officer, the mental health professional, and all other members of the Reunification Team will benefit from a common format for case data collection. Appendix E: Reunification Case Protocol provides sample formats.

Step 3: Post-Reunification Family Evaluation/Assessment

During the initial couple of meetings in the office, the focus shifts to identifying family interpersonal issues, individual issues and family issues with the outside world.

Step 4: Stabilize Family and Support Immediate Problem Solving

The overall objective of this stage is to help the family stabilize and family members to define and articulate individual and family healing theories. Facilitating a positive and mastery focused approach can promote initial adjustment.

Step 5: Identification of Future Goals

Utilizing knowledge about trauma and issues specific to child/family abduction, the clinician assists the family and individual family members in identifying and organizing their individual and collective behaviors and concerns. In identifying future goals and needs, families will fall into three basic patterns: those who see the need for treatment; those who are overwhelmed by the traumatic experience and wish for respite care and those who do not recognize when or if the child's behavior supports the need for intervention.

The key in these cases is the clinician's consistency with these families, availability to the family, and not playing into initial denial efforts by the family or individual family members. As with non-family abduction recovery, a final consideration is whether the clinician will be the sole therapeutic contact for the family or whether the clinician shares these responsibilities with other mental health professionals. Certainly many clinicians possess the expertise in both family and child intervention necessary in working with these cases. However, the experienced clinician may determine that doing both may not be advisable due to the emotional and time demands present in these cases. In addition, providing both individual and family treatment can create difficulties in therapeutic alliances. The potential exists for dual relationships in which the best interests of various family members appear to conflict. Failure to honor the integrity of those conflicting needs can be detrimental to the therapeutic alliance.

ASSESSMENT ISSUES AND QUESTIONS FOR FAMILY ABDUCTED CHILDREN AND THEIR FAMILIES

For effective case planning and intervention, it is essential to understand the details of the abduction experience for each of the family members. Often the information can be obtained from numerous sources including the investigating officer, social service caseworker, the parent and/or the child. Within this general framework, there are fourteen areas of experience which are important in the effective counseling of families of parental abduction. See Table 11.

Table 11
Assessment Areas Specific to the Family Abduction

1. **The behavior of the abducting parent prior to the abduction**
2. **Pre-abduction behavior of the left-behind parent and child**
3. **Circumstances of the initial abduction**

4. **Communications to the child about the left-behind parent**
5. **Communications to the child about the abducting parent**
6. **Circumstances during the abduction**
7. **Specific living conditions during the abduction**
8. **Circumstances of the recovery**
9. **Authority behavior**
10. **Child's behavior/separation from the abducting parent**
11. **Child's recovery emotions**
12. **Child's reunification expectations**
13. **Left-behind parent's reunification expectations**
14. **Opportunity for a reunification meeting**
15. **Parent experience during the search**
16. **Ethnic and cultural considerations**

See Appendix E for checklist.

1. The behavior of the abducting parent prior to the abduction. The behavior of the abducting parent prior to abduction is the first area for the therapist to understand. In this area, one should examine the abducting parent's plans to take the child and the child's level of participation in abduction planning or planning knowledge. For example, was the abducting parent making plans prior to the abduction? What degree of planning was involved (assistance of family, assistance of friends, moving funds, obtaining birth certificates or passports and so on)? If plans were being made, to what degree was the child aware of this planning process? Was the child asked to keep plans for the abduction a secret or to actively gather together clothing or belongings? Parents who carry out well organized, carefully planned abductions almost always have well thought out justifications for the abductions. They justify their actions to themselves, to other adults and to the child. The child experiences rapid movement, competently executed, marked by plausible explanations for removal from the other parent. The child's perception, then, is of being cared for and attended to, reducing the initial stress or confusion of leaving the home of the other parent. Unfortunately, later during the abduction or after recovery, the child learns that the abducting parent's behavior was not exclusively focused on the child's best interests. This creates substantial disappointment and confusion for the child. Alternatively, disorganized abductions create confusion for the child, but also frequently result in child attempts to take care of, or shield, the abducting parent. Upon recovery, such children are very concerned with the status of the abducting parent, which increases the difficulties of reunification with the left-behind parent.

An additional consideration in evaluating the abducting parent's pre-abduction behavior is the presence of threats to abduct. In some cases, these threats were present during the marriage and intended to be a way of intimidating and controlling the left-behind parent. In other cases threats to abduct surfaced during divorce/custody litigation. Again, they may be intended to intimidate the non-abducting parent during the proceedings to effect the litigation, or they may have been made post litigation when the abducting parent was unhappy with the court's ruling. Whichever the case, they may point to pre-meditation on the part of the abducting parent.

In some cases, the abduction at hand may not be the only instance. A prior abduction may actually have taken place in which the child was missing. Sometimes prior abduction behavior is characterized as a failure to return the child at the agreed upon time. These circumstances require special attention during evaluation about the circumstances of the initial abduction and how the abduction was resolved. The child's perceptions of these prior abductions or abduction attempts are especially important. If the child perceived the prior attempt as an abduction they may be especially vulnerable to the fear of reabduction. Interventions that may work with most children who have not experienced a prior abduction may not alleviate or reduce their fears. The recovering parent may also be justifiably fearful of additional abduction attempts.

2. **Pre-abduction behavior of the left-behind parent/child.** In some cases, a family history of domestic violence by the left behind parent against the abducting parent or the abducted child may exist. Documentation and collaboration of these type of allegations should be sought from independent sources, such as police reports, court documents, interviews with extended family members, or the couple's acquaintances. It is also useful to review any evaluations conducted prior to the abduction which may document the relationship of the child with each of the parents. In some cases documentation may exist which demonstrates fear of the left-behind parent or an abusive relationship between the abducted child and the left-behind parent. While such a history does not justify the abducting parent's behavior, it may be inappropriate or contrary to the child's best interest to return the child to the left-behind parent. Mitigating and aggravating factors should be considered in placement and case disposition (Klain, 1995, p 43).

3. **Circumstances of the initial abduction.** The circumstances of the initial abduction represent the next area for evaluation. Was the child taken by the custodial parent? Was the child taken during normal visitation contact, or was the child taken from another location (for example, school, baby-sitter and so on)? Were there any threats, force or intimidation employed during the taking of the child? What initial explanation was given to the child for the abduction? Was the

abduction not mentioned to the child or were they told they were on an extended vacation?

Sometimes children are told that they are going away to live with the abducting parent forever. Was the abducted child told that their non-abducting parent was hurting them or did not care for them? While this area is clearly effected by the parent's pre-abduction level of planning and preparation, execution of the plan does not always match the plan. An unforeseen event or resistance by the child may require a change in plans. The abducting parent may come to believe, in addition to convincing themselves that taking the child is the right thing to do, that it is necessary to convince the child as well. Frequently, this means talking to the child about harm being done to them by the left-behind parent, until the child will verbally repeat back the adult's concerns. While the evaluating clinician should always bear in mind that a minority of parentally abducted children have been physically or sexually molested by a left-behind parent (Hatcher, Barton, and Brooks, 1992), many such allegations of physical or sexual molestation of a child are never substantiated. In some cases, allegations are a result of the abducting parent's instructions to the child pre-recovery to make a report of abuse if or when they are located by authorities. Such instruction almost always results in a child protective service evaluation prior to reunification of the child with the left-behind parent. In other cases, the allegations are legitimate. The rule is that all allegations must be investigated. This substantially increases both the short and intermediate term difficulty of the reunification and adjustment process.

4. Communications to the child about the left-behind parent. Communications to the child about the left-behind parent may also occur during the abduction period. Was the child told that the non-abducting parent abandoned them? Were they told that the non-abducting parent did not want them or love them any more? Children may have been told that their non-abducting parent is alcohol or drug addicted. Other children have been told that their non-abducting parent has died, or that the non-abducting parent is a bad person who hurt the abducting parent. In a minority of cases, parentally abducted children have been told that the non-abducting parent will hurt or kill them if they are found. Other children are told that the abducting parent is seeking to take them so that they could never see the non-abducting parent again. In some cases, there is no communication to the child about the left-behind parent, leaving the child with many questions and concerns about perceived abandonment from the non-abducting parent.

5. Communications to the child about the abducting parent. Abducting parents may tell their children that they are the better parent or that they can take better care of them than the non-abducting parent. An abducting parent may tell a

child that he/she loves the child more than the left-behind parent, or that they can not live without the child, or that the child in fact belongs to them alone.

Communications to the child by the searching parent both pre-abduction and post-abduction should also be explored. While some children will not even recall the searching parent because of their age at the time of the abduction, others will have recollections of the relationship and communications with the searching parent prior to the abduction. Sometimes when the child is young, collateral sources may provide information in this area.

6. **Circumstances during the abduction.** General circumstances during the abduction cover a broad range of events. For example, were there any name changes that occurred either of the child's name or of the abducting parent's name? Were there changes in physical identity? For example, was the child's identity changed with a hair cut, hair color change, or changes in clothing styles? Were there threats to the child of non-disclosure? For example, was the child told "they will take you away from me, we will never be able to be together again" or "I'll hurt you if you tell anyone about who you really are?"

7. **Specific living conditions during the abduction.** Specific living conditions during the abduction are important to understand. Some parental abductors move frequently in order to evade authorities, creating a fugitive life style. While some abducting parents and their children maintain a new identify while living in a new home environment, most live with relatives or friends, or move frequently, living out of travel trailers or hotels. Some children suffer from school denial, frequent school changes, or limited opportunities to be in the school setting. Such abducted children are isolated socially and suffer from a lack of peer relationships. This is particularly the case when the abducting parent is concerned about the child's ability to maintain their fugitive identity. Financial resources have a clear impact upon abduction living conditions. Were there sufficient financial resources to care for the child's needs? Limited financial resources can effect provision of medical, nutritional, educational and shelter needs. Parentally abducted children, at times, may be subtle victims of medical neglect and deferred medical care. This can occur through failure to obtain preventative care such as immunizations, diagnostic care such as medical exams, remedial care such as non-emergency surgery or regular medication, or prosthetic care such as eye glasses.

In a minority of cases, abducted children are actually subjected to abuse during the abducted period. General evaluations for physical health, physical abuse, sexual, and emotional abuse should be an accepted part of the reunification process. More specific and detailed evaluations would follow abuse allegations.

Finally, it is important to understand what the child has been told about what will happen if they are recovered. Children may be told many different things about what will occur if they are found. Especially problematic are those cases in which the child has been told that the non-abducting parent is deceased or will in some way harm them if they are found.

8. Circumstances of the recovery. The recovery experience itself may complicate the child's later adjustment. Was the child returned voluntarily by the abducting parent? Was the recovery under court order? Was there police involvement and, if so, was the abducting parent cooperative or resistant? What was the abducting parent's behavior at the time of the recovery? For example, did they make statements or behave in such a way to suggest anger, fear, or warnings to the child at the time of the recovery?

9. Authority behavior. Authority behavior is also important to understand. Were authority figures helpful and supportive to the child? In one case, the child had been hiding in the back of a cafe with her mother. When the police came, they explained to the mother that they had a court order requiring that she turn the child over to the father, with failure to do so resulting in her arrest. The child was then taken outside. Without comment from either parent or from the officer, the child was given to the father, and left on her own to make the transition from mother to father. It is also important to understand the attitude of law enforcement toward the abducting parent. If there was resistance on the part of the abducting parent's side, did law enforcement use force to gain physical custody of the child and arrest the abducting parent?

10. Child's behavior/separation from the abducting parent. Child's behavior/separation from the abducting parent is an essential area of inquiry. Was the child given an opportunity to say good-bye to the abducting parent or was the child simply pulled away? Was an explanation given to the child of what was taking place and why, or was the child left to their own conclusions as to what was taking place? Where was the child taken or what happened to the child at the time of the recovery? Was there a delay between recovery and reunification, with the child being placed in foster care or with a relative under child protective services supervision? Was the child taken to the hospital, police station, or other location pending a decision about reunification? What was the child told about the actions being taken? For example, if placed in foster care, what was the child told about why that placement was being made and what the placement would be like? If a child was immediately placed with the recovering parent, what opportunities were given to the child and parent for talking about the reunification before actually leaving with the parent?

11. **Child's recovery emotions.** The child's emotions should be noted. Did the child appear to feel guilty, fearful, happy or confused? Subsequent to the recovery, what was the child's emotional reaction to reunification with the family? Was the reunification made immediately or was there a delay, if so, what were the reasons for the delay?

12. **Child's reunification expectations.** The child's reunification expectations may be influential as well. Did the child have memory of the left-behind parent? Was the child fearful of the recovering parent because of prior messages from the abducting parent? Was the child fearful because of memories of experiences with the recovering parent prior to abduction? Did the child develop the expectation that they would never see their abducting parent again? Did the child appear to be numb, apathetic, or emotionally flat regarding the reunification with the left-behind parent? Did the child perceive that the left-behind parent was dead? In some cases children are angry with recovering parents, believing that they have been abandoned or that the left-behind parent may have allowed the abduction to occur. Frequently, children have been noted to be fearful that the recovering parent will be angry at them, blaming them for the abduction. In some cases children may have the expectation that upon recovery everything at their old home will be the same as before they left.

13. **Left-behind parent's reunification expectations.** The left-behind parent's reunification expectations are as important as the child's expectations. Some parents perceive that the child will be happy to be recovered. This is not always the case, especially when the child has been gone for an extended period of time. Such children do talk about being fearful of returning to the left-behind parent because the absence was so long. Other parents have expectations around whether the child will remember them or not. Some parents expect that there will be no residual effects, as the prior family unit is instantly recreated. Each set of expectations can have an impact on child victims, as children are generally good at sensing parental anxiety or insecurity. Left-behind parents need supportive counseling to deal with expectations versus the reality of the reunification experience.

14. **Opportunity for a reunification meeting.** In the vast majority of cases, the data has shown that there is no reunification meeting or it is very brief (Hatcher, Barton, and Brooks, 1990). In working with the child and family, one wants to understand whether their first experience involved a "hug and go reunification" or if opportunities were provided to become reacquainted and discuss what is taking place in a supportive law enforcement, social service, or mental health professional setting.

15. **Parent experiences during the search.** The search can be a variable experience for left behind parents. Searches span from one day to a dozen or more

years. Some parents are isolated and unsupported and others receive support from their communities, families and friends. Some parents are savvy in enlisting local, regional or more extensive resources, whether investigative, media attention, volunteers or financial support. Others are not and do not know where to begin. Some are paralyzed by guilt, feelings of loss and betrayal. Others are motivated and energized by their emotions. Child search activities are extremely challenging for the left behind parent to implement and sustain from a financial and emotional perspective. Additional energies are required during an already stressful time. Some families meet roadblocks whether legal, jurisdictional or apathy because of others failure to understand their loss. In extended searches, the left-behind parent and family is confronted with anniversaries of the child's disappearance, birthdays and missed holidays. Understanding the left behind parents search experience and perceptions about their search is important in assessing and planning for the treatment needs of parents and children and to understand the interaction between the two.

16. Ethnic and cultural considerations. Family abductions can take place in a domestic or international context. With the increase in multi-cultural and interracial marriages, international abductions become more probable. These cases pose special problems in recovery. Child experiences also vary depending on where they are taken, how long they are gone and abducting parent resources in the locations where children are taken. Some children, who have been gone for extended periods or who were taken to other countries at an early age may not even speak English upon their recovery and return. The need for ethnic and racially sensitive assessment and intervention has gained increasing attention in the literature (Akhtar & Kramer, 1998; Foster, Moskowitz & Javier, 1996). Ethnic and cultural considerations are important in assessment whether children were transported out of the country or not.

Failure to inquire about the circumstances of the pre-abduction period, the abduction, recovery and reunification seriously limits the therapist in understanding and responding to the nuances that apply to the individual case.

STAGE II: ADDRESS THE SHORT TERM TRAUMA RESPONSE PATTERN

Once a child has been recovered and returned home, the short term response pattern for recovered child and family will be characterized by: A) Emotional/Behavioral Manifestations and B) Environmental Circumstances.

Table 12
Stage Two
Short Term Trauma Response Pattern Characteristics

A. Emotional/Behavioral Manifestations: The emotional and behavioral manifestations are directly related to issues in the abduction experience, for example, abandonment or guilt about their behavior during the missing period.

B. Environmental Circumstances: These issues result from living circumstances during the missing period or resulting from the recovery. For example, the abduction may have resulted in name or role changes. Other children may have been taken to another country or raised in an American sub-culture different from that of the recovering parent.

In parental abductions, specific emotional and behavioral manifestations may become evident for the child and the parent. They are in direct response to the abduction experience and have specific themes and content associated with them. The following table outlines the Short Term Trauma Pattern. Each manifestation or circumstance is elaborated in the following narrative.

Table 13
Stage Two
Short Term Trauma Response Patterns

A. Emotional/Behavioral Manifestations:

1. **Safety and re-abduction issues**
2. **Child lack of control**
3. **Guilt and shame**
4. **Child conflict with loyalty demands**
5. **Parent Sense of loss and betrayal**
6. **Abandonment**
7. **Child post-traumatic play**
8. **Child post-trauma omens and dreams**
9. **Child emotional responses**
10. **Child testing of the recovering parent**
11. **Child Testimony**

B. Environmental Circumstances:

1. Name and role change and sex role identity
2. Child environment issues
3. Language barriers and cultural issues
4. Visitation

Emotional/Behavioral Manifestations:

1. Safety and reabduction issues. Most children who have been parentally abducted have initial concerns about safety and reabduction. This is expressed through reabduction dreams, reabduction play, sleep difficulties, and specific statements/fears about reabduction. Reabduction dreams frequently have to do with a child being taken away by a non-specific adult from their current parent. Occasionally, specific dreams are present that the abducting parent will again reappear and take them.

Reabduction play involves playing out an abduction, with human or animal characters, and the child's responses to the abduction. Other forms of play may involve the development of metaphors aimed at protecting the child. In one case, a little girl who was fearful of reabduction discovered a mouse under her kitchen sink. She subsequently took weapons from her Ninja Turtle toys to give to the mouse and created a Ninja mouse who she presented as her protector.

Other children have exhibited sleep difficulties, as they are fearful of the dark, fearful of going to sleep at all, or of sleeping alone. Older, more psychologically mature children address their reabduction fears directly, speaking openly about reabduction fears. This can especially become more pronounced as the first post recovery contact or visitation with the abducting parent is anticipated. Safety issues also may increase in general, for example, in children's concerns about their safety at school or other locations.

Recovering parents also almost universally struggle with the fear of re-abduction at some point post recovery. Even in the unlikely event that the abducting parent is incarcerated, at some point the parent will be released and the fear will surface. This fear is fueled by the fact that the recovering parent often did not anticipate the initial abduction. Post-recovery, they do not have confidence in the belief that the other parent may not abduct again. No amount of reassurances or reasoning assuages their concerns. Only carefully thought out and implemented safety plans help. Recovering parents are sometimes hypervigilant in their efforts to protect their child from being reabducted, only to create a new set of problems

for their child. Even though hypervigilant in their efforts, recovering parents often continue to fear their efforts being sabotaged and that the child will again be snatched.

2. **Child lack of control.** Parentally abducted children often appear to struggle with the sense of having been treated as an object. This is likely due to their lack of control over the events in their life. First, they did not have control over the planning or the actual occurrence of the abduction. Nor did they have control over the abducting parent's decision to abduct. Second, they had no control over the events around their recovery. Third, they typically do not feel that they have any control around events regarding post-recovery placement. These events lead them to feeling as though they are being treated as an object who is moved around or placed without consideration of their desires.

The sense of having no control over events and being moved about at will can lead to emotional responses. Some children may respond by feeling numb in order to avoid the associated sense of not having control over what will happen to them and feelings of being devalued. Other children may respond affectively with fear and concerns about what will happen to them in the future. Similarly, children may also experience anxiety and anger regarding those same types of issues.

In response to these feelings, children in this and similar circumstances often make an effort to regain control. One of the ways to regain control is through acting out behavior. In doing so, the child or adolescent makes a statement that they can not be taken for granted. They can not be expected to comply with the requests and demands of parents or other adults. Alternatively, a minority of children respond by seeking outside achievement in areas where they feel that they do have control, either in sports, academics or other areas. This provides a sense of being able to have control over at least one thing and to direct what will occur. Other children's response to being treated as an object is regression, reverting to behavior that is younger than their chronological age. This is an anxiety based response. Finally, a minority of children respond by becoming compliant. Their compliance is based upon their assessment that they have already lost significantly. As they do not want to lose anymore, they become compliant with whatever demands are made of them, even when the demands are unreasonable or inappropriate. This is done in order to minimize the possibility that they may lose the attention, affections, or opportunity to live with the parent whose home they have returned to. In so doing, they risk the possibility of becoming an extension of the identity of the parent to whom they have been returned.

3. **Guilt and shame.** Many children struggle with guilt and shame about the abduction event. In understanding guilt and shame, one needs to understand the child's knowledge of being abducted. If the child was aware that they were

abducted during the abducted period, does the child feel responsible for not seeking help or discovery? When children realize that the abducting parent's statements about the non-abducting parent were not truthful, they feel responsible and guilty for having accepted the abducting parent's descriptions. This is often a difficult issue for children to talk about because they are reluctant to divulge to the non-abducting parent or anyone close to them what their perceptions may have been. This rises out of guilt and shame that they were so vulnerable to the attempts to influence their attitudes. In a few cases, children do not know that they were abducted. In those cases, one must determine whether the child feels responsible for not knowing that they were abducted. Often children expect that they should have been able to see or understand everything regarding the abduction.

Another important aspect of guilt and shame are questions about whether the child was made a co-conspirator. Abducting parents sometimes ask the abducted child if they want to live with the non-abducting parent. Or they may ask the child if they would like to go with the abducting parent to live with them. Frequently, children do not understand the consequences of this type of question, readily agreeing to whatever the abducting parent wishes to hear. In turn, they feel responsible for having contributed to the abduction occurring. In other situations, demands are placed on the abducted child to assist and participate in the process of not being discovered. Children may feel guilt over their participation in this process. A minority of children have been asked by the abducting parent to tell lies under threat of injury or threat of discovery. Some of these children report having "fun" in helping evade discovery as a part of the fugitive lifestyle. In a child's mind, this may be like a game. However, subsequent to recovery, these children report confusion and guilt about this same enjoyment. One seven year old child described hiding in a building when she and her mother knew that the police were looking for them. The child's descriptions of this part of the abduction experience were excited and animated. She enjoyed being secretive and being able to hide from the police. However, this process took on a very different light for the child when the police came into the building, and were about to arrest the mother.

4. **Child conflict with loyalty demands.** Children in parental abductions are often caught with a sense of conflicting loyalty demands. The recovering parent's need for validation often creates these conflicting loyalty demands. The left-behind parent has gone through a lengthy and frustrating process of locating and recovering the child. Many road blocks have been encountered. At times, the left-behind parent has likely struggled with concerns of never seeing the child again. At times, the left-behind parent felt betrayed and victimized by both the abducting parent and the legal system's response. As a result, the left-behind parent is angry with the abducting parent, wishing that the recovered child share his/her same feelings about the abducting parent. This may be communicated either by direct questions to the child about whether the child agrees about the "bad" abducting

parent or in more subtle ways. For example, the child may overhear the recovering parent's negative statements about the abducting parent, or their desire for revenge with the abducting parent. Frequently, children report suffering from confusion over who to believe. Abducted children have had different statements communicated to them by the abducting parent and the recovering parent about the incidents leading up to the abduction. They are often told conflicting information about the other parent's motivations for their behavior and interest in the child. At the very least, the child gets the impression that both parents can not be right in their statements. The child feels pressured to choose sides.

Overall, children tend to be very good at assessing adult reactions to them, especially in situations where the risk of loss is high. In order to preserve their sense of safety, children most characteristically assume loyalty to the person they are with and overtly assume the attitudes and behavior expected of them. The long term risk of this short term adaptive behavior is that a habit of acting submissively in order to maintain relationships will continue into the adult years.

5. **Parent sense of loss and betrayal.** Recovering parents' feelings of loss and betrayal may play a significant role in post recovery adjustment for themselves and their children. During the search, left behind parents are often perceived and judged by other persons and professionals as overreacting "because the child is just with the other parent". In addition to the support versus judgments of others, parents emotional responses are influenced by feelings of guilt for somehow allowing the abduction to happen and by betrayal. Feelings of betrayal can be in response to the abductor, the missing child and often to the system. For the therapist, these are significant considerations in treating these parents. It also reinforces the point that in the minds of the left behind parents, the fact that their children are missing is a major life trauma and must not be diminished or discounted in any way by the mental health professional. Left behind parents are dealing with intense loss and grief. The dynamics of the events do not end upon recovery and reunification. Additional challenges will face family members as they attempt to normalize their lives.

6. **Abandonment.** Parentally abducted children may also struggle with abandonment issues. Abandonment can be of a dual nature. Initially, the left-behind, now recovering parent may be viewed as effectively missing from the child's life. During the time of the abduction, the child may have perceived that parent as abandoning the child. As a result, the child may experience difficulty in viewing the left behind parent as a truly recovering parent. In turn, the recovered child may have had only limited or no contact with the abducting parent for several months after recovery. Subsequently, the child has concerns about feeling abandoned, or being forced to abandon the abducting parent. In a sense, the child may then have to deal with dual abandonment from both parents. Effectively, the

child's dilemma is that no matter which parent she/he is with means living without contact with the other.

Although they often do not express it to their recovering parent or initially in treatment, family abducted children often worry about the abducting parent. They worry about their safety, their living conditions, emotional welfare and if they will see them again. Depending on the child's abduction experience and attachment to the abducting parent, they may miss the abducting parent and feel homesick for that parent. These are often feelings that children are reluctant to express because of the fear associated with misinterpretation of their feelings or subtle messages that these feelings may not be accepted.

7. Child post-traumatic play. Parentally abducted children also show signs and symptomatology seen in traumatized children in general. For example, the parentally abducted child may exhibit both post-trauma play and post-trauma mastery play. After recovery, one child who had been parentally abducted would repeatedly play out, during counseling, scenarios of caretaking involving the mother and father. She was confused about the alliances that she was feeling. Another child, nine months after his recovery, was very aware of ongoing litigation. In the course of his play, he would represent the mother and father as being in conflict. This boy ultimately announced that the children in his play wanted to get rid of both parents and to get new ones. He also played out his concerns over his lack of control over what happened to him in the conflict by placing the parents under the control and direction of the children.

8. Child post-trauma omens and dreams. Some parentally abducted children will also develop omens and metaphors around their abduction experiences. Post-traumatic dreams have been noted either through direct dreams about the incident or indirect metaphorical dreams related to their issues with the abduction. A frequent complaint involves concentration and attention problems in the school placement as children begin to try to establish some sense of security and safety, many having not attended school during the abduction. Anxiety symptoms, fearfulness, regression, acting out and aggression have all been observed in parentally abducted children. Caretakers often described impaired trust as well as separation anxiety. However, the relative frequencies of these symptoms among parentally abducted children has yet to be clearly established.

9. Child emotional responses. It is helpful to understand and examine the child's emotional responses as well. Much to the surprise and disappointment of recovering parents, parentally abducted children may often exhibit emotional bluntness upon the reunification with their parents. This bluntness may have almost a disassociative quality about it. It is a child's mechanism for attempting to deal with the conflict and confusion brought up by the reunification. This emotional

apathy may be related to their concerns about what to expect from the recovering parent as well as their own feelings of confusion and uncertainty about the reunification with the parent. In some cases, children have been told that a parent either abandoned them or was dead. Such perceptions may still be intact at reunification. It is a big step to ask a child to move from perceiving a parent as dead or abandoning them to a perception that a parent is alive and has constantly searched for the child. This emotional apathy may also extend to new significant persons in the recovering parent's life. In fact, children may resist involvement with new adults in the family, individuals they perceive as strangers. For example, children may resist establishing a relationship with a new step parent, as they are angry that the recovering parent's life has continued while the child was missing.

The recovered child also may exhibit feelings of conflict and ambivalence, stemming from confusion over parental motivation for the abduction. The child may struggle with feelings of betrayal towards: (1) the abductor for lying to them about the non-abducting parent, and (2) the non-abducting parent for not intervening or preventing the abduction from occurring.

Some children who have been parentally abducted display a lack of stability and security in their feelings. This is secondary to the changes that occur with the recovery as well as possibly having to move frequently to protect the secret of abduction. Even in cases where the child was aware they were abducted but given different perceptions about their relationship with the non-abducting parent, the child has a difficult time looking at and integrating an alternate view from what they were told. Essentially, this confusion has to do with learning that what you think is the truth may not be the truth. This can have the impact of shattering and undermining the child's trust and confidence in his/her ability to understand the world.

It is not surprising then that the child symptoms associated with family abduction also may include the general gamut of symptoms including problems with concentration, anger and acting out, defiance, withdrawal, decreased school performance, eating and sleeping problems, somatic complaints and so on.

10. Child testing of the recovering parent. With reunification, parentally abducted children frequently test the genuineness and security of the recovering parent. This can be acted out through demands for attention and affection which may be: (1) over stated or, (2) by putting themselves into potentially dangerous or unsafe situations. For example, one young girl would repeatedly sneak out at night in such a manner as to see whether the recovering parent would set limits on her behavior. In turn, this was very difficult for the recovering parent who wanted the child to like him/her after having been gone for so long. Being put in the position of having to set limits on a recovered child was quite dismaying for the parent.

11. Court Testimony. Various kinds of hearings (child custody, visitation, juvenile court, child abuse/neglect proceedings, and/or criminal prosecution) may follow family abduction. Testifying in proceedings that so directly affect their parents and themselves is a major event in the adjustment of recovered children. Recovered children sometimes express concerns that they will be reabducted. Sometimes they feel responsible for what happens to the abducting parents and assume responsible caretaking roles for their parents. Most recovering parents have the desire to have the abducting parents held responsible for their feelings of betrayal and loss. They feel revictimized when custody is disputed and relitigated. This is often a very difficult issue for recovering parents as they do not understand why or how custody issues can be revisited in view of the crimes committed against their children.

When a child's court room testimony is required, there are seven areas which must be addressed: (1) child anticipation of testifying, (2) child reactions to court delays, (3) child pre-trial preparation, (4) child disclosure and guilt over their part in the abduction, (5) child fear of confronting their abductor/recovering parent and child concerns about family presence during their testimony, and (6) child concern/feelings of responsibility about the outcome.

First, in looking at a child's anticipation of testifying, it is important to look at their interpretation about what that means for them. For some children, it is beneficial to role play the steps in the legal process. Testifying is perceived by them as an opportunity in which they can stand up for themselves, regaining a sense of control and self-assertion. For others, the anticipation of testifying is an overwhelmingly frightening event which may be perceived as a revictimization. Sometimes children fear that they will be held responsible for the abduction. In cases of sexual exploitation, children frequently express concerns that if the judge does not believe them, they will be sent to jail. It is the child's belief that someone is going to be held responsible and if the judge believes the adult, they will be held responsible.

The second area involves the child's anticipation of testifying and their reactions to normal court processes and delays. Children, as is true of most adults who do not work closely with the legal system, do not understand the normalcy of delays and continuances. First, it is helpful to children as well as family members to explain and diagram in writing normal steps of going through the legal process. Such explanations need to include the different types of hearings, their purpose, and who is present at the hearings. Second, it is helpful to explain that delays and continuances do not mean that their feelings or thoughts are not important, but rather that these delays are a normal part of the process. A third element to

examine with the child's anticipation of testifying is the child's expectation of possible outcome.

The third area which requires attention is pretrial preparation. In preparing children for the court process, the children's concerns should be reviewed by both the attorney and the mental health professional. Children can feel intimidated and bullied to respond in specific ways which may or may not be consistent with their needs and feelings.

The fourth area involves child disclosure and their guilt and embarrassment associated with the abduction. As discussed earlier, these children often feel they are at least in part responsible for not preventing the abduction or for their part in hiding during the missing period. They may be concerned that others will view them as responsible. Of specific concern, abduction victims who were sexually victimized or demeaned while missing often have concerns about court disclosure of these events. Young children and adolescents alike report feelings of intense embarrassment in such situations. They share concerns about being perceived as weak, vulnerable, and being subject to revictimization by others.

The fifth area for the child victim is fear of confronting the abducting or left behind parent in the courtroom. Often, court will be the first time that the child will have seen the parent since their location was discovered. Children raise concerns on several levels including their safety, fear of the parent, and/or fear of getting in trouble by the parent. Sometimes victims bring up concerns about having to relive and tell the details of the incidents during the abduction. Some victims wish to have their families present in the courtroom while they testify and others do not. Families often have a difficult time understanding when the latter is the case. It is very important for the mental health professional to work with all family members to respect the needs of the child victim in this regard. This process and anticipation of it in itself can result in significant distress and anxiety.

Finally, the sixth area is child victim concern/sense of responsibility for the outcome. The desired outcomes for child abduction victims are often different than those of others around them. For example, recovering parents may think that their recovered children are angry about the abduction and want abducting parents held responsible as they do. Extended family and recovering parents are often surprised to learn that the children are unhappy that their abductors had received a sentence. In turn parents may be angry with recovered children for not supporting their need to be vindicated. They may forget that the child has two parents and feels responsible for what happens to them.

Several publications are designed to help the professional working with children going to court (Barth and Sullivan, 1985; Bernstein, 1982; Bernstein et al.,

1982; Gothard, 1987). Other resources are for use with or by the children themselves (Beaudry and Ketchum, 1983)

Environmental Circumstances:

1. Name and role change and sex role identity. Cases in which children were made to change their names and roles can present particular difficulties, especially for young children. When children and their abducting parent have taken an assumed name and have been gone for a length of time, the children may be confused about what their real name is, as well as that of their abducting parent. This confusion can often be picked up by asking the child what their name is, or if they have an alternate name. The same can be done during interviewing for the name of the abducting parent. The child may often communicate understanding of the abducting parent with the label of the assumed name but not their legal name. For example, the child may communicate confusion and inability to discuss the matter. The child may also see the abducting parent with the assumed name as two persons. When there are name changes, children have been observed to have difficulty understanding what their role is relative to the abducting parent (depending on which name they are using to refer to themselves). During the mental health professional's interview, a child's response may depend on whether the questions asked use the abductor's assumed name or legal name. For example, a child may give very different information when questioned using the parent's assumed name than when questioned using the parent's legal name. Obviously these factors are important not only from the immediate psychological treatment perspective, but also from a later forensic perspective if there are civil or criminal proceedings against the abducting parent.

Name changes can also occur with the recovering parent. Since parental abductions can be quite lengthy, recovering parents may have taken legal steps to either change their name or may have remarried.

Whichever the case, one needs to look at how the child understands the name change and how the child perceives himself relative to that name change. For example, if a person has remarried or simply changed their name, the younger child may now perceive that the adult is no longer their parent. New children may also be present in the recovering parent's home, either in the form of a stepchild or a half-sibling. Each such relationship needs to be individually assessed with each child.

Children who have been forced to assume the appearance of the opposite sex during the missing period face another challenge. Developmentally, children generally establish sex role identity of being a male or female at about the age of three. Assuming the appearance and role of the opposite sex can interfere with or

confuse young children around sex role identity issues. Some children will have to go through a process of re-establishing their sex role identity. Others may feel some embarrassment or confusion about what assuming an opposite sex role identity says about them. They may be embarrassed to bring the topic up. They are equally concerned about what the clinician will think of them if they reveal that they pretended to be the opposite sex. They do not have the ability to attribute the behavior to the demands of the abduction situation and separate the behavior from themselves and personal culpability. It can often be a buried issue that goes not get addressed unless the educated clinician brings the topic up.

2. **Child environment issues.** Parentally abducted children may also experience anger at being taken away from the environment created by the abducting parent. Certainly, the environments created by abducting parents are not always negative. The abducted child may well resent being removed from that environment, having established a close bond with the abducting parent. It is only natural that they experience concern for the welfare of the abducting parent and the consequences of discovery to the abducting parent. Finally, children who have been abducted may be disappointed as they discover the weaknesses of the recovering parent. Few recovering parents are able to live up to being perfect individuals, with the ability to recognize and respond to each of the child's demands.

Obstacles in this area may especially occur in recoveries involving teenagers. If the teenager has not had a negative or abusive experience with the abducting parent, been in the home of the abducting parent over the course of many years, have an established circle of friends, and have a sense of success within their school environment, they may not be receptive to being uprooted to live or even visit a parent who they do not know or have not seen for a period of years. It is not unusual in the recovery of a family abducted teenager for the teen to challenge return to the searching parent with pleas for consideration of their "rights" and needs. Sometimes teens threaten to run away if they are placed with the searching parent and therefore removed from their established group of friends and the life they have built during the years they were missing. Removal from their established routine and placement with the searching parent may not be appropriate or serve the teen's best interest.

3. **Language Barriers and Cultural Issues.** International abductions can pose a unique set of circumstances in which the returned child is monolingual and/or has limited ability to speak the recovering parent's language. For example, some children who have been taken to a foreign country at a very young age may only speak the language of that country. In some cases the language barrier has made it especially difficult for the child to address the specific defined issues because of the limitations on communication with the recovering parent or others in their

environment. Not only are they faced with becoming acquainted with the recovering parent but also face learning a new language and culture. These children may feel even more isolated.

For some children who have lived in foreign countries which are antagonistic to the American government or culture, they are also faced with going to a country which they have been taught is unfriendly, hostile and responsible for the problems in the country where they lived while missing. The most extreme examples have come up in cases where children have lived with extended family in Middle Eastern countries. Because of what they have been told about the United States, they may fear for their safety. In addition, they are reluctant to discuss or verbalize their concerns out of fear of reprisal. These children have another layer of messages they must untangle, not only about their recovering parent but also about cultural attitudes, alliances and beliefs. One such child recounted how she felt when she returned to the United States to live with her recovering mother. As she got off the flight she immediately felt fearful and began to vigilantly look around for uniformed officers. She had been told that authorities in the United States did not like people from the Middle East and routinely arrested them for no reason. She expected that since she had lived in the Middle East for so many years it would just be a matter of time before she was arrested. The ride home was an anxious one, not only because she had no independent recollection of her mother but, also, because she expected to be mistreated and discriminated against by all around her.

4. **Visitation post-recovery.** Because the majority of missing children are returned to the searching parent, this issue will typically be in reference to visitation with the abducting parent. Some children feel abandoned by the abducting parent and because of the limitations on their contact with that parent. They want to visit the abducting parent. Other children may be fearful or ambivalent about contact with their abductors.

In other cases, the child is not returned to the searching parent. They may remain with the abducting parent or be placed with another family member or in alternate care. The child may have similar concerns or ambivalence. They may be eager to resume contact with the searching parent or they may be frightened. Whatever the situation, the clinician must explore the child's feelings about visitation with either parent and the reasons behind those feelings.

Coordination of services with the therapists treating the recovering and/or abducting parents to facilitate comprehensively addressing the issues optimizes adjustment.

Brief or Time Limited Therapy

A number of families are only interested in immediate symptom reduction or resolution. They are not interested in addressing the longer term issues as discussed in Stage III. In those cases, treatment will stop at this point. Some families who stop treatment at this stage will not return for additional intervention. Others will return at a later time to address additional issues as they evolve, often with a different clinician, either due to the family relocation or therapist unavailability.

This manual is designed to be beneficial in identifying and addressing child or family issues at whatever point they enter or re-enter treatment post recovery. It is also designed to address a brief short term model of treatment or longer term interventions.

STAGE III: THE LONGER TERM TRAUMA RESPONSE PATTERN

The longer term treatment issues emerge in two steps or phases. They are summarized in Table 14.

Table 14
Longer Term Trauma Response Pattern

A	**Review of Event Related Issues:** Events that occurred during the abduction and as a result of the abduction are revisited in an attempt to master the experience. The goal is to integrate the abduction experience and address unresolved questions and affect.
B	**Implement Coping Methods for Abduction Related Events and/or Assumption Violations:** This includes implementation of coping methods aimed at mastery of abduction related concerns. Violations of basic life assumptions, e.g., "my parent or spouse will have my best interest in mind" and "bad things don't happen to good people" are reviewed and reintegrated.

The following table identifies the two types of issues that emerge for family abducted children and their families after recovery. As was true in the prior stage, these issues are abduction related. The specific circumstances of the abduction becomes significant in understanding and addressing the individual or family concerns.

Table 15
Stage Three
Longer Term Trauma Response Patterns

A. Review of Event Related Issues

1. Adjusting to the child's developmental level
2. Getting to know the child/parent again
3. Narrowing the perspective
4. Grieving the losses
5. Reassessing the path to the abduction

B. Implement Coping Methods for Abduction Related Events and/or Assumption Violations

1. Sorting through the messages
2. Trust and problems in attachment
3. Assumption violations

Review of Event Related Issues:

1. Adjusting To The Child's Developmental Level. One of the more challenging tasks for recovering parents is catching up with the developmental advances their child has made. The picture recovering parents often have of their child is "frozen in time" to when the child was taken. While they may expect the child to look different in appearance, making the transfer in other areas is not always an equally simple task. For example, some parents have wanted to continue to pick out their child's clothes after the recovery just as they did prior to the child being taken. This may create problems for the child who is now school aged and accustomed to making their own choices in this regard. Or a parent may still want to bath their child as they did before the abduction. This may be inappropriate for the child who is now older and feels their body space is being violated or intruded upon. Often making these adjustments may require outside intervention to remind the parent of the changes that need to occur in his/her parenting style. Some parents may be resistive to these observations because of the sense of loss that is associated with not being present during these developmental transitions.

In the longer term perspective, some parents are reluctant for their recovered child to grow up. Even several years after the recovery, some parents will resist their child growing up, wanting to make up for lost time. Others will attempt to

over protect their child and in that way also negate the child's capability and developmental level.

2. **Getting To Know The Child/Parent (Again).** For some children who have been recovered after a family abduction, the task they face is getting to know a parent who they don't remember or who they have envisioned to be deceased or forever absent. Essentially, the task may be one of living with and getting to know someone who is essentially a stranger. Some children initially have questions about whether the recovering parent is their parent at all. They look for clues that will prove or disprove that the person they are now with is indeed their parent. For example, one little boy who had no recollection of his recovering mother spent several weeks mulling this personal dilemma over in his mind. Finally he deduced that she must be his mother or she would not have pictures of him as a baby in her possession. Another child quietly debated this issue fueled by the fact that her appearance was quite different than her mother's. While her mother was Caucasian and had light hair and a light complexion, she was dark haired and had a dark complexion, resembling her Iranian father. The fact that she did not look anything like her mother made the issue harder for her to resolve. It was only when pictures from the time of her birth were produced and relatives reassured her that this was indeed her mother that she began to entertain that possibility.

While other children struggle less with the question of whether the recovering parent is indeed their parent, they may view the recovering parent as essentially a stranger. They have no recollection of the parent and the relationship must be built from the beginning. Some children quietly accept the task, feeling they have no choice and a large measure of curiosity about this new parent who they know nothing about. In some cases their only information is what they were told by the abducting parent, which may be less than flattering, if not outright frightening.

Other children may have some recollections of the time that they lived with the recovering parent that have been interwoven with the things that they were told by the abducting parent. They are challenged with sorting out what they were told with what they now experience. Sometimes the information is consistent but frequently what they were told about the searching parent is disparate with what they now experience. They are faced with having the perceptions they had built during the missing period and reality challenged. Who should they believe? What should they base their perceptions on, what they were told or what they experienced? It is no wonder that some children are initially cautious and distant in their approach to the recovering parent.

For children who have no independent recollection of their parents or who have been absent from the recovering parent for an extended period of time, they

must essentially get to know their parent almost as if it were the first time. These lessons are learned in a variety of contexts. They must learn their recovering parent's expectations of them, preferences, approach and style in dealing with challenges, interests and activities, sense of humor, and so on. If they have a step-parent, the same is true of that relationship.

In the same way, the recovering parent is challenged with reacquainting themselves with their child. They have to learn about their child's strengths and weaknesses, interests, food likes and dislikes, social abilities, familiarize themselves with their current developmental level, and at the same time deal with the child's questions about the parent and the information they came to believe about the searching parent during the missing period. In some ways it is analogous to a foster parent learning about a new child who has been placed with them but with the added component of loss. During the process of becoming reacquainted, many parents are constantly bombarded with the sense of loss of time and experiences while their child was gone.

3. **Narrowing the perspective.** In some families, the abduction can become the focus for attributing all old or new problems which may arise. In some situations, the source of a problem or symptom may indeed be the abduction experience. However, some problems are clearly independent. Sometimes this narrowing of responsibility is created by the child and sometimes by the recovering parent. For example, an eleven year old girl who had been gone for nearly five years complained in treatment that the family never did any type of activity together. The recovering mother said that indeed, her daughter was right but knew why the mother was not physically active. The child, who had a lot of emotion invested in the issue became angry and then began to cry to the point that she couldn't speak. When asked why she couldn't be active the mother explained that she had been diagnosed with a disabling muscular disease. The disease had been diagnosed when her daughter was missing. The girl had assumed that her mother had developed the disease because she was missing and felt responsible for her mother's illness. This belief had also been fueled by the mother's statements that she had been diagnosed because of the stress that she was feeling while her daughter was missing.

Another child was doing poorly in school. The academic problems were attributed to the stress of being abducted and her poor attendance while she was missing. While the the missed academic exposure during the missing period certainly contributed to the problems, an observant teacher referred the girl for testing and evaluation and she was diagnosed with a learning disability.

4. **Grieving the losses.** Becoming reacquainted with one another can be a reminder for the recovering parent and the older recovered child of the losses they

experienced because of the abduction experience. For parents those losses are focused around lost time and opportunities with the child. For example, some parents feel a loss over missing their child's first day of school, or losing their first tooth. Another area of loss is financial. Extensive searches that span several months or years can be very costly, leaving the recovering parent depleted to the point that managing the day to day expenses is difficult. Some parents have to forgo the dream of owning their own home or other goals because of the financial burden. This is typically exacerbated by the cost of additional litigation over custody and visitation post recovery. Recovering parents may also grieve the loss of support of extended family and friends. Well meaning family or friends sometimes directly or indirectly blame the searching parent for the abduction. Statements are made about the searching parent's poor judgment for getting or staying involved with the abducting parent. As a result, the recovering parent feels a sense of loss in regard to significant relationships. At another level, searching parents also feel alone in their process. Others are not always sensitive to, or do not comprehend, the feelings associated with having a child parentally abducted. For example, family or friends may not be able to identify with the fear that one will never see their child again or have to live without knowing where they are or what has happened to them. Or, they may have difficulty appreciating the degree of betrayal the parent feels by the abducting parent for taking the child. Searching parents feel detached and isolated when their loss is minimized or excused "because the child is at least with the other parent." Such comments are often alienating. Another level at which those issues may occur is with authorities when the parent perceives the authorities are not as invested in locating the child as the parent. In other words, the amount of time and effort invested in the location of the child by authorities may be perceived and experienced as minimizing or diminishing the searching parent's loss. This loss can be expressed as grief or anger.

While younger children may not realize the loss created by the abduction, older children may go through a mourning process over lost opportunities in much the same way that their parents do. In addition to lost opportunities, they may also mourn over having to confront parental limitations and weaknesses that become evident in the abduction/recovery process.

5. **Sorting Through the Messages.** Family abducted children basically have to deal with two sets of messages, those from the abducting parent and those they receive post recovery from their recovering parent. The messages from the abducting parent were typically communicated during the missing period about their life before the abduction, the searching parent and why they were abducted. The messages from the recovering parent may similarly be about life before the abduction, the abducting parent, the search efforts for the child, and the parent's current feelings and attitudes about the abducting parent. It is rare that the

messages from the abducting parent and the searching parent are consistent. And in some cases the child may be faced with a vacuum of information about the searching parent. In some abductions there is no mention of the left-behind parent. Sensing that the abducting parent does not want to talk about the left behind parent or that questions generate anger, children learn not to ask.

During the initial period after recovery and often extending well into treatment, children engage in a process of trying to figure out what to believe. Some children outwardly adopt the messages of whichever parent they are with but this is typically only a facade beneath which the questioning and assessment takes place. Other children openly challenge the recovering parent with the messages they were given by the abducting parent. For some children this serves as a test of the recovering parent. For others it is a way of supporting or maintaining the beliefs and world view they adopted while living with the abducting parent. These are children who have been so fully indoctrinated that not questioning the information they have about the recovering parent would require them to abandon their basis for interpreting the world. Other children by nature have a rigid make-up that makes it difficult for them to assimilate and respond to discordant information.

Implement Coping Methods for Abduction Related Events and/or Assumption Violations:

1. **Reassessing the path to the abduction.** A long term issue for some recovering parents is the question of "how did I get into this mess?" The factors that are examined are: 1) outside or other variables, for example, what were the abductor's dynamics or shortcomings that led to their behavior? 2) Personal control variables specific to the abduction, for example, what could I have done to predict or prevent the abduction? 3) Interaction or relationship variables, for example, what dynamics between us led to the abduction and what do I look at in the future to prevent getting caught up in a similar dynamic? 4) Personal dynamics issues, for example, what personal dynamics or ways of viewing the world led me to choose the relationships that I do? While individuals may focus on one or more of these questions and get focused on self or other directed blame, the successful resolution looks at and integrates each of the elements.

2. **Trust and problems with attachment.** While child and parent both face immediate issues of trust post abduction and recovery, a deeper, longer term set of trust issues also emerge. The immediate issues typically have to do with trust as it relates to the abduction and current safety issues. The longer term issues tap into personal doubts. After getting some temporal distance from the abduction, children and adults go through a re-evaluation process in which they may realize that their perceptions were inaccurate or incomplete. In turn, doubts about whether their

perceptions and judgments are accuratein other areas and relationships may also emerge. This level of doubt exists at a personal level.

Doubts that are "other" directed may also emerge. Feelings of betrayal associated with the familial abduction can be especially poignant because the betrayal took place by a person or persons who the child believed they could trust to have their best interest in mind. When the betrayal occurs by such a central, significant figure in their life, it can result in a breakdown in the overall ability to trust in any significant relationship. The same dynamic can develop for parents, especially if there is a past history of similar interpersonal boundary violations.

In some cases, a family abducted child may have been abducted at such a young age that the abduction has resulted in serious interference with the child's attachment to the recovering parent. Some clinicians (Ainley, 1995) believe that any separation between a parent and their child extending more than two weeks presents a serious interference with the bonding/attachment process. The consequence is a child who may have a deficit in their attachment with the parent. These may result in attachments that are overly dependent, hostile aggressive attachments, avoidance to attachment and so on. When this occurs specific treatment for attachment disorders will be necessary.

Attachment issues may be associated with either or both parents. The nature of each attachment must be explored.

3. **Assumption Violations.** These are child and family responses to violations of basic life assumptions. The basic assumptions violated in an abduction fall into four categories: (1) assumptions about people in general, (2) assumptions about a meaningful order about how the world works, (3) assumptions about personal integrity and vulnerability and (4) assumptions about the integrity and competence of significant other persons. In cases of family abduction, there are added assumptions that may be violated. Parents generally assume that if they are loving and good parents, their children will grow up unharmed in any significant way. Also, there is the child's assumption that the world is good and their parent will protect them. Children also have a basic trust in authority and that adults generally act in the best interest of children.

The assumptions that fall into the first two categories have been discussed by Janoff-Bulman (1992). In her book, *Shattered Assumptions*, she divides life assumptions into those core beliefs about the external world, ourselves and the interaction between the two. She describes how most people believe the world is a good place and that people are generally "good, kind, caring and helpful" (p. 6). People also assume that events are generally positive with more positive outcomes than negative ones. It can be argued that this belief is based on our general

experience that things that happen to most people most of the time are good. People are typically optimistic about their own future. Further, people believe that misfortune is not random or without meaning. We generally ascribe to the cultural belief that things are just and happen for a reason. Typically we look to this justice as being personally or family based justice. Most of us have a difficult time looking at the possibility that we do not have control over all the events in our life and that things can happen even though we were not negligent or didn't do something to cause the event. Our very economic system is based on the belief of rewards and punishment. Therefore, our assumptions about our personal fate is one of "security, trust and invulnerability" (Janoff-Bulman, p 18). We believe in our own integrity and virtue which makes us worthy and protects us from negative random acts. Therefore the final assumption is that "because I am a good, competent, careful person, nothing bad can happen to me."

We also make assumptions that those who are closest to us by nature or design, such as marriage, will love and care for us. By nature of our relationship of being parent-child, husband-wife, best friends, doctor-patient, and so on, we expect the other person will act in a manner consistent with our needs and best interests. We also assume that if we do a good job in our capacity as a child, parent, spouse, or friend that we will be rewarded with a favorable outcome in that relationship. Thus, parents generally assume that if they are loving and good parents, their children will grow up unharmed in any significant way. Also, there is the child's assumption that the world is good and their parent will protect them. They believe that authority is right and will not harm them. Thus, children are typically vulnerable to the demands or coercion of an adult, whether stranger or familiar.

In general, our assumptions are that: (1) people in general are good, kind and caring and will not intentionally or arbitrarily try to hurt us. (2) The world is just and ordered and things do not happen to people at random unless they have been somehow negligent or bad. (3) Because I am a good competent, careful person, nothing bad will happen to me. (4) I can count on those people closest to me to not harm me, to have my best interests in mind and to watch out for my welfare. (5) If I do a good job as a friend, spouse, or parent, I will be rewarded with a favorable outcome in my relationship with that other person.

Family abduction violates both parent assumptions and child assumptions about the world. Both children and adults find that the basic assumptions they lived by and made decisions by no longer apply or work. At the very least they do not trust their prior assumptions as valid. For some people the questioning is immediate. For others the immediate response is denial or numbness and the questioning begins later. Whenever the questions begin, the challenge is the same. Both child and adult reassess their assumptions and beliefs about the world, about people and relationships. Then they must rebuild the assumptions that will guide

their beliefs about how the world works and their personal capability to deal with the world. This is a critical process in trauma recovery because it dictates how the individual will interact with people and their environment, possibly for the remainder of their life. For example, some individuals may determine that the world is dangerous and people cannot be trusted. Behaviorally this may translate into the person becoming phobic, isolative, depressed , anxious, or hostile. These feelings then become the seeds from which new or modified coping styles develop. For example, hostility can be used to create a protective barrier by keeping people at a distance.

While discussion of all the variations in how assumptions may be reworked is not practical, another version which merits discussion is the assumption that people cannot be trusted. This can develop whether the abductor was known or not known to the abduction victim. The assumption leads to the individual not being able to trust significant persons or relationships in their life. Although they are able to initially establish a bond or have the appearance of engaging in trusting relationships, they inevitably began to question or test the other's sincerity. Through their questioning or testing, they inevitably push others away. When the other person pulls away, it further reinforces their belief or assumption that others cannot be trusted.

Certainly this process is not solely dependent on the abduction process. This is where understanding the other stressors and life experiences of the parent, sibling or abducted child is essential to the clinician's work. As referenced earlier, a suggested format for conceptualizing and organizing these various contributors is the double-ABCX model discussed in Chapter Two. In fact, any individual family member may already have reworked their assumptions based on a prior loss, trauma or life experience. The patient and therapist may be working with the abduction as a reinforcement of a prior life assumption.

Working with individuals who are reassessing their assumptions is a process rather than a state. Often the clinician will recognize the process in the individual who begins to discuss their belief about the trustworthiness of people. Sometimes the process is characterized by expressions of disappointment about people or humankind in general. For example, they may state they are disappointed that there are people in the world who can hurt others without remorse. Or the process may be characterized by statements about how they don't understand how a person could hurt someone else. These expressions of "disappointment" or "having a hard time understanding" are indications that the process of reassessing assumptions is fluid and still ongoing.

Other indications that a person is engaging in the process of reassessing assumptions are questions like "why did this happen to me" or "what is the

meaning or purpose of this event for me." There may also be a self assessment in which the person looks at their responsibility or guilt. As Janoff-Bulman states, this is not necessarily a negative process. Guilt can be assumed at two levels, internalized self loathing which is damaging or assessing ones actions in order to re-establish a sense of control over one's life. The later may lead to a renewed sense of empowerment.

For the clinician it is important to recognize that: (1) rebuilding assumptions is a process which takes time. (2) The process of rebuilding assumptions cannot be rushed or arbitrarily decided. Individuals must take into account past experiences and questions about people and the world before they can truly rebuild an assumption. (3) As long as the person has not clearly defined an assumption and is still in the process of rebuilding, the clinician has the opportunity to assist the process of building healthy assumptions that will allow the person to optimally function in the world. (4) It is improbable that most people can go through an abduction experience without making some adjustments to prior pre-abduction assumptions.

Perhaps the larger challenge occurs when the parent, sibling or child comes in years after the abduction incident, not because of concerns related to the abduction but rather because of interpersonal difficulties or mood related symptoms based on their rebuilt assumptions. In those cases it is necessary to determine the current life assumptions and the experience base of those assumptions. Therapy can then proceed to examine how those assumptions impact their interpersonal relations and mood. Other life experiences may be identified that could allow the person to approach the world with a somewhat modified framework.

PHASE IV- TERMINATION/PERIODIC RECONTACT FOR CHILDREN RECOVERED FROM FAMILY ABDUCTION AND THEIR FAMILIES

The amount and length of treatment required will clearly vary from case to case depending on a series of variables including the abduction experience, other stressors, individual coping abilities, and psychological mindedness. Another pivotal factor in family abduction cases are the relative psychological health of the parents and subsequent parental adjustment after the recovery and reunification. Recovered children and family members will vary in how salient the various defined themes will be for them, when these themes will emerge, and their resources (whether developmental or psychological) for coping with and working through these issues. From a developmental perspective, child victims may have progressed as far as possible for their age and developmental capabilities in resolving issues. In fact, some issues may not emerge until a later developmental milestone is obtained. In other circumstances issues may emerge or re-emerge after

a trigger event. For example, for a recovering parent it may be when the child moves to another level of independence and there are demands on the parent to relinquish some parental control which in turn precipitates anxiety or depressive symptoms. For a child it may occur when a problem develops with one of the parents or a parent develops a problem in a new relationship. There are endless developmental and situational precipitants that may result in the return to treatment.

In general, the best policy is an open door policy for the victim and the family to return to treatment for intermittent periods when the need arises. These intermittent recontacts may be very brief, for example four or fewer sessions. Circumstances often develop where a therapist is leaving an area or the victim and/or family leave the area. When possible, the therapist should provide referrals for follow-up contact if the family remains in the area and the therapist is no longer available. In cases where the family or victim are relocating to another area, the therapist may want to provide resources that may be helpful in identifying potential therapists. Some possible resources may be Victims Witness, often located in the local district attorney's office or local and state professional associations. These may include state psychological associations or state licensed social worker associations.

CHAPTER SEVEN - FAMILY CHILD ABDUCTION-FOUR FULL LENGTH CASE HISTORIES

The first two cases are presented in the Double ABCX format to demonstrate the utility of gaining information about the abduction experience and assist in assessing individual and family functioning. The Double ABCX format also provides a useful way of organizing the information as it comes in over the initial evaluative meetings as well as new information that comes out during the course of treatment.

The second two cases, cases three and four, incorporate all of the same material but are organized according to abduction related issues. The issues are presented sequentially as they appeared in treatment and are italicized to assist the reader in their identification. They illustrate the material presented in the prior chapter. Treatment interventions are discussed. This format allows the reader to explore the issues as they may appear in treatment.

Table
Case Study Questions
Cases 1 and 2

1. How does an actual case look using the Double ABCX Model?
2. What kinds of information can be generated using the Double ABCX Model to organize and conceptualize a case?
3. How do the various factors impact the child and victim?
4. What types of symptoms and impact do you see in actual cases?

DOUBLE ABCX MODEL CASE PRESENTATION
CASE #1

The first family or parental abduction case involves a single five year old child. The marriage between her parents had been a second marriage for the father. His children from his first marriage were already adults. The father was 16 years older than the mother. After the couple were married, they moved from the southeast to a city in the southwest for work opportunities. Marital discord developed around the father's excessive drinking and the mother's unresolved

issues about a lonely childhood. After several years they were separated and divorced. Disputes over visitation began almost immediately and involved litigation. The mother had moved in with another man. The father and mother's boyfriend would frequently get involved in confrontations when the father would arrive to pick up the child. After a period of time, the mother chose to leave with the child and go to another state. The whereabouts were unknown to the father. The mother had custody and the father was told by the authorities that he could take no action regarding the disappearance. It took several months before he was able to establish his daughter's location. Subsequently, the mother returned to the southwest city where the father was still living. Visitation resumed, as did the disputes. Additional problems erupted when it was learned that the child had been molested by a male friend of the father's whom he occasionally allowed to stay at his house while the child was visiting.

The Family Crisis Event (Factor A). The family crisis event began after the child alleged that the father's friend had molested her. With the already antagonistic relationship between the child's natural parents, the mother began to blame the father for the molest. She began to raise questions about whether the father actually knew about the molest and had not intervened. This was made despite the fact that the child had initially disclosed the molestation to her father and he made the initial police reports. Subsequently, the child alleged an incident of physical abuse by the father in which the father had slapped the child when she was non-cooperative. The father admitted this incident and was agreeable to seeking counseling and establishing supervised visitation. The mother expressed ongoing concerns about the father being involved with the molestion of their daughter. Eventually the child began to make statements about the father molesting her in the same way as his friend. An investigation ensued and the father was cleared of all allegations. At that point, the father resumed supervised visitation. The mother announced to the child's therapist, who was working with the child on molest issues, that she was moving to a different apartment closer to her work the following weekend. Subsequently, when the father attempted to locate the mother, he was unable to do so. There were no contacts with the father by the mother. The child was not brought in for her next regularly scheduled therapy appointment.

Due to the prior incident where the mother had taken the child out of state, the father had immediate concerns that the mother had abducted the child. He sought police assistance but was told that it was a domestic matter. Subsequently, the father hired a private investigator. The mother failed to produce the child to testify at the criminal case against the father's friend. Subsequent to this incident, the father sought to obtain a temporary custody order. He was successful in getting the order. Leads suggested that the mother may have gone back to the state where they met and married and may be with friends. With court order in hand the father went to that locale. The child and mother were known to be in a service station

where the mother worked. They were hiding in a room in the back of the station. Upon finding them, the officer informed the mother that the father was present to pick up the child and that if she did not comply with the court order she would be taken to jail. The mother complied with the court order and took the child to the father's vehicle. The child left with the father. No reunification meeting was held.

Family Stressors Other than the Abduction (Factor a). This family experienced several significant family stressors other than the abduction event. The mother had very limited financial resources. Both she and the boyfriend with whom she resided worked on a part time basis. Making ends meet was very difficult at times. The mother also experienced problems in her relationship with her boyfriend. While he knew of her plans to abduct the child, he was not interested in participating and did not accompany her when she left. The child also had ongoing school difficulties including problems with short attention span and poor concentration. Due to the severity of these problems, the school was pursuing a cognitive evaluation of the child. In addition, the child had an actual history of molest. The father's friend acknowledged that he had indeed molested the girl. She showed typical post-traumatic stress symptomatology associated with that event. There was pending criminal court action regarding those molestation charges requiring the child and family's involvement. The father, during the course of the allegations of physical abuse and sexual abuse, had moved in with his significant other and her teen-age children. As a result, the child was faced with establishing relationships with her father's new family. While the father had addressed his excessive drinking, the conflicts between the mother and father had been ongoing. The conflicts reached the point that on one occasion the father and stepfather got into a physical altercation when the father went to pick up the child.

Pre-Abduction Family Crisis-Meeting Resources (Factor B). Pre-abduction family crisis meeting resources typically involved avoidance or distancing as viable coping mechanisms on both parent's part. If there did not appear to be a solution to a problem, the response was to leave the area or the situation. The father had a long established pattern of denial that he had developed during the time when he used alcohol excessively. Decisions tended to be emotion based.

Post-Abduction Crisis-Meeting Resources (Factor b). Post-abduction crisis meeting resources included soliciting legal consultation on the father's part. Through the legal consultation he was able to obtain a temporary custody order allowing him to take physical custody of the child upon locating her. There was also the immediate involvement of a private investigator to assist in locating the child. The extended family was supportive both financially and emotionally and provided information to the private investigator.

Pre-Abduction Perceptual Definition of the Family Crisis Event (Factor C). The father's pre-abduction perceptual definition of the family abduction crisis event was that the mother may abduct the child since she had taken her on one prior occasion. He also knew from experience during the preceding months and years that the mother would try to influence the child in an effort to deny the father access to the child. This was reinforced by the unsubstantiated allegations of sexual abuse made toward the father in the months preceding the abduction.

Post-Abduction Perceptual Definition of the Family Crisis Event (Factor c). The father's post-abduction perceptual definition of the family abduction crisis event was that the child had not been adequately cared for by the mother during the abduction. He raised concerns about whether she had been adequately fed, bathed and allowed to sleep. After the recovery the child slept excessively.

He interpreted this to mean that the mother did not care for the child's needs. He generally believed that the child was not disturbed by the event of the abduction but at the same time believed that she was angry at her mother. This was based on the fact that the child had made a statement that she was angry at her mother for not calling. Other than this, the child did not discuss the mother. Based on the child's infrequent comments, the father assumed that the child had no interest in seeing the mother or that she would request to do so. At the same time, he also perceived that the mother was neglectful because she did not call or talk to her on the phone even though the opportunity had been provided.

Because of the temporary custody order and the fact that the mother did wish to retain custody of the child, the mother also consulted an attorney. The father was of the firm belief that the child's fears relating to him were due to the mother's efforts to instill those fears in the child. While he was open to and hoped that his daughter would have ongoing contact with the mother, he felt strong in his conviction of wanting custody of the child. He was also concerned that if he was not awarded custody that she may reabduct the child in the future.

Immediate Experience of Stress Due to the Abduction (Factor X). The father's immediate experiences of stress due to the abduction was anger with the mother for her actions. He was angry not only that she had taken the child again but also that in his eyes she had attempted to influence the child to make the allegations of sexual abuse against him. Based on his prior experiences, he expected that there would be no assistance from authorities in locating his child. At the time of recovery he felt a great deal of relief and held the expectation that there would be no residual effects to the child since she had been with her mother. He also hoped that the child would be able to return to live with he and his significant other and her children to create an instant family.

The child experienced feelings of confusion. She was uncertain how she felt. She would make comments about not knowing who to believe and at times would endorse the statements of her mother and within minutes endorse the statements of her father. She expressed concerns about her left-behind tearful mother and her mother's welfare. She appeared to feel some sense of confusion and guilt associated with not having the opportunity to say good-bye to her mom. She expressed in therapy that in reality she wanted to see her mother and that she missed her mother even though she was not stating this directly to her father. During the time of the recovery she felt a sense of intrigue and excitement in hiding from the police, however, this excitement quickly turned to fear when the police officer found them in the back of the cafe and announced to her mother that she would be arrested if she did not comply with the court order. The child discussed how she did not know how to respond during the recovery, whether to hug her mother or to go with her father. The child slept excessively during the first two days after the recovery. The recovery had been emotional and confusing for her. She felt caught between the two people she loved most, and didn't know what to expect. Her mother had told her that if found, her father would hurt her. And she felt guilty for not giving her mother a hug good-bye.

Intermediate and Long Term Experience of Stress Due to the Abduction Event (Factor x). Both the child and the family showed intermediate and long term experiences of stress due to the abduction event. The child expressed ongoing confusion about the conflicting messages she was receiving from her mother and father. This was in regard to the statements that had been made to her while she was gone as well as the statements that had subsequently been made by her father post-recovery. She also had ongoing questions about her mother's welfare and when she would be contacted by her mom. The child had become quite proficient at monitoring and responding to parental assumptions to gain approval and acceptance. She would state to her mother the things that her mother would wish to hear and in turn tell the father contradictory things when she was with him. She expressed an ongoing concern of reabduction. While she wanted to spend time with both her mother and her father, she also was clear in stating that she was concerned about whether her mother would try to take her again. Difficulties with concentration and attention were ongoing and as a result she was evaluated for learning disabilities and attention deficit disorder. She was diagnosed with learning disabilities and placed in a resource classroom. She seemed to improve with increased structure in the home and school.

Despite the father's desire to allow his daughter to have contact with her mother, he expressed an ongoing distrust of whether she may again try to abduct the child, sabotage his relationship with her or make new allegations of abuse. As a result, when his daughter made medical complaints, he would immediately take her to the school nurse or physician rather than doing any evaluation on his own.

There was ongoing stress due to pending litigation regarding custody and visitation. Subsequent to the custody hearing, in which full custody was granted to the father with visitation to the mother, the child returned from visitation expressing that she had been told to keep a secret by her mother. This raised substantial concerns on the father's part as the last time she had made such a statement to him it had been regarding the mother's plans to abduct the child. The child went on to tell several sources that the secret was that the mother was angry at the judge and was going to reinitiate custody proceedings when she could save the money to do so. She made the promise to the daughter that she would soon be living with her. The child stated that while she would not mind living with the mother she also enjoyed living with the father. With the ongoing conflicts and controversy, the father's relationship with his significant other also ended.

CASE # 2

The second parental abduction case involves a mother abducting one child. The mother had a military police background and the father had recently left the military to enroll in a criminal justice training program at a junior college. The mother had been married once prior to marrying the child's father and had one child from that marriage. The father had also been married once prior to his marriage to the child's mother and had one child from the first marriage.

There was one child, a daughter, who was the product of the parents' marriage to one another. After their daughter's birth, there were allegations of marital violence and non-prescription drug abuse resulting in a series of separations and reconciliations. During this conflicted period, it was learned that the daughter suffered kidney failure and lost one of her kidneys. Allegations of physical and sexual abuse, as well as neglect, were extensive. There were several custody disputes originated by the mother. Despite allegations by the mother that the father had been neglectful to the child, the court made a determination that these allegations were not substantiated and maintained custody with the natural father. The relationship between the natural parents was bitter and conflicted.

The Family Crisis Event (Factor A). The family crisis event began after the custody dispute in which the father was awarded custody. The mother at that time threatened that she would abduct the child. Due to the father's concerns about the ongoing conflicts, he sought and was granted a court order to move from Pennsylvania to Florida. In June the child was picked up by the natural mother and her new boyfriend for summer vacation. The visitation order stated that the child would visit until the beginning of the school year and during the interim, the father would have the opportunity for phone contacts with the child. The child, along with the mother and boyfriend, returned to the mother's home. Over the course of the

summer, the father made numerous attempts to call the child. He eventually made arrangements to call on a certain day and time due to the difficulty in making contact with the child. Over the course of the summer, he was successful in making two actual phone contacts with the child. His concerns were raised when his daughter made a comment about moving and about her mother cutting and curling her hair. The following week when the father called, he learned that the mother's phone had been disconnected.

Over the next 32 months, the child was missing and the case was investigated. The investigation involved several law enforcement agencies in four states. The investigation was complicated with lack of interagency coordination and communication. The father would alternate between losing hope and pushing himself forward to continue efforts to locate the child. One day, in his junior college work placement at a local police department, he saw a teletype indicating that the mother had been arrested on a military post for illegal weapons possession. There was no mention of the abduction warrant or whether the child had been found. Without knowing whether the child was with her mother, the father flew to the state where the mother had been arrested. Once there, he learned that the child had indeed been living with the mother and the mother's boyfriend, who was in the Air Force. The mother attempted to have the child legally detained. The father hired an attorney, was allowed to be reunited with his child, and to return to his state of residence with the child.

Family Stressors Other than the Family Crisis Event (Factor a). For the father, family stressors other than the family crisis event included alienation from his older son. During the course of the custody dispute, the father's children had made sexual abuse allegations that the father had abused them during the period when they were growing up. Because of a sense of betrayal by his son's statements, the father's contact with his extended family initially diminished, and then became non-existent. Another source of stress for the father was limited financial resources. Any money which he may have been able to save had been used in the prior custody litigation. Due to relocating to a new area, the father also had limited external supports and friends. The father had only lived in the area for one month when the child had gone for visitation with her mother. The abduction occurred only three months after his relocation.

By history, the father also had a tendency toward high levels of anxiety. He had experienced prior episodes of anxiety attacks. Although he had not been a drug user during the course of their relationship, the father's live-in girlfriend had a history of substance abuse problems. Since the time of their relationship he was an active member of Alanon.

Pre-Abduction Family Crisis-Meeting Resources (Factor B). The father's pre-abduction family crisis resources were marked by his tendency toward depression and withdrawal when he faced difficult situations. Over the years, he had also come to waiver between a response of passive acceptance and apprehension in response to the child's mother. This behavior was exacerbated by his sense of helplessness in being able to counter her ongoing accusations toward him. He had come to the point of expecting ongoing and conflict about his daughter's custody.

Post-Abduction Family Crisis-Meeting Resources (Factor b). The post-abduction family crisis resources were the father's immediate notification of law enforcement about the child's absence and the disconnected phone. He also contacted NCMEC as well as law enforcement agencies, social service agencies, state clearing houses and non-profit organizations. He solicited, and was successful in obtaining, federal law enforcement involvement and sought dual warrants from both the state of his residence where the child was not returned, as well as from the state from which the child was taken. Despite the lack of information and leads, he maintained ongoing contact with investigative agencies.

Pre-Abduction Perceptual Definition of the Family Crisis Event (Factor C). The father's pre-abduction perceptual definition of the event involved concerns about possible abduction. Based on the mother's statements to him, he feared that she would retaliate when she lost custody in the court hearing prior to the relocation. Further, he was concerned given her direct statements that he would not retain custody of the child. This had been reinforced by the mother's repetitive allegations of abuse against the father.

Post-Abduction Perceptual Definition of the Family Crisis Event (Factor c). The father's post-abduction perceptual definition of the event was guided by his ongoing fear of feeling helpless and responding to the mother's maneuvers to detain the child. He feared her military law enforcement background and that she would reabduct. He viewed the legal system, in general, as ineffective. He saw his child as having been abused and damaged by the abduction.

Immediate Experiences of Stress Due to the Abduction (Factor X). The immediate experiences of stress due to abduction included father's anxiety attacks and sense of distrust about what was going to happen in the future. He also lacked confidence in agency response given his past experiences while the child was missing. The child showed signs suggesting that she was confused about what had taken place. Upon recovery the child was reluctant to have physical contact with the father. The child appeared to have limited memories of her father and inquired about whether he had ever abused her. During the course of the abduction, the child's last name had been changed and the mother had changed her complete

name. The child exhibited confusion about her own last name. The child also appeared confused about the natural mother's name. At times, it appeared that the child was uncertain as to whether the two names represented two people or one person with two names. The child also talked about confusion as to who she perceived as being the father. During the course of the abduction, the mother had established a live in boyfriend. This boyfriend also had a young child who was approximately the same age. Subsequent to the recovery, the child was unsure as to whether the step-father was still a father.

Soon after the recovery, the child also made allegations of abuse, suggesting that she had been tied to another child as a punishment and that she had been spanked severely by the mother. The child showed signs of anxiety and somatic symptoms. She complained of stomachaches and headaches. She expressed fear and concern about reabduction including nightmares of being reabducted.

Intermediate and Long Term Experience of Stress Due to the Abduction (Factor x). The intermediate and long term experiences of abduction stress involved an ongoing custody dispute that spanned over the course of more than two years post recovery, as well as criminal charges related to the abduction. Psychological evaluations of all family members were ordered by the judge in his effort to resolve the dispute over custody. In addition to the unresolved allegations of physical abuse that the child had made against the mother, there were also the continued allegations by the mother that she had evidence of abuse by the father prior to the abduction.

The father worried about his daughter having unsupervised visits with her mother. Supervised visitation which followed by unsupervised visits were ordered. The anticipation of unsupervised visits renewed fears of reabduction for the father. The same fears were expressed by the child. The mother continued to make allegations of misconduct toward the father complaining that he was not forwarding the reports that she was entitled to from the school and other sources.

The child continued to have school difficulties. As a result, the child was evaluated. It was determined that the child was not learning disabled, but rather had ongoing fears and anxieties about reabduction. There was intermittent continuation of nightmares and sleep problems depending on the issues at hand. As with the father, the child expressed concerns about reabduction and what to do if reabducted. The child exhibited post-traumatic play. The child was quite concerned about the mother coming to the home and abducting her from the safety of the father's home. The child created magical figures, such as a Ninja mouse to protect her. In addition, the child's play also demonstrated ongoing frustrations with the conflict between the parents. At one point, the child played out a scene where a

child had control over the parents and essentially the child announced that the she needed new parents as there were problems with the current ones.

The supervised visits were approached with ambivalence by the child. In one respect, the child appeared to be happy and appreciate the opportunity to have supervised visits. However, at the same time, the child was careful to express concerns that while visits were OK, she did not wish to go to the mother's home.

The father's anxiety attacks were an ongoing issue as concerns about the possibility of reabduction increased. These were exacerbated by the fact that the criminal abduction charges were reduced to misdemeanors.

ISSUE BASED CASE FORMAT:

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1. What is the impact of a brief family abduction on children and left behind parents?
2. What type of issues may come up for the family post recovery? How do individual and family dynamics impact post recovery adjustment?
3. What issues typically appear in the beginning, middle and end of treatment?
4. Should the abducting parent be included in post recovery treatment?
5. What modalities work best in working with children and parents post recovery?

CASE # 3

Nearly twelve years after a long and troubled marriage and recent divorce, Jenny and Allen's mother packed the children in her car as they said farewell to their father in the manner that had become typical for their weekend visitations over the past year. However instead of driving home or to the park as they regularly started their visits together, they began on a long car journey. The mother feared that if she did not take her children, the battles would continue and she would eventually lose some or all of her visitation rights. She was also very angry

at Jenny and Allen's father over unresolved financial differences. She felt he was trying to manipulate her with money.

As is true in a number of parental abduction cases, the abduction was preceded by years of conflict and disagreement which only intensified after the parent's divorce. Sarah and Paul had met ten years prior to the abduction in a whirlwind relationship. Within weeks they were living together. Despite recognizing their difficulties and actually ending the relationship after six months, they were again drawn to one another and eventually married. Both had married and divorced before. Despite their differences they assumed Sarah's maturity, Paul's carefree attitude, and their strong attraction to one another would be enough to overcome the problems between them. They were both bright, highly educated, and exhibited good people skills in their work.

The fabric of their early relationship was at times volatile. Problems were identified and discussed through arguments but never resolved. Despite his education and talents Paul had never had to apply himself and went from project to project. The two children, Jenny and Allen, were born after six years of the marriage. It was after the birth of the second child, Allen that the relationship deteriorated even further. Paul's business endeavors were not going well and he needed Sarah to return to her profession.

Sarah's career was going well, his was not. Paul embarrassed Sarah in her work environment. Her father died suddenly and she began to feel life was tenuous. At that point she questioned whether she would continue the marriage. Recognizing that the marriage was at a point of collapse, Paul took on a new job with longer hours and Sarah also began spending less and less time at home. The children, who were four and six years old, were left at the baby-sitters for longer and longer periods of time.

Jealousy was not an unfamiliar feeling for Paul. When Sarah ventured off for an extended business trip, she called him telling him of running into old male friends and the attention she was getting. He became increasingly frustrated. When Sarah returned from the trip the couple did enter counseling and appeared to be making progress. However the undercurrent of jealousy and conflict remained. After another explosive argument about childcare, the couple separated. The children moved to a new residence with their mother. In the meantime, Paul's teenage children from a prior marriage returned to live in his home. Responding to the daily demands of a profession and family became increasingly difficult. Money was also tight. The children lived increasingly with Paul for the ensuing two years. However the problems in the marriage continued, becoming the problems in the separation. It seemed the only point of cooperation between the parents was around providing care when one or the other of the parent's needed to be out of

town for business. Jenny and Allen however also spent long hours, sometimes ten hours or more at their baby-sitter. A year into the separation the divorce settlement agreement had still been unsigned. Both parents believed the other was trying to leverage the other using financial and custody issues. The eventual agreement was ordered by default when Sarah was away on business. Visitation was set up on a schedule with a 40/60 split.

A few months later, around the holidays, the disagreements about finances again arose and with it anger and resentment. Sarah feared Paul would take the children based on her insufficient means of supporting them and Paul increasingly feared Sarah would take the children and run to another country. These fears became especially prominent when Sarah suggested that she take the children with her to live in another country where she felt she would be better able to support the children and provide for their needs. In the meantime, Jenny and Allen were caught between their parent's battles, ascribing their own meaning to what was happening and what was about to transpire. For example, in one hotly debated incident that went on for days, Jenny was suppose to be signed up for skating classes. After hearing her parents argue about it for days she was hysterical and crying when she arrived at the ice arena to sign up for the program. Later she expressed her fear that if she signed up it would prevent her from seeing both parents over the course of the class. She fully believed that making a choice about whether to participate or not would be equivalent to making a choice about which parent she would live with for the winter months.

As Sarah's distress level grew, due to financial concerns, Paul became increasingly concerned that she may simply take the children. Paul shared his concerns with his friends who advised him to contact the U. S. State Department to block Sarah from getting new passports for the children. He did so approximately two weeks prior to the abduction.

On the weekend of the abduction, Paul had accompanied a friend to traffic court. He found himself feeling very anxious. He recognized that Sarah was angry, distraught and felt there was no way out . Due to his concerns, he called and left a message on the answering machine for the children to call him. The next day he called twice and felt relieved when he reached the children by phone. The next day he was scheduled to pick the children up in the morning. He called to let them know that he was on his way. There was no answer. After several unsuccessful attempts to call, he went to the police station and asked what he should do. He explained that he was sure they were gone and that she had taken them. The police agreed that a missing person's report would be filed if the children where not returned by evening. In the meantime the father drove by the home and saw a car that belonged to one of Sarah's friends. However, the uneasy feeling that something was not right remained. He literally went over and looked thorough the

windows. The house was not bare, yet somehow he felt he knew they were gone. At five that afternoon he returned to the police station and filed a missing person's report.

The next day Paul began to talk to people, a lot of people. He contacted Sarah's former therapist who reassured him that they were probably just on a brief, temporary vacation. He talked to her friends and business associates. He called the detectives working on the case. As the week progressed and he talked to his family, he began to learn about other resources that other parents had used to find their children. He learned about various missing children's organizations and finally selected one to assist him in his search. He learned about and contacted attorneys who specialized in the area of parental abduction and called them for direction. Paul began to view his immediate mission as having to do one the biggest sale jobs of his life, to get everyone as invested as he was in finding his children.

He educated himself about helpful avenues for locating children such as flagging school records. He worked at having the different agencies involved in the search for Jenny and Allen communicate with each other about strategies for locating the children. He paid attention to every little piece of information he could gather including leads from Sarah's friend who had gone into the house. He learned Sarah had spent a large sum of money to have her car repaired the week before the disappearance. He called foreign consulates fearing the children had been taken out of the country. In desperation he even went through Sarah's trash on the curb, piece by piece and gained access to a social security number and ATM number. He learned through this that she had closed her accounts.

Interwoven with his efforts to search were fears and thoughts of the possibility that he may never see his children again, know about their welfare, or see them grow up. Nights were the worst, it was a time when it was difficult to actively do anything to look for Jenny and Allen. And there were triggers that led to thoughts about what the future would bring. The triggers were the childrens' pictures about the house, their toys and clothing. Taking the children was a betrayal Paul had thought about, but never really expected. He coped by calling friends across the country late into the night.

Paul was told not to assume anything and to call everyone who may even remotely have knowledge of Sarah. He called her best friend, Kathleen and was told that Sarah had told her she was going to disappear and that it was best for Kathleen not to know the details. Eventually he called Sarah's family. He called more than once and even wrote a lengthy letter trying to explain his understanding of the problems. After a few days, the family called back and indicated they had also been contacted by law enforcement. In a conference call with the police and Paul, the family indicated that they were aware of Sarah, Jenny and Allen's

location. However one of the conditions for divulging the information to the police was that Sarah be told that it was a family decision to reveal her location and not the decision of any individual family member. They were unified in their belief that abduction was not the solution to the problems. They also informed the authorities that Sarah would be at the current location for only two additional days. The following day warrants were issued and the FBI obtained a UFAB warrant. The children were indeed out of the country.

Stage I: Recovery and Reunification

The children's welfare and reactions to the pending recovery became a concern to Paul. Paul's concern was that the children not be placed with strangers after their recovery. At the same time he sensed that law enforcement was concerned about what his behavior would be if he were to go to the recovery site. They were worried that Paul may somehow interfere with the recovery. The decision was made that Paul would go to the city where the recovery was to be made.

Paul was driven by authorities to the location where the recovery was to take place. He was left in a large room to wait with no other instructions. After a relatively short period he could hear Sarah and the children talking outside. Sarah was brought into the room where Paul was waiting and they talked briefly. Sarah left and the children were brought in. They seemed unaffected, talking as if they had been on an extended vacation. The meeting was brief and Jenny and Allen were allowed to say good-bye to their mother.

Paul felt elated to see his children and to be on a plane flying home with them in hand. At the same time he felt numb from the experience. At the first opportunity, his children from his first marriage were phoned and filled in on the details of the reunification. They had been concerned about their two younger siblings and needed to know they were safe and on their way home.

Jenny and Allen were calm but clearly concerned about their mother. On the flight home, they asked questions about when and how she would return. While the experience had been described as a playful vacation there was also some confusion and a degree of knowledge on Jenny's part that this was different than other vacations. Jenny, who was the oldest, indicated she had asked her mother while they were gone when she could call her daddy. She reported that she was told by Sarah that she "couldn't call her daddy because he will find us and put mommy in jail." Jenny and Allen certainly had many memories of verbal and uncompromising arguments between their parents and hang-up phone calls. It seemed to them that their mother's statement was a possibility.

Stage II: Short Term Trauma Response Pattern

Paul's theory was to reintegrate the children into their old routines as quickly as possible. At that point little was known about Jenny and Allen's *perceptions or feelings about the recovery and reunification* other than what was observed. No questions were asked about the children's assumptions or interpretations of what was taking place. Nor were there questions about the children's beliefs or fears about what may take place next. When Jenny and Allen inquired about their mommy, they were told by Paul that he did not know where she was. His answer reflected his feelings of the time, that he hoped he would never see her again. This was partly out of fear that if Sarah reappeared she may reabduct, and partly out of feelings of anger and betrayal that she took the children the first time. He also told Jenny and Allen that what their mother had done in taking them was wrong and when she did return, mommy would have to deal with the judge. Paul also assumed that since the children did not discuss their mother or bring her up, they were not disturbed by her absence or the many unresolved issues. The only acknowledgment the children did make was their awareness that the situation continued to be adversarial between the parents. They told their father that their mother had said she hated him. Neither of the children felt comfortable saying "gee dad, I really miss seeing mom". So it seemed for a while that mom didn't exist. Jenny and Allen had no idea of whether or when they would ever see her again.

Upon Sarah's return, Paul was so *terrified of reabduction* that he took the children to another community for several days. At this point the children had not seen their mother, did not know where she was for months and didn't know she was back. In the next few weeks the adversarial relationship reignited between the parents. Charges were filed against Sarah for child concealment. As is often the situation in parental abduction cases, civil petitions were also filed by Paul for sole custody of Jenny and Allen.

In the meantime Allen was taken to therapy because of increased symptoms and difficulties. Although both children lived and were being raised in the same household, their manner of coping were quite different. Allen was angry and aggressive in his behavior towards peers. He was non-compliant at school as well as home. Jenny, the older child, was quiet and withdrawn, she observed much that went on, said very little and silently made her assessments of the situation and what she needed to do to survive. She was simply trying to figure out the *loyalty demands of her parents.* She also was trying to mitigate any chance of further *abandonment.* Her need for treatment did not become evident for several months. Each child was taken to see a different therapist. Their therapists ascribed to different orientations and different approaches. Allen's therapist focused on the individual issues of the child in a psycho dynamic play therapy. Jenny's therapist

believed in dealing with all the individuals in the system with the hope that eventually they would be able to come together in a different manner.

Allen's therapist found him to have long term difficulties with anger and aggression. He was developmentally delayed in his expression of feelings. His only avenue for expression was through aggressive acting out behavior. He had many feelings about his parents conflicted relationship, their angry verbal attacks on one another, the abduction, not seeing his mother for an extended period and not knowing her whereabouts or whether she would return to his life. And then there was his confusion about the messages he was getting from each of his parents. He was indirectly getting the message that he could not have both parents but would have to choose between them. Although he couldn't express it, he was struggled with pulls on his *loyalty to choose between his parents.*

Six months after their recovery and reunification with Paul, the children had their first supervised visitation with their mother. The first supervised visitation between Sarah and the children was supervised by Jenny's therapist who had encouraged Paul to allow the visitation to occur. The therapist was convinced that the mother would not re-abduct and basically promised that if there was a problem she would come forward and testify on his behalf in court. During the first meeting, Jenny and Allen just wanted to touch their mother's face and have physical contact. The mother had also brought each of the children a book about a mother who always remembered the children, even when she didn't see or spend time with them. In the meeting, Sarah told the children the she loved them and "you knew I was going to come, you knew I was looking for you". While the meeting was very touching there was reason for concern about what the mother's messages may have communicated to the children about the long absence since last seeing her. Was it possible that the children felt by implication that the father was responsible and actively interfering with seeing their mom? After the first supervised visitation, the therapist began seeing the mother with Jenny and Allen. Then she began seeing the two children together.

A little more than a month after Jenny and Allen were returned, a series of *allegations of abuse* that Paul was physically and sexually hurting the children began to filter in to Child Protective Services. An investigation ensued. The initial investigation of sexual abuse allegations was completed quickly and the allegations determined to be unsubstantiated. In fact it was out of these allegations that a recommendation had been made to Paul that Jenny needed therapy and her therapy had begun. The allegations continued they began to include allegations of physical abuse by the father with photographed bruises from undisclosed sources. In addition to the ongoing criminal proceedings regarding the children's concealment, there were also civil proceedings regarding custody, and there were interviews by law enforcement and a CPS worker investigating the new allegations. Eventually

the children were taken out of Paul's home and placed in foster care. Concerns over the mother's flight risk remained but the children couldn't stay at Paul's given the new allegations.

In repetitive interviews, Jenny denied allegations of physical or sexual abuse. Both children, however, did make statements reflecting their awareness of the antagonism between their parents. At one point during an investigative interview, Allen stated that he did not get to see his mommy enough and wanted to spend more time with her. At the same time he was afraid because he thought his father would be angry. Allen also went on to say after being placed in the foster home, that he was worried that he was not going to see his mother or father again and that he was afraid that his mom and dad would be arrested. One of the dilemmas facing the investigating officials was how to interpret these statements. Did Allen's comments mean he was literally fearful of physical violence or might they reflect the instability in his life.

The children showed significant *emotional responses.* While Jenny was withdrawn, quiet and fearful, Allen was angry and acting out, not only towards other children at school, but also towards himself. He would pinch himself on the hands, neck and leg. Sometimes he would bite his hand leaving teeth marks in his skin. When asked about why he did these things he talked about being worried about his sister. He talked about *nightmares* in which he was separated from Jenny. In general he seemed more anxious about a number of different issues. When in the presence of Sarah, the children would say they wanted to be with their mother and that their father mistreated them. At one point during a visit Allen reportedly said "I hate my life; I don't want to be here on this earth." He also said that he wanted to kill himself. When in the presence of investigators Jenny and Allen would say they wanted to see both their mother and father.

Paul describes feeling shocked and devastated. Over the course of the next several months there was a great deal of activity with ex-partie hearings about the placement of the children as well as trying to collect information about the case and from the children. The children were returned to their mother's home after only a few days in foster care. The determination was made that Sarah was no longer a flight risk and that contacts with Paul would be supervised. Allen's statements to investigators about the incident were difficult to interpret. He told them that his mother told him that his father had hit him with a shoe and that she knew this was true because she knows the past and the future. He went on to say that he did not recall if it had occurred. "Maybe it did, I don't know; my mother knows the past and the future and said he did it with a shoe."

When the issues of sexual abuse had initially been raised, Paul wasn't sure how to proceed other than to support the investigation and evaluation of the

children and to fully disclose any information requested. But when the physical abuse allegations occurred he wanted to insure that Allen was interviewed by an experienced professional. He wanted Allen's therapist to interview him but the therapist was not available. Paul called Jenny's therapist and asked if she would evaluate the child. Initially she said no but in a later phone call agreed. Another doctor, an independent evaluator who had been appointed by the family court judge regarding the custody issues, concurred that the evaluation for physical abuse be done by Jenny's therapist. When Allen's therapist, who was out of town, learned of the plans she called and objected to the evaluation. Inevitably it did not take place.

The children were taken in for multiple physical examinations of the alleged sexual abuse with no physical signs of trauma. The allegations continued for several months with the Jenny and Allen continuing to be questioned and evaluated. A parent who knew Sarah told authorities that the allegations were being discussed with other adults in front of the children. Paul claimed that the problems for the children began when the mother returned after their recovery from the abduction. Allegations and counter-allegations were being made by Sarah and Paul. Practically speaking Jenny and Allen remained caught between two antagonistic parents, each *wanting the children's loyalty and validation* and blaming the other for the ongoing struggles. As was so well identified by the family therapist, the primary barrier in the children's treatment and progress was not their coming to treatment but rather Sarah and Paul's ongoing rage with the other.

The investigation for the physical abuse allegations was ongoing for ten weeks. The conclusions of the investigation were that the allegations were unsubstantiated. Interim recommendations were made for the children to maintain primary residence with the mother and visitation with the father pending the ongoing family court ordered independent evaluation. The evaluation process was not over for either the parents or the children. And, no matter what decisions were made about custody and visitation, Jenny and Allen remained caught between two parents who had many scars and wounds from their battles over the years. The children were loyal and affectionate to both parents.

Despite the divorce, many aspects of Sarah and Paul's relationship were unfinished. Both were seeking acknowledgment and vindication for the injustices that they each perceived the other had directed toward them. There were reservoirs of anger over each other's verbal assaults on one another over the years. There were resentments about each other's participation in the parenting process. Sarah resented Paul's control over financial matters. He resented her lack of assistance with the children during the peaks in her career, even though he wanted her to be employed.

The doctor who completed the independent evaluation recommended joint custody and a 60/40 split with Sarah having the children primarily on the weekdays and Paul having them for extended weekends when he would be more available. The judge ordered a 50/50 split. Neither Paul nor Sarah were pleased with the ruling. They both felt a great deal of distrust with the other. The initial adjustment was rocky. Paul would try to call Jenny and Allen while they were with Sarah. Often he would get the answering machine and no return call. Each time he would go through an emotional process of frustration and fright because he did not know if Sarah might reabduct the children. Paul's distrust was increased by the fact that when Jenny or Allen had any physical bumps or bruises, Sarah would take the children to the doctor for evaluations.

Paul wanted to remain rigid about the schedules and even if the meant that Jenny and Allen remained in day care for ten or more hours a day. Paul was concerned that not adhering to the schedule would result in more litigation with Sarah using it as an avenue to get more money. The concern was addressed directly in treatment.

The therapists tried to include both parents in the children's therapy. One would drop them off and another would pick them up. Jenny's therapist even initiated a joint session between the parents. Both approached it with great ambivalence and it did not go well. At the therapist's persistence they continued to occasionally meet together. A clear turning point occurred on Jenny's birthday when Paul called and requested some extra time with her and the mother agreed. A few days later Allen requested a few extra hours with his father. Sarah agreed. Then Allen requested an extra overnight with Paul. Although reluctant and concerned, the mother agreed. With those successful negotiations, Jenny and Allen began to show marked improvements in their behavior. Allen was much less aggressive and no longer had the school behavior problems which where a big part of his initial referral to therapy. Jenny was less withdrawn and had actually become more assertive. Even with the gains in negotiating child care questions, the parents remained cautious towards one another. Minor disagreements quickly escalated with one or both reverting to making threats. Even so, the bumps along the way were resolved. Sarah and Paul were able to school shop cooperatively for the children. With each successful outing the children continued to improve.

Despite the improvements Paul continues to scan for cues of change or stress that might cause the current degree of cooperation to come tumbling down, or worse for the children to be reabducted. The *vigilance* is less but remains. At the same time he feels a relief at not being a single parent and sharing the parenting responsibilities for Jenny and Allen. He sees that having a relationship with both parents has produced an increased sparkle and happiness in the children.

Stage IV: Termination/Periodic Recontact

Over the months Paul and Sarah learned that Allen had gotten a bruise in a hot tub, sitting on a drain. Future treatment needs included ongoing co-parenting work with the parents with sessions aimed at addressing issues they cannot negotiate. Trust, especially around sensitive issues continues to be difficult for both parents . Periodic check-ups with Jenny and Allen to assess their adjustment and address issues as they arise were advised.

Teaching Points
Case #3

1. Even brief abductions can produce significant post abduction trauma.

2. Because of the nature of family abduction, the recovery is only the beginning point for these families to heal. Old conflicts are often fought out in the legal arena.

3. Prevention efforts in high-conflict divorces may reduce the risk of abduction in some of cases. Therapist intervention through education of the parent in high-conflict divorces about the emotional and psychological toll of abduction on the child and the child-parent relationship, along with emphasis on mediation of custody, support and visitation issues in the separation/ divorce is needed.

4. Treatment is marked by three levels of intervention:
   - beginning treatment issues often anxiety related
   - middle treatment issues, often related to ongoing stresses and trust violations
   - end of treatment issues, often related to assumption violations and require new ways of relating

5. Optimal treatment results in return of cooperative parenting between parents. However this is case detail dependent.

6. Successful treatment may require cooperative endeavors between multiple therapists.

CASE #4

Richard and Katie had been married for nearly fifteen years. Throughout their marriage Richard had been the head of their household in many respects. It had been a very traditional marriage in which he worked and she stayed at home with the children. He expected and she complied with the belief that he had the final say on any decisions. She had structured her own and the children's life around his. When he tired of living in one area of the country and wanted to move, she picked up and relocated without complaint or question. They had moved a half dozen times during their marriage. Their last move had taken them to a rural area of the midwest and they had settled there much longer than typical. They had actually lived in the same house for three years. They were religious and their church and beliefs played a very central role in their day to day lives and in their marriage. Yet, while they were involved with the church and had many acquaintances in the community, they did not have friends. Their most frequent contacts were with Richard's aunt and her family who lived in a nearby community.

Katie's childhood history had been difficult. She remembered when her parents had divorced and how devastated she felt. She was the youngest of three children with an older brother and sister. Because her mother had to work long hours to support the family she had been raised by her older siblings and extended family. Katie saw how hard her mother worked and didn't want to make things any harder. When her uncle began sexually abusing her and threatened her not to tell, she kept the secret.

It hadn't helped through the years that her father was so distant and disinterested in her life. As she entered her teenage years, her self esteem was low. So when she was seventeen and met Warren, an attentive older man at the mall, she was swept off her feet. She had never received so much attention nor had she ever felt so cared for. It felt so good that it must be right. After a brief courtship they married. It didn't take long before she began to feel there were prices to be paid to be cared for and to be special. Her husband was jealous and possessive. He would become enraged if she seemed interested in other's company or friendship. As a result she remained very isolated and alone. Eventually she asked for a divorce.

Her feelings about herself were very low and she was vulnerable. She met Richard at her job in a small cafe where she was a waitress. Richard seemed to know what she needed. It was a whirlwind relationship, Katie remembered seeing the desire to control her come out in his behavior but she minimized it and he apologized. Soon after they married.

They had three children, Carolyn, Sam and Rita early in their marriage. They seemed happy until Katie resisted the idea of starting a side business with Richard. He began to complain that she was being rebellious and non-submissive. He became resentful when she was not home from church or the market precisely when he thought she should.

Katie knew there were major problems in the marriage when Richard ordered her out of the bedroom. For months she had talked to him about the furnace. It wasn't working and several people had commented to her that it was dangerous. But Richard was reluctant to talk to the landlord because he was concerned that the landlord would raise the rent. Katie was getting concerned. Winter was approaching and she just wasn't willing to do anything that put her kids in danger. She called the landlord and talked to him about the furnace. Richard was furious. He felt Katie had gone to the landlord behind his back. He viewed her behavior as overstepping his authority. He felt he had lost control. That night he told her she couldn't sleep in the bedroom and locked the door.

For two months she had slept on the sofa in the living room. Many nights she would cry herself to sleep. Richard had told her that while they were married legally he did not consider them to be married in the eyes of God. He had also talked to Katie about wanting her to move out but she was firm, "if he felt the marriage was over and wasn't willing to work on it than he would have to be the one to move out." As the days turned into weeks and then months, she began to worry about what impact their problems were having on their children. She wondered "what kind of picture are they getting as far as a role model for a family, a husband or a wife? What kind of mother or father are they going to be?" She tried a couple of different times to get back into the bedroom and to have things appear to be more normal. One incident was after he took the children on a trip and told Katie she could not go. When he returned with the children she stayed in the bedroom. Richard announced that nothing had changed and he expected her to move back onto the sofa.

She was scared because he had been violent with her on a couple occasions in the past, but she had to try again. The outcome was the same. He told her not to make him get physical and then he threw her pillow into the living room, pushed her out of the room and locked the door. The next day she consulted with an attorney and filed divorce papers and a petition to have him move out of the home.

For the next several months Richard slept in their camper. Sometimes he kept it at his aunt's and sometimes at his work. From the beginning Katie was concerned about Richard having all of the children overnight at one time. From the time that their oldest, Carolyn, was a baby Richard had talked about taking her. Even before Carolyn was born and Katie was pregnant he had told her that he

could take the baby so far into the wilderness that Katie could never find them. He hadn't said it a lot over the years but it had an impact on Katie. She had the visitation papers drawn up so that he could never have all three of the children overnight. In fact, the only time he could have all three at one time was to take them to church. Initially the children stayed overnight, two at a time, but the camper was cramped and uncomfortable. The children began to complain and the overnight visits were stopped. He still had visitation a couple nights a week and all day on weekends, just no overnights. There were court hearings on visitation and the judge ruled in her favor. Richard was very angry.

During the next few months there were several incidents that worried Katie. Although she felt Richard had been the one to force the divorce, he seemed to be struggling with his inability to be in control of her or the children. When she left the cat outside for a day, he came and took the cat. Later when he returned two of the children from visitation he pushed her when she wanted him to return the pet. Another time he broke into her home and took several personal items and gifts that he had given her over the years. Another time they got into a verbal disagreement and he told her that God told him that death was at her door. When Richard left a message that he was returning the children four hours late, she called the police.

During the visits, Richard would talk to the children about Katie. He told Rita and Carolyn that their mother was rebellious and was going to die an early death. Rita would return from the visits and tell her mom of the conversations. They scared Rita. Katie reassured her that she didn't need to worry and that she was not going to die an early death. He would also tell them that he was going to take them on a camping trip during the early part of summer. This also concerned the children, especially Rita. They did not feel comfortable going on a long trip with their father. Katie again reassured them that the judge was going to listen to everything and would make a determination. She hoped that this would communicate that nothing would be done against their wishes.

When summer arrived, Richard made plans to take all of the children for a Sunday outing with his aunt and her family. They had plans to go boating on a nearby river. Katie was running late in getting ready for church, so she wasn't paying much attention. It was a hot summer day and the children were dressed in bathing suits, shirts and shorts. He told the children to go back in and to each get a pair of long pants. Katie questioned him about why they needed pants when it was so warm. He said they were going to go to a park first and he didn't want them to get bitten by mosquitoes. Then he told them to go and get a warm jacket. Katie again questioned him. He said they were going to stop for dinner on the way home and may get cold. She pointed out it would still be daylight.

Just as Richard and the children were about to leave, the youngest came running back and gave Katie a hug and kiss good-bye. That was the last time Katie saw the children for nine months. She later learned he had planned and prepared for the abduction for weeks. His aunt had helped him buy a van. Over the prior weeks he had hoarded some of the children's clothes when they would go home from visitation. Whatever extra went with the children never came back. He had also cashed in his retirement account at his job.

Katie and her best friend had decided to go shopping after church since the children were going to be with Richard until nine that evening. They had gone to a nearby shopping mall and when it became obvious that she was going to be a few minutes late, Katie called Richard's aunt and left a message on the recorder. When she arrived home she called his aunt again. Again there was no answer. At that point she became concerned that there could have been an accident and decided to drive to his aunt's house. The boat was there, the lights on and the car home. Katie went to the door and talked to Katie's aunt. She just kept repeating the same phrase, "we haven't seen them all day". She remembered Richard's threats that he would take the children. She knew he had taken them.

As she drove home, Katie was in shock. Things kept pouring through her mind. She and Carolyn had gotten into an argument that morning about what she was going to wear. Katie was late that morning and in a hurry. She wished she hadn't had the argument with Carolyn. Thoughts crept into her head of "what if I never see them again" but she tried to not think ahead and tried to think for the moment. "What am I going to do for right now?" When she arrived home she called the police and then a friend. Just after midnight she called Richard's parents. Richard's parents didn't seem too concerned or compassionate. They told her that everything would be fine, after all the children were with their father. The police had called his aunt. Richard's aunt called minimizing her concern about Richard's failure to return the children.

It was the hardest and most overwhelming thing that Katie had ever experienced. She felt without her faith and the support of her church and friends, someone could sweep her away in a butterfly net. She had viewed Richard as a negligent father in many ways. He hadn't been concerned about their safety with the furnace and he just wasn't careful. When the children were toddlers he'd absent mindedly leave a glass of bleach sitting out. This seemed outrageous, she had been such a protective mother, spent her time at home with the children, and then he just swept them away. It was hard to get used to the lack of noise in the house and the feeling that one day she was a mother and the next day nothing.

The children, Carolyn, age 11; Sam, age 10; and Rita age 4 didn't learn about the abduction until the morning they were taken. Richard had taken them to a

restaurant for breakfast as was customary. While there he announced he had a surprise for them. They were going on a vacation. He went on to say that and they would not see their mom for a very long time. Carolyn, who was especially close to her mother started to cry. He demanded to know why she was crying when Rita who was only four was not. She was especially hurt by this and would remember it through the entire time she was missing.

The evening after the abduction there was a phone call from Richard; Katie's friend answered. Richard told her that Katie had three minutes to speak to the children and not to ask any questions. When Katie took the phone she talked to Carolyn first. She asked her "where are you?" Richard took the phone and said "you have three minutes, don't ask any questions, if you do I am hanging up." Carolyn got back on the phone. She asked her if they were still in the same state. Carolyn said "yes." She asked if they were camping and she again said "yes". The phone got switched to another child and she was only allowed to speak for a very short time to each. When it was Carolyn's turn again, Katie told her to get to a phone and call her mother or call 911.

Richard got back on the phone. He told her that she should think back to the last six months. He said he had to go. That was the last time she heard from them. The following Sunday, Richard's aunt called and said they had heard from Richard. She said they were fine and having a good time camping. There would be more phone calls of a similar nature. Katie felt like they were trying to break her or get her to the point that she would do anything to get them back. She really felt they were trying to destroy her. In one of the calls about three weeks after the children were taken, Richard's uncle told her that the children had not mentioned Katie in the last three weeks. She wasn't about to let him know it bothered her but after she hung up she cried. At the same time the phone calls gave her hope; they were messages for her that the children were still OK and the calls would motivate her to look.

Richard had indeed taken the children camping. For the first several days he moved them often from one location to another. Eventually they moved to another midwestern state. Initially they lived in the van. Then he rented a house. Before moving to the new community he had changed each of the children's names because of concerns of being discovered. Carolyn was changed to Mary, Sam was changed to Geoff, and Rita was changed to Gina. He also changed their last name to Murphy.

Getting the children into school had not been difficult either. It was a small community and he explained they had been home schooled before so there were no records. The school never asked for verification of immunization and took Richard's word that they had been immunized.

With Richard's work hours, he had allowed his oldest child, Carolyn to drive the car. She was suppose to put her hair up so that people wouldn't notice how old she was. Rita would claim after their recovery how one time, when they were all with Carolyn, she had almost driven off a cliff.

The children had begun, in their own ways, simply to accept the fact that they were not going to see their mother and that they would live by the alias's that their father had assigned them. Because of the value system in their family, they also were not about to challenge their father's authority.

The investigative process was slow and frustrating. The police were searching but always ended up a few days behind. It took weeks to get approval for a phone tap. Richard's aunt was not cooperative at all. She clearly was talking to Richard frequently but she wouldn't help the police.

Dealing with reactions of acquaintances or strangers was difficult. While Katie's friends were supportive and understood the impact of the abduction and the threat of never seeing her children again, others didn't. She encountered comments that suggested it was no big deal that the children were gone because they were with their father. Others reminded her that it would be worse if they had been taken by a stranger.

In an effort to gather enough money for a private investigator she had put up posters and money canisters. Richard's aunt raised a ruckus with the store manager of the local general store. The store owner removed the cannister and said he didn't want to get involved.

But there were people who offered help and support. A photo shop donated prints for making posters. Another man gave her 500 posters. The National Center for Missing and Exploited Children assisted her in making and sending out posters and letters to 1000 pediatricians in six nearby states. Carolyn had a severe asthma problem and would need follow-up care. She also contacted regional non-profit organizations for missing children. They also helped her print posters and offered ideas about how to search for her children.

Katie pursued media coverage. Initially they were uninterested. When she finally got a station to do a story, it didn't run for weeks. After the show was finally aired the radio stations and local paper also contacted her and did stories.

Stage I: Recovery and Reunification

The children were located after posters of the children and a description of Richard and his van were distributed. A postal worker in the locale where Richard was living recognized the poster with the photos and descriptions. The police went to the school and showed the poster to the school administrators who identified the children by appearance even though they had differnt names. The children were all called into the office together. Rita, now five, was petrified and didn't say a word. She just cried. Initially Carolyn lied for her father and said that she was Mary, not Carolyn. She did not want to come home. Finally Rita confronted Carolyn and told everything. They learned from the children where their father was working and he was arrested. That night the children were taken to a foster home. The lady was nice and the police tried to make them feel comfortable but it was really difficult. They didn't know what was going to happen. The next morning the investigator flew to the town where the children were recovered. The children liked the investigator and answered his questions. After the interview, the children called their mother and spoke to her for the first time in nine months. It was confusing in some ways, the children were still using their assumed names and they were a little worried that their mother might be angry with them.

Katie had learned about the possible recovery the morning before with a call from the investigator. It was his day off but he was going to the office because the call had come in that the children may have been located. Within a half hour he called Katie with the news of the recovery. She wanted to leave immediately to see her children. The investigator asked her not to go. She didn't understand why but he had helped her a lot and she honored his request. He explained that he would be back with the children on a plane by the next evening. Before flying back, Katie had several phone conversations with the children to get reconnected. Indeed, the next evening they all flew in on the same flight, the children, the investigator and Richard who was cuffed and chained. Seeing their father cuffed and knowing he was going to be taken to jail was very difficult for the children. Before he left the airport they each said a tearful good-bye to their father and he to them.

The reunification took place at the airport. Katie received no preparation for *what to expect* or what she may encounter. She was at a loss. As she was driving to the airport she was concerned about what the children's feelings were going to be with their father on the plane and knowing he was going to jail. She feared that the children would view her as the "bad guy". Her entire family showed up along with friends and other well wishers. When the children got off the plane they each responded differently. Carolyn, the oldest was somewhat aloof and standoffish. She casually said " Oh hi, mom" almost as if what had just taken place over the past nine months had never happened. Rita, the youngest, ran up to her mother gave her a big hug and kiss and then clung to her. She was reluctant to let go now that she

had her mother back. Sam was also a bit distant, he wasn't as close to his mom as the other children and just didn't know quite how to take all this in.

On the drive home the question that Katie had feared the most came up. Carolyn was the spokesperson and asked why their father had to be taken to jail and why mom had to call the police. Without any guidance or warning that there may be direct questions she answered it the best she could. She explained that she wanted to find them. There were steps she had to follow and that one of those was to call the police so she could get the help that she needed. What happened after that was not up to her, it was out of her hands. Their father had broken the law and now he was going to be disciplined.

Stage II: Short Term Trauma Response

Assuming their correct names took the children a few weeks. For the most part they were back on track after a week. Sometimes they still bring up the other names in a joking or teasing way. It was easier for the older children than for Rita. She struggled with it for a couple of weeks. Each child also gave a police statement and *reviewed the details of the abduction.* Carolyn recalled that her father had told them before the abduction that he was going to take them. She also reported that he would tell them that God had told him to take the children.

When the day of the abduction finally came she recalls that she told him he couldn't just take them without letting their mother know. She started crying. They were in a restaurant where people knew them. Richard reached across the table and closed her mouth. Another friend of their father's also came by and made plans to meet Richard and the children at a campground about a hundred miles away from home the following week. During the day they met with a number of different people significant in their father's life. They met and had lunch with their aunt and uncle. Carolyn felt they all knew what was going on and knew that it was going to happen before it actually transpired.

During the first few days of the abduction their father talked to them about changing their names. He told them about the change of their last name first and then let each work on their first name. They had to rehearse their names and their brother's and sisters' new names hundreds of times.

Once they reached the community where they would settle, he talked to the children about how if discovered he would go to jail. Ironically, the night before they were recovered, Richard had talked to the children about what to do if the police ever came to the door. He instructed them to run for the backdoor and to meet him in town. He also said if they get you they'll take you home and "I'll come and get you again." That really scared Rita.

Sam also relayed much of the same information that Rita had, but he seemed more detached from both his mother and his father. He didn't seem to favor his mother over his father, he just was distant from both. He explained their name changes and how they came by their various names and practiced. He answered many of the questions with "I don't remember." Sam's style was just to take whatever was happening into stride, to roll with the punches.

Carolyn was torn, but she would be honest in answering the questions put to her. She struggled with *loyalty conflicts.* She worried about her mother and her mother's feelings but she had also come to feel responsible and protective of her father. Despite the fact that what he had done was wrong, he was still her father and she didn't want him to be in trouble. As any pubescent girl might feel, she also enjoyed the responsibility and the feeling of independence that she had experienced during the months with her father.

Carolyn disliked conflict and wanted peace. She thought both her parents were wrong. She held many of her feelings inside. Sam just went with the flow and tried to adapt. Rita was fearful of reabduction, couldn't sleep alone, had stomach aches and was very clingy. She was not able to let her mom out of sight for weeks.

Immediately after their return there was a lot of concern about what was going to happen to their father. While he was in jail, the girls would bring up their father in their prayers. Katie would try to reassure them that their father would be all right. Richard received a brief jail sentence. At the recommendation of a psychologist who evaluated the children just after their return, the children did not see or talk to their father for several months after their recovery.

All of the children were diagnosed with Post Traumatic Stress Disorder by the psychologist. Two of the children expressed *fears of reabduction.* Two of the children were having *nightmares* about the abduction. Rita had dreams for the first month that her father would come through her bedroom window and steal her again. Rita also expressed more generalized fear of abduction beyond their father; it had generalized to a fear of being taken by anyone. *Trust* was also an issue during the initial period. The children felt their trust in their father had been betrayed by his actions.

Letters from the father were suppose to be written carefully so they would not negatively impact the children, either in terms of telling them how hard it was for the father to be in jail nor to make them feel guilty. The letters however contained subtle references and some not so subtle suggesting that the reason he had taken the children was because of Katie. There were also phrases of having "evil raise up against me especially in your mom's heart. I just wanted her to be

even a little bit nice, just a little." He also blamed the fact that he did not return the children on Katie because "she was intent on putting me in jail."

Stage III: Long Term Trauma Response

Richard did not like the results of the first evaluation suggesting his contacts be limited to letters. His attorney was successful in getting another order for evaluation of all the parties. The evaluator completed the evaluation of the children with Richard present.

In the meantime, Katie had been trying to arrange therapy for herself and her children. Because they were not physically or sexually abused, they did not qualify for Victims of Crime Funds and she did not have the resources to pay for a private therapist. Eventually she was successful in pursuing therapy through the local community mental health center. The initial visitations between the children and father were set up through a special court appointed advocate (CASA). Initially they were with the CASA and then for a hour or two in the CASA office without supervision. These visitations were very difficult for Katie, she feared that Richard would again try to abduct the children.

Katie found herself going through a *series of transitions.* She didn't want Richard to experience the same pain of not knowing about his children that she had experienced when he had taken them, but she was very angry. At first it was all she could do to talk to him on the phone. She went through another phase where she could not even be in the same room with him. Next she got to a point where she could meet with him if it was for counseling. Finally she began to talk to him more openly about parenting issues.

The biggest changes that Katie had seen with Carolyn was that she had grown aloof not only with Katie but also from Richard. She didn't know *who to believe* and also struggled with *feeling betrayed by both parents.* It was almost as if she had detached herself from both of them. There was not the warmth and closeness that Katie had always known before Carolyn was taken.

One of Rita's initial issues had been the fact that she had lied to her teacher about her real name while abducted by his father. She felt really terrible that she had lied. So she was assisted in writing a letter to her teacher saying that she was sorry that she had lied but her daddy wanted her to and her real name was Rita. In effect she *felt like a co-conspirator.* The letter was a way to make amends with her teacher.

There was also *guilt* that they had not called the authorities or their mother while they were gone but to date this remains a difficult one for them to deal with.

The children have not had the opportunity to deal with it individually with a neutral person such as the therapist and it was too risky for them to address directly with Katie.

Katie struggled with the same issue. She knew that the children were in a situation where they felt they had to go along with what was happening and accept it. She knows they had been taught to listen to their parents and comply. She knows that as a role model, for most of their lives she had modeled compliance and Richard being the undisputed head of the home. But it was very difficult. Katie had thought that if anyone would call their parents it would be Carolyn, Sam, and Rita because of the closeness that she had with them. She found it mind boggling that they had access to a telephone and didn't call her. There were times when one or another of the children was sick and thought about calling but they didn't. They were afraid their father would get arrested or be disappointed in them. For Katie, she knows the logical reasons why it happened, but in her heart it didn't make sense to her. The children and she still haven't discussed it directly. She doesn't want them to feel guilty and they're not ready.

The *fears of reabduction* were addressed by the therapist through direct discussions about having permission to call 911 or to contact another person in authority, such as at school, if this were ever to occur again. They discussed abduction as something that was not right to do and that although their father had gone to jail, the only way they could have the opportunity to see both their parents and work the differences through was to report it. Katie reflected that she had never thought about the need to teach her children to call 911 because of a problem within the family.

Stage IV: Termination/Periodic Recontact

Katie, Richard and the children continued to be actively engaged in treatment. After a year of ongoing treatment with the children and each of the parents, the court granted Richard unsupervised visitation. While the mother was anxious, she had no choice but to cooperate with the court order. Besides the therapist and everyone else involved in the case had assured her that Richard would not re-abduct the children. The time of the visitation was specified and Richard was to return the children home by 5 PM on Sunday evening. Richard and the children never returned home.

This case demonstrates the following points:

Teaching Points

1. The lack of therapeutic intervention for the left-behind parent negatively affects the parent. Left -behind parents and non-abducted siblings are an underserved population by mental health services. Treatment guidelines need to be established for these populations.

2. The details of the pre-abduction family stressors helps to put the abduction experience into a meaningful context which then helps identify the relevant factors contributing to the abduction.

3. Detailed understanding of the events leading up to the abduction, the abduction experience itself and the feelings and perceptions of each of the family members is necessary to understand the individual issues and intervene effectively. For example, Rita's dishonesty to her teacher about her real name was a specific source of guilt that required a focused response.

4. Individuals differ in their response to family abduction. Careful evaluation and intervention requires inquiry into each family member's perceptions and symptom development.

5. Identification of the family stressors and dynamics leading to the abduction and direct discussion of those influences is an important treatment goal.

6. Treatment issues or symptoms develop in a step wise progression.

CHAPTER EIGHT - FAMILY ABDUCTION: SAMPLE TREATMENT TECHNIQUES AND THERAPIST QUESTIONS

In this chapter, two areas will be addressed: (1) sample treatment techniques and (2) therapist questions. Table 16 outlines the issues addressed in each.

Table 16
Therapist Questions and Sample Treatment Techniques

A. Early Intervention
   1. The Left-Behind Parent and Non-Abducted Siblings
   2. Prevention with the High-Conflict Relationship

B. Sample Treatment Techniques
   1. Symptom Specific Interventions

C. Therapist Questions:
   1. Child Placement
   2. Diagnostic Issues
   3. Therapist Background and Experience

Early Intervention:

1. The Left-Behind Parent and Non-Abducted Siblings. The need for intervention with the left-behind parent and family members begins when the child is missing. The scope of this project does not include intervention prior to recovery and reunification. The challenges and emotional responses facing left-behind parents and families is extensive. Often searching parents/families are in the most pain and in need of support and intervention. As noted previously, specific treatment guidelines for these populations need to be established. Mental health service providers will benefit from accessing current publications about the demands of searching for a missing child as previously referenced (OJJDP, 1998).

2. **Prevention with the High-Conflict Relationship.** Attempts have been made to identify the factors which increase risk of parental abduction (Johnston et. al.,1994). Often in high-conflict divorce and custody situations, the emotional stressors are acute. The identified risk factors: (1) belonging to an ethnic or cultural minority group that holds different values about child care arrangements after separation and divorce compared to the prevailing laws and procedures of the states' courts; (2) low socioeconomic status including low income, education, and occupational position; (3) psychological characteristics which reflect narcissistic, sociopathic personality disorders in which individuals may hold beliefs conducive to child abduction; (4) transient, unmarried relationship status in which couples were never married and had a brief, unstable relationship and the conception was unplanned; and (5) concern about child neglect, sexual abuse and family violence in which the abducting parent is attempting to rescue the children from violent, neglectful and/or criminal environments provide a guideline for defining those populations that may most benefit from preventative measures.

While the risk factors identified pertain only to those features that differentiate abductors and their family situations from highly conflictual and violent couples who used the formal resolution processes of family court, they provide parameters for what types of factors may influence parents to abduct. Given the low socio-economic and single, unmarried status, these parents may be less likely to access the mental health services. Therefore prevention strategies should be provided through established service agencies that these parents already visit, such as, child-wellness clinics/providers, public social assistance agencies, child welfare agencies and low cost legal clinics. However, the mental health provider should also include an abduction prevention segment in their work with high-conflict parents in treatment. Mental health providers also need to inform parents of the long term emotional harm for abducted children and the long term damage done to the relationship of abducting parents and their children.

Reminding angry parents and directing them to available resources for mediation may be helpful. In addition coordination of services and discussions of risk with other professionals associated with the parents, such as, mediators, attorneys, court and social service personnel, may facilitate effectively working with these couples. Finally the mental health services provider should direct those families who express concerns about the possibility of abduction, who are in conflict about the best interests of their children and parents who fit the risk factors to resources about child abduction and the steps they can take. Having materials on hand and/or being able to direct parents to the resources that can provide them with the steps to take to protect their children from abduction is recommended.

According to Johnston (1994) in the article "High-Conflict Divorce," inter parental conflict after divorce (defined as verbal and physical aggression, overt

hostility, and distrust) and the primary parent's emotional distress are jointly predictive of more problematic parent-child relationships and greater child emotional and behavioral maladjustment. These same findings are supported by long term studies of children of divorce (Wallerstein & Kelly, 1974; 1976; 1980). As a group, children, especially boys, of high-conflict divorce as defined by Johnston et. al. (1994), are two to four times more likely to be clinically disturbed in emotions and behavior compared with national norms. Court-ordered joint physical custody and frequent visitation arrangements in high-conflict divorce tend to be associated with poorer child outcomes, especially for girls. It is important to keep these factors in mind in treatment post abduction and recovery.

Abduction prevention and early intervention with high-conflict parents that stops an abduction from happening is the best intervention. While beyond the scope of this project, prevention is an important part of intervention with high-risk parents.

Sample Treatment Techniques:

Following are a few possible interventions for commonly occurring symptoms and issues in family abductions. The experienced clinician will have a number of additional techniques that can be applied. This is intended only as a sample of the type of interventions that may be implemented.

The symptom complaints of family abducted victim children and their families typically include: (1) fear and anxiety, (2) sleep disturbance and nightmares, (3) withdrawal/depression, and (4) somatic complaints. An added general area is acting out behavior and defiance.

Fear and anxiety. These symptoms are generally associated with specific fear of re-abduction and intrusive thoughts about the abduction. Four useful interventions are: (1) defining and re-establishing family safety rules, (2) concrete implementation of the rules and defined safety plans, (3) teaching mastery skills and (4) teaching relaxation skills, and (5) educating the parents, and to the extent appropriate, the victim child and siblings.

Defining and re-establishing family safety rules is a four step process: (1) Work with the family in establishing what their current safety rules are. Often family safety rules are directed at stranger abduction or exploitation without consideration of risks within the family. Typically they only include having an established secret code word when someone other than the parent comes to pick up the child; ensuring the parent has information about who the child is with, address and phone numbers; providing the school with a copy of the custody/visitation order and directly discussing any limitations that may exist; teaching the child

appropriate responses if someone other than the parent or their designee tries to pick the child up. The clinician will find that some families have no defined or clear-cut safety rules. (2) Have the child, sibling and parents define specific safety concerns that have developed as a result of the abduction. (3) Develop written safety rules based on past rules and current specific concerns. When a family has no defined rules, have family members write safety rules. A helpful resource in this process may be the publication, *My 8 Rules for Safety* (written in 23 languages), published and distributed by the National Center for Missing and Exploited Children (1992). (4) Review and write the rules for each family member.

Another powerful technique in dealing with fear and anxiety is actual, concrete implementation of a safety plan. Safety plans differ from safety rules. While safety rules define rules and expected behaviors on the part of family members, safety plans are specific plans to address specific fears on the part of the child or family. For example, a child who was abducted by a parent may fear any situation where the recovering parent is not present. A common fear is being re-abducted on the school yard. A safety plan may be developing a strategy for the child to go to a playground teacher or principal if they feel uncomfortable or see their abducting parent near the school yard. In turn the teacher or principal will assume responsibility for taking the child indoors to a safe location and call the other parent or police. Concrete implementation of the plan includes having a meeting of the parents and child with the playground teacher and principal to outline the child's fears, the proposed plan and obtain agreement from school personnel in front of the child to follow the plan. This concrete follow-through with the child's participation can be reassuring to the child that people are aware of their fears, know the plan and have committed to follow the plan. Questions about whether others are aware and committed can be alleviated. Sometimes, however, periodic follow up and review may be necessary by the parent to re-establish the child's belief in other's commitment to their safety.

Teaching mastery skills involves identifying a skill that will help the child feel safe and teaching and practicing that skill to mastery. One example of this type of skill is teaching the child how to dial for help either by calling home or dialing 911. This works best when the exercise is concrete and not just discussed. While away from home the child should actually call home from a pay and private phones. Optimally the child will reach another family member or an answering machine on the other end to reassure them that they can call home. To extend the exercise the child should leave a message if they reached the answering machine so that the child understands the parent will get the message. Another skill is teaching a child how to call the operator to make a collect call. These skills can be practiced on family outings.

Another mastery skill is giving the child some alternatives of how to respond should the abducting parent again approach them and demand that the child go with them. Many children are fearful of saying no or challenging a parent or authority. It may be helpful to give the child a script of what they can say, for example, "I can't go with you without calling mom first." Or, "the rules here at school are that I have to check out at the office, I'll be right back." That gives the child a chance to inform an adult of what is happening and let them take charge. Children vary in their ability to assert themselves with adults. Carefully script a response that is appropriate to a particular child's developmental level and ability. Then the task is to review and practice the response.

Relaxation training for parent and child can be helpful in dealing with anxiety symptoms. Trained clinicians can assist children or parents in applying these skills to specific anxiety generating incidents. Another useful alternative is the use of self-hypnosis for those clinicians who have skills in this area. However, the clinician should be careful about the introduction of such skills subject to the misinterpretation of these techniques which would discredit the child in pending legal actions.

Educating parents about what to expect from a recovered child is also helpful in alleviating anxiety among recovering parents. Providing them with knowledge, realistic expectations about their child's behavior and the tools to observe their child's behavior is often reassuring. In the same way, for those parents who just want to go home and assume everything will be just like it before the abduction, education provides them with a framework to be more appropriately attuned to the behavior.

Sleep disturbance and nightmares. Sleep disturbance is typically a result of specific fears, intrusive thoughts about the abduction at bedtime, or nightmares about the abduction experience. Sometimes the already discussed techniques can be helpful in reducing sleep disturbance. Additional interventions may include: (1) reframing or changing the outcome of the dream; (2) use of concrete props to alleviate fear; (3) mastery skills.

Reframing or changing the outcome of a dream involves having the child tell the dream in as much detail as possible and then having the adult or caregiver talk with the child to reframe the dream in which the outcome is favorable or the child obtains mastery over the feared interaction.

Use of concrete props would include having a night light or intercom added to the room if one is not already present, providing the child with a whistle to call the parents, bolting windows, etc. A concrete mastery skill for a child who is fearful of being abducted at night is to do something to make their room more

secure, for example, securing windows so that they cannot be opened from the outside or going through a routine with the child before bedtime of locking doors. Concrete actions which include the child are more reassuring to the child than just telling them what an adult has done. Because of their participation, there is no question of whether the adult has actually followed through. Encouraging the parent or caregiver to make this a playful or fun activity may need to occur in some families where child or parent actually experience increased anxiety because of the meaning they attach to the routine.

Withdrawal and Depression. For family abducted children these symptoms are typically reflected with decreased interest in normal activities, difficulty concentrating, tearfulness and increased sensitivity, and isolation. Four useful strategies in symptom based treatment are: (1) direct detailed discussion by the family of the abduction event; (2) establishing and implementing a family/individual healing model; (3) establish or re-establish healthy family routines and patterns.

Direct discussion about the abduction told in a family format, with each family member contributing, provides an opportunity to practice communicating about the experience. The recovering parent should be cautioned to talk about their feelings on learning the child was missing and their efforts to locate the child but not make derogatory statements about the abducting parent as this could be detrimental to the child. It may also serve to limit open communication and cause the child to edit their responses. The therapeutic environment provides an opportunity to have this discussion which may otherwise be too overwhelming for the family. Creating the opportunity for dialogue between family members about the traumatic experience is another way to reinforce mastery when done in a planned and careful manner. This can meet with some resistance from the family or individual members. Sometimes this resistance can be overcome by giving a clear and concise explanation of why the discussion is important. Some families are concerned that discussing the abduction will be traumatic. Sometimes this resistance can be reduced by having family members have the initial discussions in dyads, for example abducted child and mother or non-abducted sibling and victim child. Start with the dyads that have a chance of success.

Many children have ambivalent feelings in reference to some aspect of the abduction or even the parents. They may be angry about the abduction but still love the abducting parent. In other cases these feelings are directed towards the searching parent. Most parents want validation of their feelings about the other parent from the child. But, it is important for the child have permission to have ambivalent feelings if they are to work through their concerns. The family meeting is an arena in which this can hopefully be achieved.

Family and individual healing models focus on assisting the family and individual family members develop a sense of mastery by picking one issue and working towards mastering that goal. This focus helps in mobilizing individual family members in problem solving behavior. For example, a goal may be to plan and implement a strategy for being reintroduced to extended family members. Alternatively, the family may discuss and develop a strategy for the recovered child/children to meet peers in their neighborhood or community, or in cases where former playmates are nearby, renewing contacts. In cases where there are new children in the home, such as half or step-siblings, it may be useful to instruct the parents to develop a time where the children can each demonstrate their favorite activities, plan a mutual activity, and so on.

Parallel to the family focus of mastery is individual focused mastery for each family member. This can be helpful in reintegrating the child into the family. For example, a child who was responsible for taking out the garbage before the abduction can be reintegrated into the family by being encouraged to reassume responsibility for that chore. Likewise an older child who was active in a youth group, sport or special interest prior to the abduction would be supported in resuming those activities.

Establishing healthy routines and patterns in the family can also be an effective way of having family members overcome feeling alone and isolated. For example, it may be helpful for the family to establish a routine of checking in at the end of a busy day. Each person can report on their activities for the day and their plans for the next day may. Or using meal times to have discussions about a general question, sometimes serious and sometimes humorous, can help facilitate communication and a sense of importance to the family. Topic areas may be "What was your most embarrassing experience?" or, "if you could have three wishes, what would they be?" Another more playful question may be, "if you could be any animal, what would it be and why."

Somatic concerns. Many of the same approaches that are helpful in addressing prior symptoms are also effective in reducing or alleviating somatic complaints. However, careful note should also be taken of unusual or chronic complaints. For example, a child who has chronic complaints of headaches should be referred for medical clearance to insure there are no physical contributions. A related assessment consideration is whether the somatic symptoms are general complaints or relate specifically to part of the abduction experience. While relaxation and other general techniques may be helpful in reducing general somatic concerns they are less likely to be effective with incident specific complaints. In the later case, interventions specific to the concern may be indicated.

Acting Out Behavior and Defiance. Because of the confusion associated with different, if not conflicting parental messages, feelings of betrayal, questions about the custodial parent's sincerity in their concern for the child, and possible resentments over the disruption to their life, children abducted by a family member often express these feeling through acting out or by intentionally testing other's behavior. Interventions may include: (1) direct discussion of the child's ambivalence or questions regarding the custodial parent, (2) identification of child losses/disruptions that can be remedied, (3) restatement and reinforcement of the family rules, (4) clear communication about expectations and consequences.

Direct discussion of child ambivalence and questions provides an opportunity not only to clear the air but also to discuss and problem-solve unresolved questions and feelings. For example, the child may need to ask the parent about specific allegations or statements made by the other parent. In the case example involving two children abducted by their mother and told that their father abandoned and abused them, the children needed to discuss the circumstances of their abduction and the allegations by the mother that their father had physically abused them prior to the abduction. Clearly it is best for the recovering parent to do this in a non-blaming way to avoid putting the children back in the middle. Or a child may feel a sense of loss over the changes that occurred in leaving friends or a school where they felt comfortable and supported. This is especially true for recovered teenagers. Often they are reluctant or refuse to relocate to the recovering parent's residence. When a recovering parent has remarried during the missing period, the recovered child may have questions about the decision to marry.

Sometimes children have experienced specific losses that can be remedied. While some family abducted children may lead a fugitive lifestyle, others integrated into a community with established friendships and activities. A child who played soccer and was on a team during the missing period could be enrolled in a similar program post recovery. A child may also have become accustomed to a specific routine or special ritual with their abducting parent. They may grieve the loss of the special bond they felt with the abducting parent in those rituals and not want to give it up. For example, they may have had a special bedtime storytelling routine. In another case, the child had become accustomed to a birthday cookie rather than a birthday cake. While the clinician may encounter some resistance by the recovering parent to make some concessions, these adjustments for the adult may be minor in comparison to the benefits for the child.

Some recovered children have a difficult time adjusting to the rule changes from one household to the next. They require time and reminders of the family rules. Other children may be aware of the new rules but test the boundaries of how far the rules can be stretched. Still other children test the parent to see just how committed the parent is to the rules and how willing they are to enforce them.

Whichever dynamic is in effect, the parent needs to consistently restate and reinforce the family rules. This is typically difficult for a recovering parent, especially if the child/children have been gone for an extended period. These parents may struggle with having to reinforce the family rules because of fear of rejection by the child and/or wanting to make up for the time lost during the missing period. Indeed, recovering parents may be reminded by the child that the abducting parent didn't have the same rules with the added salvo that the child liked it better in the other parent's care. Since the majority of family abduction cases result in another custody dispute post-recovery, these comments can be difficult for the recovering parent. The astute clinician is aware of these intervening factors and that the recovering parent may initially be reluctant to follow through on suggestions aimed at setting appropriate boundaries. Other recovering parents may have the added difficulty of not possessing the skills to appropriately set limits.

Coping Styles. Cognitive coping styles fall along continuums. The dimensions most useful in understanding the response to abduction are approach vs. avoidance and internalization vs. externalization. Clinicians may include other continuums they have found useful for conceptualization and intervention. Identifying the individual coping style of the recovering parent, sibling or child victim will give the clinician some guidance in understanding the individual response to the trauma. Individual differences in perception of an abduction event and response to the event have been observed in cases where more than one child has been taken. Similar differences can be seen between individual family members.

Differences in individual coping styles are salient at two levels. The first is at the family dynamic level. Different family members will interpret and cope with the event differently, depending on their style. Family intervention at some point is typically necessary to work with the family on accepting their different perceptions and coping styles. Family intervention also will need to address conflicts, resentments and misunderstandings that develop because of these different coping styles.

The second level at which understanding the specific individual coping style is important is in developing specific treatment plans. The individual coping style assists the clinician in understanding what resources and limitations each individual will have in addressing the specific abduction related issues. Another perspective is that it assists in identifying what types of intervention will work and which probably will not. Both internalizers and externalizers will have to come to the point of identifying and appreciating their survival skills and the effectiveness given their recovery. However, the process each goes through to arrive at that point

will look very different. The clinician will also have to be more astute to these issues because the internalizer is less likely to express their struggles and concerns.

In the case of the approach versus avoidance issues, avoiders will have a more difficult time continuing in treatment. At times, their avoidance makes it difficult for them to see the need for treatment. At other points when their avoidance is too severely challenged in the therapeutic process, they may try to escape to relieve the tension they experience. In keeping with their avoidance they will have a difficult time expressing the reasons behind their decision to leave treatment directly.

Other related dimensions that emerge are minimizing (a form of avoidance) versus catastrophizing (a form of approach) the abduction. Some people will compartmentalize the event and wall it off from the rest of their existence while others will try to integrate it by giving it meaning or identifying what lesson is to be learned from the experience.

Working with cognitive styles can be very tedious and demanding. It is often difficult for people to see the limitations of their styles or to approach a problem from another perspective. However, attacking a person's coping mechanisms prior to providing them with alternatives can leave them helpless to deal with or defend against the painful affects associated with the trauma of being abducted or having one's loved one abducted.

Return to Therapy:

Due to a combination of factors, many abducted children and their families may need to return to treatment to revisit abduction related issues. In some cases this may be due to the implementation of a brief therapeutic model at the time of the initial referral. While brief therapy may have been helpful at the time, some families and children will need to return to treatment as they transition through normal developmental phases and new symptoms develop or old issues re-emerge. In other cases some issues may not have adequately been resolved. Whatever the reason, the clinician should be prepared for the need for periodic return to treatment.

Some children and their families may be embarrassed by the return of symptoms and perceive that they have failed because they "should be better" with the previously prescribed number of sessions. The clinician will need to examine these perceptions and must be prepared to convey the message that "nothing is wrong with the short term model of reunification but the need for longer term treatment doesn't mean they have failed."

Caretaker factors in treatment follow-through. Caretakers of abducted children will also fall into three general categories. As referenced in the section on reunification, one group may or may not perceive the child's symptoms or need ongoing treatment for themselves. Whichever the case, they are not interested in treatment and will not follow through with treatment. Sample interventions for those groups are referenced in the reunification section of Chapter Three. A second group will have some awareness of the issues but are so overwhelmed by the traumatic experience that they simply desire symptom based treatment aimed at symptom alleviation or reduction. In the third group, the primary care-giver typically understands the issues, identifies the need for intervention and desires on-going treatment aimed at addressing not only symptom relief but also reworking the assumption violations. The texture of this process is in part molded by the experience and in part by the cognitive coping styles with which the individual and family approach treatment.

Therapist Questions:

1. Child Placement. Return of a family abducted child to the searching parent should not be the automatic assumption. While most family abducted children are returned to the searching parent, it is not always in the child's best interest to do so. This occurs in the following circumstances:

1. The recovering parent cannot provide an adequate environment or parenting for the child; or, the parent has a documented history of abuse towards the child. In some cases, the searching parent may have not provided adequate care for the child pre-abduction or exhibit significant problems that interfere with parenting, for example severe substance or alcohol abuse, severe mental illness, abusive behavior toward the child and the absence of an inadequate residence.

2. Neither parent can provide an adequate environment or parenting for the child. In some cases, both parents present a history of inadequate parenting with multiple problems that prevent them from providing for the needs of the child. In those cases it may be in the child's best interest not to be placed with either parent.

3. The recovered child/adolescent has been missing for a number of years and removal from their current environment would be detrimental to the child, for example, the recovered child who is an adolescent who is in their last year of high school with an established network and friends. Sometimes these recovered children will resist return to a parent they do not know or being removed from their current environment. However this should not be assumed in all cases just because the recovered child is initially fearful or reluctant to return to the recovering parent.

See Chapter Seven for the types of communications the abducting parent may give the child about the abduction and searching parent during the missing period.

2. **Diagnostic Issues.** The clinical evaluation of the abducted child and family members must also consider appropriate diagnosis. As documented in the literature, trauma may lead to a variety of diagnostic syndromes including depressive disorders, anxiety disorders, adjustment disorders, attachment disorders and so on. Some children and adults may develop a series of symptoms that do not meet DSM-IV (1994) criterion for a diagnosis. Others may not have experienced the abduction as traumatic. Accurate diagnosis is essential for case formulation and implementation of a treatment plan.

The presence of symptoms that do not meet DSM-IV (1944) criteria for diagnosis represents a difficult issue for some mental health providers when a diagnosis is required for third-party reimbursement for services. Recovering parents may lack the financial resources to pay for treatment due to the cost of searching for their children while they were missing. As in the case of other types of trauma, mental health service providers are caught between the knowledge that these children would benefit from the opportunity for treatment versus the dangers of stigma, later in life, from over diagnosis. While it is beyond the purview of this manual to resolve the individual practitioner's dilemma, a general guideline includes exploring all diagnoses within the general category/categories where the symptoms fall, including NOS (not otherwise specified) designations. If a particular child does not meet diagnostic criteria, they should not be diagnosed and alternative funding resources or service provider options should be explored.

One diagnosis that has been overused in the area of trauma treatment is Post Traumatic Stress Disorder (PTSD). While PTSD may be an appropriate diagnosis in some cases, it is not always the correct diagnosis and should not be used as a diagnosis of convenience. Failure to thoroughly evaluate may lead to misdiagnosis and consequently inadequate treatment. Some children and their families may come to treatment with dual diagnoses. Some conditions may have developed even prior to the abduction and remained untreated. For example, some children have an undiagnosed learning disability or attention deficit disorder in addition to the issues due to the abduction. Other children may have developed phobias as a result of the abduction. Likewise a parent may have an undiagnosed depression that would require evaluation by a medical doctor for possible use of psychotropic medication in addition to treating the problems associated with the abduction. The important message for the clinician is to thoroughly and carefully evaluate each individual case.

3. **Therapist Background and Experience:**

While many mental health professionals have the basic clinical knowledge and training to provide treatment to a variety of clinical populations, the following offer some practical guidelines.

1. Background in understanding and treating trauma. Background, training and experience on assessment (Kordich-Hall, 1993) treating trauma victims is a prerequisite for working with abducted children. Background and experience can be obtained through reading the literature, such as the texts written on treatment of trauma by James (1989), Herman (1992) Lowenstein, (1995) and Janoff-Bulman(1992). The inexperienced clinician can also arrange for supervision and case centered consultation from experienced clinicians in the field.

2. Knowledge about the specifics of family abduction. A great deal of printed material about family abduction is available as previously referenced in this document. It is imperative that mental health service providers who have not had prior contact with families of missing and recovered children access this material to familiarize themselves with the specific logistical, financial, legal and emotional challenges and disappointments facing searching and recovering parents. Popular novels also illustrate the experiences of these families (Doyle & Nichols, 1994; Mahmoody & Dunchock, 1992).

3. Background and familiarity with developmental issues. The mental health professional should also have experience in treating children and/or adolescents and knowledge of the developmental issues and limitations of the age group they are treating. This knowledge is necessary to provide appropriate interventions for the developmental level of the child.

4. Readiness to Deal With Complex Issues. Family abductions are often multifaceted cases. This is due to the child's conflicted feelings about the abducting and recovering parents. In some cases their may be abuse allegations either pre or post recovery that are still pending. Custody and visitation are often revisited post recovery with efforts to return the issues to the courtroom. It is often useful for the clinician to have more than one mental health professional working with the family.

5. Evaluation of the Potential Influence of the Clinician's Personal Issues. Family abductions can tug on the mental health professionals personal family issues, either from childhood or from their current family status. As is true in treating other forms of child exploitation, the responsible clinician must evaluate and be aware of his/her own biases and vulnerabilities in making the decision of whether to accept a case for treatment or refer it on.

6. Forensic Involvement. Because of pending criminal and/or civil court actions, the mental health professional is often called upon to provide an evaluation of the child or various family members or testify in legal proceedings. For the treating clinician, it is important to define the differences between clinical and forensic evaluation, and the difference in the treating versus evaluation role. In cases where forensic evaluation is needed, it should be completed by an independent professional, other than the therapist. However, this does not mean that the treating clinician may not still be called into the courtroom to give testimony as the treating professional.

Family abductions are complex cases, and require careful consideration by the clinician of both their qualifications and ability to intervene in such cases.

PART IV
FUTURE NEEDS

CHAPTER NINE - LIMITATIONS AND NEEDS OF THE MODELS

Clinical evaluation across the samples of missing children support the face validity of the model for identifying, evaluating and treating child and family needs. However the model has not been adequately tested. Development and review of the literature, expressed desires of project therapists, discussions with parents, and input from missing children's organizations, colleagues and other disciplines identified areas for further development. These include (1) treatment and or support for families during the missing period, (2) treatment for families in which the victim is recovered deceased or missing long term, (3) providing resources for mental health professionals in the courtroom, (4) interventions which account for ethnic and cultural diversity, and (5) prevention.

In non-family abductions, Boudreaux, Lord and Dutra (1999) found patterns of characteristics depending on the age and sex of the child. In a study of 550 child abduction victims, females (70%) were at higher risk than males(30%). Younger victims (ages birth to three) were more likely to be male. Females from pre-school through high-school were three more times likely to be abducted than males. In cases in which victims were abducted and murdered, teenage girls were at highest risk, followed by younger girls, younger boys and teenage boys. Perpetrator motivation for non-family abductions also vary including desire to possess a child, sexual gratification, financial gain, revenge and desire to kill.

In family abductions, males and females are equally likely to be abducted by their parents (Forehand, Long, & Zogg, 1989). These abductions are likely to occur in the context of custody disputes or to be correlated with a history of family violence (APRI, 1995). Risk factors of low socio-economic status, belonging to an ethnic or cultural minority with different values about child care arrangements after separation and divorce, concern about child neglect and family violence, unmarried/transient status, and psychological characteristics which reflect narcissistic, sociopathic personality disorders have been seen in some samples (Johnston, et. al. , 1994). In some cases the location of the family abducted child is known but retrieving the child was an issue (Forst & Blomquist, 1991). Motivations for family abduction may include (1) parent fear of losing custody, (2) parent dissatisfaction with custody decisions, (3) retaliation against an ex-partner, (4) parent belief that the other parent is harming the child and (5) parent perception of having a right to the child (Agopian, 1981). When abduction involves taking a child to another country, searching parents face increased obstacles and barriers to recovery.

The variability in perpetrator motive, offense patterns and victim preference suggests the importance of not viewing child abduction in generalized terms. Prevention efforts and post recovery interventions should be based on perpetrator, offense and victim characteristics.

- **Professionals Should Understand And View Family And Non-Family Abduction As Separate And Distinct Experiences.** The children and families in each of the abduction subgroups need to be treated as two separate populations with different issues and treatment needs. The needs, concerns and symptoms manifested in each abduction subgroup differ and require a different knowledge base and intervention. Individual needs depend on the case-specific fact pattern and pre and post-abduction stresses and coping resources for the child and family. Programs should be developed to train mental health professionals, victims witness professionals and social workers on the needs of family and non-family abducted children, assessment of these children and their families, and the unique and sometimes counter intuitive reactions and treatment needs of this population of exploited children. Further refinement of treatment needs and interventions will evolve with application of the models.

  In addition the special needs of ethnically and culturally diverse groups requires attention. Cultural differences in child rearing attitudes and values impact what constitutes effective intervention. Additional work with inter-city, rural and families of varying socio-economic levels will result in further refinement for these diverse groups.

- **Intervention Strategies For Unserved Populations Should Be Developed.** Mental health interventions which target the needs of searching parents/families of children during the missing period have not yet been developed. Parents/families of children recovered deceased and those with long term missing children are other underserved populations. Mental health treatment strategies and guidelines are needed for these populations.

- **Abduction Prevention Materials Should Be Developed and Distributed.** The diverse perpetrator behaviors, offense patterns and victim characteristics evident in abduction suggests the importance of developing prevention materials based on the risk for younger children to older teens for each type of abduction. For family abduction material should also be targeted at specific risk groups of parents which includes information about the detrimental impact of abduction on the abducted child and on the child/parent relationship.

- **Multi-Disciplinary Training And Information On The Impact Of The Abduction Experience.** Optimally, training will be provided in multi-

disciplinary forums which promote coordinated intervention and services. Workshops should be designed and incorporated into the educational curriculum for judges, attorneys, social service personnel, victim's advocates, investigators and mental health service providers to facilitate comprehensive understanding and coordination of services for both child and family. Multi-disciplinary training will also facilitate mental health provider response to questions from the courts and other disciplines aimed at the best interests of the child.

- **Educational Material For Parents And Siblings Of Missing Children Should Be Developed And Disseminated.** Summaries of the information in this project, with special attention to assisting the parents to more adequately anticipate and respond to the needs of the recovered child and their siblings should be developed. Siblings need information that will help them feel less isolated and powerless when the primary focus of the family's attention is on the recovery of the missing child.

CHAPTER TEN - RESOURCE LIST

Abduction Projects Funded by the Office of Juvenile Justice and Delinquency Prevention

National Incidence Studies: Missing, Abducted, Runaway, and Thrownaway Children (NISMART) This study was undertaken in response to a mandate of the Missing Children's Assistance Act (42 USC 5771 et seq.). The study estimated the incidence of missing children in 1988 in five categories: family abduction; non-family abductions; non-family abductions; runaways; thrownaways; and missing because they have become lost, injured, or for some other reason. This report was released in 1990 and is available from the Juvenile Justice Research Clearinghouse (JJRC), 1-800-638-8736.

Family abductions include those instances in which a noncustodial parent keeps a child overnight in violation of the terms of agreed visits (broad scope) to those in which the child is transported out of state with the intent to keep them (policy focal). The estimated 354,100 broad scope family abductions included 163,200 more serious policy focal family abductions. This report was released in 1990 and is available from the Juvenile Justice Research Clearinghouse (JJRC), 1-800-638-8736.

Obstacles to Return and Recovery of Parentally Abducted Children This study identified major legal, policy, procedural, and practical barriers to the recovery and return of children who are victims of parental abductions and suggested recommendations as to how they can be overcome. It includes valuable resource material for attorneys as well. Report available from JJRC, 1-800-638-8736. A follow up training and dissemination project will be underway at the American Bar Association Center in Children and the Law, (202) 331-2250.

National Study of Law Enforcement Agencies' Policies and Practices Regarding Missing Children This study systematically describes the role of law enforcement agencies in both responding to reports of missing children and in the identification and recovery of these children. Report available from JJRC, 1-800-638-8736.

The Reunification of Missing Children This project examined a large sample of cases of recovered children and their families. This study found that nearly all of the children and their families received no services to help with the reunification process. The only agency personnel usually present at the reunification were law enforcement officers. The only agency that maintained contact with the families after recovery was the National Center for Missing and Exploited Children. (This project also developed multidisciplinary training material including a film, *When*

Your Child Comes Home, and training manuals on reunification). Report available from JJRC, 1-800-638-8736.

Families of Missing Children: Psychological Consequences This study found that the vast majority of missing and recovered children experience significant trauma and long-term distress as a result of abduction as well as further trauma at the time of resolution or recovery. Report available from JJRC, 1-800-638-8736.

Missing and Exploited Children Comprehensive Action Program (M/CAP) M/CAP serves communities by helping them develop coordinated, comprehensive procedures for management of missing, exploited, and abused child cases through the development of a multi-agency team and integrated case management system. For more information on this ongoing program, contact the M/CAP office (703) 734-8970.

Training and Technical Assistance for Prosecutors in Parental Abduction Cases The National Center for the Prosecution of Child Abuse at the American Prosecutors Research Institute (APRI) provides ongoing technical assistance to prosecutors and investigators on specific cases. The project has developed specialized information for prosecutors with experience in these kinds of cases. A manual on prosecuting parental abduction cases is being prepared and training conferences have been given to provide technical assistance. For more information on this ongoing program contact APRI, (703) 739-0321.

Study on the Prevention of Family Abductions of Children Through Early Identification of Risk Factors This program stud(ied) the circumstances likely to precipitate the abduction of a child by a parent or family member, including family domestic violence. The goal (was) to develop a means to define families at risk for abduction and evaluate prevention intervention strategies. For more information contact the American Bar Association Center on Children and the Law, (202) 331-2250.

Training and Technical Assistance for Nonprofits Working with Families of Missing Children This program is providing technical assistance and training to the nonprofit community to assist them in better serving families with missing and exploited children. Among the issues covered in the training are coordination with law enforcement, reunification preparation, assistance and follow up, issue and prevention education, community outreach, referrals, networking, improving service delivery, and advocacy. For more information on this ongoing program contact the National Victim Center, (703) 276-2880.

Overcoming Confidentiality Barriers to Find Missing Children This study primarily focuses on legal research to examine barriers, such as confidentiality

issues, to obtaining information necessary for the location and recovery of a missing child from such places as schools, public agencies, and medical facilities. For more information on this soon to be completed study, contact the American Bar Association Center on Children and the Law, (202) 331-2250.

Issues in Resolving Cases of International Child Abduction This research project is designed to document the cultural and institutional barriers to the recovery of children who were taken to or retained in another country by a parent or family member. For more information contact the American Bar Association Center on Children and the Law, (202) 331-2250.

CHAPTER ELEVEN - REFERENCES

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PART VI
APPENDICES

APPENDIX A - NON-FAMILY LITERATURE AND RESEARCH REVIEW

Child abduction by a stranger or non-family member typically are motivated by the following: (1) ransom, (2) abduction for sexual, sadomasochistic or ownership purposes, (3) creating an instant family and (4) accidental abductions occurring during the commission of another crime. Overall, most non-family abductions are for sexual purposes however, there are recent cases of ransom abduction as well. Infant abductions are often for the purposes of creating an instant family. The following provides a brief historical overview of non-family abduction.

Historical Context of Non-Family Ransom Abduction. On a warm summer's day in Germantown, Pennsylvania, five-year-old Charlie Ross is playing with his six-year-old brother in the fenced front yard of his family's house. The date is July 3, and Charlie is looking forward with great anticipation to the fireworks displays of July 4. Two men drive by, and engage the boys in conversation. Promising to take the boys to the store to buy fireworks, the two men manage to get the boys to ride away with them. The two men and the two boys drive around in the northern section of Germantown for approximately two hours. At this point, without explanation, the six-year-old brother is released, and the two men disappear with Charlie Ross. The year is 1874 and America's first documented child kidnapping has just occurred (Alix, 1978; Nash, 1986).

The first media report of the case appeared on the front page of the New York Times on July 5, 1874, stating that Christian K. Ross, the boy's father, had offered a reward of $300 for the recovery, or information leading to the recovery of his son. Omitted from this first news report was the fact that Mr. Ross had received a letter the day after his son's disappearance demanding $20,000 ransom or his son would be killed. The Times continued to carry reports of the case day after day.

On July 14, a Times editorial reflected the mood of the country: "The Philadelphia kidnapping still remains an unresolved dreadful fact-one suggestive of exceedingly unpleasant reflections which, from their very unpleasantness, should receive thoughtful consideration. A boy is taken away in open day by two men, who are keeping him from his family for the purpose of extorting money. The child is probably in no danger of life or limb, for his kidnappers have offered to restore him for twenty thousand dollars, and he must be in their eyes too valuable a piece

of property to be put in any needless peril. There seems to be no new clue to the detection of the kidnappers. The father is said to be prepared to pay the ransom demand, and anybody who calls this an act of weakness had better try to imagine what he would do himself if his own child were in the hands of these unknown scoundrels. (New York Times, July 14, 1874, p. 4)

On July 21, eighteen days after the kidnapping, the New York City Police Department received a tip that William Mosher and Joseph Douglas were the abductors. Mosher and Douglas had long criminal records for robbery and burglary in New York and New Jersey. At the time of the kidnapping, both men had escaped from jail.

Charlie's father agreed to pay the expenses of the investigation outside New York City, and New York City police detectives were then assigned to search for Mosher and Douglas, wherever the leads might take them. The next day, the mayor and city fathers of Philadelphia pledged a $20,000 reward. As days passed with little new news on the case, the Times continued to cover the issue with general articles on child kidnapping, citing historical material, and reported sightings of Charlie in New York, Massachusetts, Pennsylvania, Missouri, and Louisiana.

Finding Charlie Ross became a national issue. In August, the Times carried stories of an attempted lynching of a group of gypsies in Pennsylvania, who were believed to be holding Charlie. Parents with a child resembling Charlie were accosted from Nebraska to Vermont. Then in mid-August, with frustration mounting over the lack of any solid leads, suspicion turned toward the Ross family itself. The Times began to report rumors that Mr. Ross was somehow involved in the crime. Many letters of support were received at the Ross house. Crank letters and behaviors also occurred, as exemplified in the case of the ventriloquist who caused quite a disturbance at a Philadelphia warehouse when he tricked others into believing that the voice of Charlie Ross was calling for help from inside a storage trunk.

It is now December, and almost six months have passed since the kidnapping. Mosher and Douglas are still at large. On the night of December 14, Mosher and Douglas enter a summer home on Long Island, New York to commit a burglary. However, their entry triggers an alarm in the main house. As they are attempting to leave the summer home, Mosher and Douglas are discovered and shot by police. Both men die, but Douglas confesses to the kidnapping of Charlie Ross before dying.

Mr. Ross continued to be determined to find his son, traveling across the country to see hundreds of boys in hopes of finding Charlie. He eventually gave in to the offers of circus promoter P. T. Barnum for a new $10,000 reward campaign.

In February, 1878, he told the Times: "This makes 573 boys I have been called to see, or have been written about, and my hundreds of failures to identify each waif as my own has taught me to entertain no sanguine hope. I suppose I shall continue going to see boys till I die, but I don't expect to find Charlie in any of them." (New York Times, February 6, 1878, p. 1). Beginning in 1882, a new development took place as the Times began to report stories of teenage boys coming forward, claiming to be the long-lost Charlie Ross. Mr. Ross searched for his lost son until his death. Charlie Ross was never found. Although it occurred more than 116 years ago, the Charlie Ross story, the public reaction and the resulting media attention as shown in the New York Times coverage could easily reflect today's headlines on a child kidnapping.

The Lindbergh Kidnapping. On March 21, 1932, as new anti-kidnapping legislation remained stalled in the U.S. Congress, twenty-month Charles A. Lindbergh, Jr. of Hopewell, New Jersey was kidnapped. On May 11, 1932, the child was recovered deceased, resulting in tough new federal anti-kidnapping legislation bills signed into law by President Herbert Hoover on June 2, 1932 and June 22, 1932. These bills are characteristically referred to as the "Little Lindberg Laws."

Nonetheless, kidnapping of children for ransom continued, including nine-year-old George Weyerhauser of Tacoma, Washington in 1936; six-year-old Robert Greenlease of Kansas City, Missouri in 1953; and thirty-two-day-old Peter Weinberger of Long Island, New York in 1956. Spurred by the Weinberger case, Congress passed the Keating Bill in 1956 which authorized the FBI to enter the investigation at kidnapping cases without being restricted by the prior seven-day waiting period from the date of abduction.

Despite this additional set of federal legislation, child kidnapping for ransom continued, including eight-year-old Lee Crary of Everett, Washington in 1957; nineteen-year-old Kenneth King of Beverly Hills, California in 1967; six-year-old Keith Arnold of Detroit, Michigan in 1973; sixteen-year-old J. Paul Getty of Rome, Italy in 1973; and a school bus of twenty-six children from Chowchilla, California in 1976.

Alix's (1978) review of ransom kidnapping citations in the New York Times Index showed incidence peaks in 1933 and 1974, with children as the majority of victims prior to 1920.

Historical Overview of Non-Family Abduction of Children for Motives other than Ransom (sexual, sado-masochistic, ownership). Non-family abduction of children for motives other than ransom has also been recorded throughout history. Child abductors with sexual, masochistic motives have been

predominant (Wilson, 1990; Wilson and Seaman, 1988), including Roman Emperor Tibertius; Ibrahim Ibn Ahmed, Prince of Africa and Sicily in the 9th Century. In more contemporary times, the presence of non-family child abductors with sexual motives has continued, John Wayne Gacy in Chicago, Illinois in 1978; Wayne Williams in Atlanta, Georgia in 1980; Ted and Mildred Gaum in Riverside, California in 1984; Andro and Marge Garcia in Twenty-Nine Palms, California in 1985; Herb Coddington in South Lake Tahoe, California in 1986 and Carla and Paul Bernardo in Toronto, Canada in 1994.

While many have killed their victims, others have been recovered and returned to their families.

Non-Family Abduction Research

Psychological information on non-family abducted children and their familes comes from four primary sources. These include inquiries into the circumstances and effects of stranger abduction, such as Terr's (1979) study of the victims of a 1977 school-bus kidnapping in Chowchilla, a small town in the central valley of California. Hatcher (1981) studied the behavior of both child and adult hostages/kidnap victims and developed a conceptualization of the stages a victim passes through in attempting to cope with abduction or detention against one's will. The third souce is an OJJDP funded project, Families of Missing Children: Psychological Consequences of Abduction (Hatcher, Barton & Brooks, 1992). The fourth source, another OJJDP funded project is: Reunification of Missing Children (Hatcher, Barton & Brooks, 1992b). The findings of these four investigations about the child and family experience of non-family abduction are summarized in brief.

I. Findings From the Chowchilla Abductions:

Circumstances of the Abduction. In the incident studied by Terr, 26 children, who were riding the school bus home from a day in summer school, were commandeered by three masked abductors. All 26 students and the bus driver were abducted and transferred at gun point to two vans. They were then driven around in total darkness for 11 hours, and transferred individually from the vans to a buried truck trailer. The buried trailer was poorly lit, contained minimal food supplies, and contained only two wheel wells as bathroom facilities.

After transferring the captives to the buried trailer, the trailer was entombed by shoveling dirt over the ceiling entrance. The children and their driver were buried for 16 hours. Toward the end of this period, a few boys and the driver managed to dig their way out, establishing the opening through which the entire group finally escaped. After escaping, the bus driver telephoned the police, who then took the captives to facilities in a nearby prison overnight for debriefing and

questioning. The children were finally reunited with their families the next morning, having survived a total of 43 hours of abduction, confinement, separation from their families and uncertainty about survival.

Sex of the Child Victims. The group studied by Terr consisted of 17 girls and 6 boys. While the sex of the victim may not be a factor in the abduction of children for ransom, in cases where the victim is taken for the purpose of sexual gratification, the sexual preferences of the abductor determine the sex of the sought-after victims (Finkelhor, Hotaling, and Sedlak, 1990).

Age of the Child Victim. Children in the Chowchilla kidnapping ranged in age from 5-14 years (Terr, 1979). In another study by Hewitt, Beaudry and Moran (1986), four children ranging in age from 5 to 12 years old were abducted. Pre-adolescent and adolescent girls are more likely to be abducted than males or younger children and constitute the age group most at risk.

Characteristics of Abductors. While there has been no quantitative study of the characteristics of child abductors who are not related to their victims, the following description of the abductors in the Hewitt, Beaudry and Moran study fits closely descriptions of abductors obtained from other anecdotal accounts.

The abductors were both Caucasian males. One committed his first kidnapping at age 35, while the other accomplished one kidnapping at age 42, followed by a second kidnapping at age 49. Both had a history of arrests for sex charges, and both reported being sexually abused as children. Their life histories presented a picture of loneliness, isolation and powerlessness. Abduction provided them with an experience of control and power. The abductors had developed a conscious plan for control of the victim which centered upon: (1) convincing the child that he was not wanted by family and friends, and (2) bonding through participation in sexual activity.

Functioning/Stressors Prior to the Abduction. Data on child and family baseline functioning prior to the non-family abduction are very limited. Based on her observations of 23 children in the Chowchilla kidnapping, Terr reported the following information:

(1) Socio-economic status of the victim families ranged from extreme poverty to middle-class.
(2) In 5 of the families, no major preexisting problems were evident; (i.e., separation/divorce, mental illness, alcohol abuse, violence, death, frequent moves, and/or chronic illness).
(3) In 8 of the families at least one of these problems were present.

(4) In 10 of the families, 2 or more major problems existed prior to the abduction.

It is not known whether these characteristics differ from those of families not experiencing a non-family abduction. Of the child victims themselves, parents reported that prior to the abduction:

(1) One of the group of 23 had recognized serious preexisting emotional problems and three children had previously undiagnosed psychiatric difficulties.
(2) Two children had serious preexisting physical disabilities.
(3) Six children had evidenced more transient developmental difficulties.
(4) The minority of children (11) were reported as not having any prior emotional and/or physical problems.

Pre-abduction Family Resources. As stranger abduction is often a random event for the victim, it would be expected that the families who experience such an event are typical of families in general, in terms of pre-abduction crisis-meeting resources. Terr (1983) described ten of the families in the Chowchilla kidnapping as having a strong bond with their community. These families had extended family ties in the immediate area.

Post-abduction Family Resources. Terr (1983) observed that parents of children taken in the Chowchilla kidnapping were recipients of much post-abduction community and media attention, which included a trip to Disneyland. None of the families had sought trauma-related counseling or mental health services to help them cope with the after-effects of the trauma. Terr described a community bonding that took place around the shared traumatic event of the kidnapping. Friendships were formed among families who shared this experience. Long-term follow up revealed that the bonding was temporary, as the kidnapped children did not keep up their relationships with each other, and mothers of the kidnapped children who had developed friendships did not maintain those friendships.

Post-abduction Perceptual Definitions of the Abduction Event. Kidnapped youngsters remembered quite vividly how they themselves and their peers had responded at the moment of abduction. At the instant of the bus takeover, children in the Chowchilla kidnapping remembered crying, but they reported no paralysis of action, numbness, flailing about, amnesia, or severe depression and withdrawal (Terr, 1983). In terms of immediate cognitive-perceptual reactions, eight of the children were aware they were being kidnapped, with most of the others having a vague, less comprehensive idea of what was happening to them.

Cognitive Perceptual Errors. One common initial response was the misperception of the kidnappers appearance, including the mistaken belief by some children that there were additional abductors. Inaccurate descriptions of the abductors included a "bald man, a lady, a black man, a man with a peg leg, a chubby man, and a man in the front seat of a green van." Children's descriptions of their abductor, therefore, may be unreliable. We do not know what part of the child's errors in reporting comes from his misperception ("seeing") versus the child's desire to please a questioning adult.

Two children reported both visual and auditory hallucinations during the abduction event. For example, one boy who was primarily responsible for digging the children out, hallucinated several times while digging and was convinced that this would result in his mind being permanently damaged.

Child Emotional Reactions to the Abduction Event. Five months after the abduction and recovery, Terr established contact with the group of kidnapped children and their families. Over the next 8 months, the children, along with one or both parents were interviewed. At the time of interviews which occurred between 5 and 13 months following the abduction the following findings were obtained.Three major fears developed in the group of children as a whole:

(1) **Fear of separation**: Five children remembered worrying that they would never see their parents again, while 2 others were preoccupied with separation from their siblings.

(2) **Fear of death:** During their initial capture and transfer, many children (particularly those 8 and older) reported experiencing great anxiety about what would happen next. These fears included being shot, smothered, asphyxiated, or burned to death. Eight children remember being aware that they might die at any moment.

(3) **Fear of further trauma:** Several children actively misperceived the abductors return at some point during their captivity, despite the fact that this never occurred.

In addition to the perceptions reported above, the kidnapped children placed importance on two phenomena. These were labeled by Terr as "retrospective significance" and "omen" formation. "Retrospective significance" refers to the last contact the children had with parents, siblings, or an earlier event, becoming intricately associated with both the thoughts and feelings of the child about the abduction episode. For example, several children had fights with their parents the morning of the kidnap.

The formation of "omens" refers to events prior to the kidnapping which could have served as portending signs in a way that would have enabled the child to avoid, or prevent, the trauma. As children sought to understand their abduction, they frequently made psychic connections, or what Terr has referred to as "omens", linking events which occurred prior to the abduction, to the abduction event itself. This occurred for Bob, age 14, whose mother usually drove him home after school each day. On the morning of the abduction, Bob had taken a long time getting ready and his mother told him to take the bus home from school. He initially experienced the abduction as a punishment but came to believe that he was placed on the bus so that he could help the other children.

Family Reactions to the Abduction Event. Pre-crisis event styles of coping may be activated by families in their attempts to deal with the crisis of a non-family abduction. Family members involved in the Chowchilla kidnapping had a tendency to react with over protectiveness often mixed with hostility toward "outsiders." Many of these families demonstrated hostility directed at the media, town officials, and administrators. In the Chowchilla incident, law enforcement officials were typically seen as allies and a source of unity among parents who were invested in seeing the abductors found and convicted.

Another method families have of coping with stress or adversity is to relocate away from the perceived source of the family's trouble to a new location. Terr observed that a total of 5 victims had moved away from Chowchilla by 13 months following the incident. Some of these moves occurred for reasons unrelated to the kidnapping. However, in some cases abduction related factors were a consideration in the decision to move. These factors included fear of another kidnapping. It is not known whether these were more transient families for whom this was pattern of coping.

In her book on the Chowchilla kidnapping, *Too Scared to Cry*, Terr (1990) describes the growing realization on the part of parents that something might have happened to their child when the expected child did not arrive home on time. In terms of the family's immediate response to the trauma of their child's abduction, Terr describes an initial sequence of: 1) confusion giving way to 2) severe apprehension, followed by 3) a tendency to feel guilty for not having prevented the abduction.

Intermediate and Long-term Experience of Stress Due to Abduction. Following the escape and recovery of the children in the Chowchilla kidnapping, the children and their parents were immediately bombarded with media interest and attention. The families became overnight celebrities, and for many the kidnapping brought them a once in a lifetime opportunity to receive the positive regard of their community and a concerned public. Since the children were not physically

damaged by the event, family members were free to express their joy and relief. Parents were reassured that the children were not likely to be emotionally affected by the experience (Terr, 1981), so that it seemed that the nightmare was quickly over.

After a period of four months, some parents began to express concern about their children's emotional reactions, and Dr. Terr, a psychiatrist who specializes in the treatment of trauma, was contacted for consultation. Her observations of the children during the year following the event and four years after the kidnapping contain the most complete information on the long-term experience of stress by non-family abducted children.

Psychological Consequences. A variety of psychological consequences were observed in the children studied following their abduction:

Dreams and Fantasies. Dreams were another important data source in understanding the psychological reactions of the Chowchilla victims, indicating that:

(1) All of the children studied had dreams relating to the kidnapping following the event.
(2) One third had both terror dreams and other dreams as well, one fourth had only terror dreams, including dreams about personal death.
(3) Approximately one half had exact repeat playback dreams or modified playback dreams.
(4) One fourth of the children reported fantasies of revenge against the kidnappers.

Traumatophobia. Twenty of the 23 children still feared being kidnapped again, 5 to 18 months post-trauma, and 21 experienced fears such as being left alone, sounds, confined spaces, open spaces. These fears following trauma have been called "traumatophobia" or the fear of further trauma (Rado, 1942). Children remained sensitive to changes in their environment which reminded them of the abduction. Many felt they had to be permanently "on guard" to protect themselves against future insults, intrusions or traumatic occurrences. For some children, the fears became so intense that, on occasion, they screamed, fled, or called for help.

Post-trauma Performance Decline. Some children showed declines in cognitive functioning and school achievement. Terr reported that there was a worsening in school performance in one-third of the children in the Chowchilla kidnapping, and 2 children showed improved performance. The decrements in academic performance were felt to be secondary to

misconduct in the classroom, school avoidance, or the inability to concentrate.

Time Skew. Distortions in time sense or sequencing of events were observed by Terr in one third of the children. A perceived ability to predict traumatic experience, omen formation, as well as the belief in a foreshortened future (i.e., refusal/to make future plans, expecting the worst) were also noted.

Voluntary Re-experiencing of the Trauma. One fourth of the Chowchilla children reported daytime visions of the episode. These visions took the form of intentional recall of the kidnapping events. Terr emphasized that none of the children experienced involuntary flashbacks such as those reported by adults following trauma.

Continuing Sense of Vulnerability. One new finding in the Terr's follow-up study was the presence of profound embarrassment and shame in many of the children. It was described as a feeling of being naked, humiliated, or totally exposed when anyone knew how vulnerable they had been during the kidnapping. They preferred for no one to find out that they had been victims. Their temporary losses of personal autonomy still affected them 4 to 5 years after the trauma (Terr, 1983). It appeared that the children were not "toughened" at all by their experiences, and what most often occurred was a narrowing of their concern with outside events.

Terr (1990) has expressed a concern that even with intervention some of the effects of an abduction may be permanent alterations in the psychological make-up of the child victim. While some of these persistent effects may be related to the circumstances of the abduction, Terr found a strong association between preexisting physical and/or emotional difficulties and the development of post-traumatic symptoms in the Chowchilla kidnapping children. Symptomatology was found to be associated with: 1) the child's prior vulnerabilities, 2) family pathology, and 3) community bonding. Some of the factors associated with persistent symptoms are the following:

Sex Differences in the Manifestation of Symptoms. Terr (1985) found that it was much more common for boys to experience severe symptoms (5 out of a total of 6 boys) than for girls (5 out of a total of 17 girls). Sex differences appeared to be related to the extent of community ties, with boys' families demonstrating weaker bonding to the community than girls' families. Such family bonding may serve as a protective function in guarding against the development of severe emotional problems.

Collapse of Early Developmental Achievements and Confidence Loss. Some of the intense and persistent fears developed by the Chowchilla children appeared to be tied to the destruction of early developmental achievements or basic trust. According to Terr's observations, collapse of early developmental achievements following trauma surfaced as the inability to trust, and impaired ability to function autonomously. The inability to trust seemed to be associated with the shame a child feels due to "the temporary loss of personal choice."

Expectation of Foreshortened Future. This loss of choice and autonomy has been associated with the inability to see oneself in the future, the attempt to predict the future, and a belief in personal responsibility. Four to five years after the event, the abducted children often had a pervasive pessimism manifested by a sense that their future would be limited. Some expected a shortened life span and future disaster, while others were unable to foresee the possibility of future marriage, children, or career.

Compulsive Repetition. Terr reported repetition of dreams, post traumatic play, and reenactment of the trauma in children she saw, which often persisted many years after the trauma. Although the aim of repetitive behavior, which frequently appears in children through play, is to relieve anxiety, Terr did not believe that it significantly lessened the anxiety of the Chowchilla children. One child, who was 7 years old at the time of the abduction, frequently played games in which her dolls or her younger sister traveled but returned safely. When Leslie was 10 years old she ran away from home and accepted a ride from a stranger. Instead of experiencing this as an abduction, Leslie explained that the most important thing to her was that she was running away or, in other words, that she was directing her own actions, as opposed to being directed or abducted by another person.

Monotonous Repetition of the Abduction in Play. Eleven of the kidnapped children reported that they frequently "played" the kidnapping experience, but in a manner which involved monotonous repetition. This quality of monotonous repetition stood in stark contrast to the activity of untraumatized, "normal" children, whose play is oriented toward relief of anxiety. Typically, anxiety relief comes about by replaying situations in a manner in which they can symbolically gain mastery over prior events which they were unable to successfully control. In other words, for normal children, play provides an important opportunity for growth and development as well as a means of lessening anxiety. This quality was not evident in the play of the Chowchilla kidnapping victims.

Contagion. An additional facet of post-traumatic symptoms in children that Terr (1985) observed was that the symptoms seemed to be contagious for other family members or peers. As the traumatized child acted out the trauma repetitively, other individuals associated with the child were traumatized through this exposure. One example of contagion of another family member occurred when one girl, who was 12 years old at the time of the abduction, frequently jumped out of closets frightening her sister. A stranger abduction is likely, therefore, to have ripple effects that impact other family members as individuals and the functioning of the family system. The stranger abduction event may also produce a generational effect, as the event becomes part of the family history.

Major family problems were found for families during the 4-5 year period following the abduction of their child(ren). Terr (1983) found that 15 families experienced significant problems including family death, alcoholism, divorce or separation , family violence, or long distance moves. Terr (1983) concluded that brief treatment 5-13 months after the kidnapping did not prevent post-traumatic symptoms in these children 4 years later.

II. Stages of Adaptation to an Abduction:

Hatcher (1981) studied the behavior of both child and adult hostages and developed a five-stage conceptual framework for understanding the abduction experience. The following stages describe the child's changing responses over time to abduction or control by a stranger.

Child Hostage Stage 1. During the first moments of the abduction, the child's reactions are, expectedly, more primitive than adult behavior under similar circumstances. For most American children, their first association is with an experience seen on television or in a movie: "It was just like on TV or something."

Behaviorally, the child hostage seems to select from one of three response patterns; freeze, panic with crying and screaming, or making jokes. In contrast to the adult patterns, attempts to immediately flee or fight are rare. The freeze response is accompanied by internal fear, anxiety, and thoughts of being hurt. Crying and screaming is a high frequency reaction if a child is physically seized, or if one child in the group begins crying. Some children will first attempt to make jokes. These children appear to be assuming a known role, the comedian. The comedian is one of the few roles the young child has learned that will gain acceptance from most adults and peers.

In each of these response choices, the child's conception of what is about to happen is variable. He may see the captor(s) as "bad," "robbers," or "bad people

Mommy told me to stay away from." He fears that something very bad is going to happen, but he is not very sure what that is going to be.

Child Hostage Stage 2. The second child stage is characterized by acceptance/respect for captors. The child, in wishing to be a hero, has brief thoughts or ideas of taking action. As one might anticipate, these are not formulated into a more organized heroic action plan in the way that the adult does. As with the adults, action is rarely taken, but the fantasy shows up once again as an important defense mechanism.

Child Hostage Stage 3. The third stage is characterized by increased interaction between victim and captor and is characterized by the development of simple survival strategies. Both physically and mentally, the adult captor is able to exert such extensive control over a child that it is not surprising that the child's response is characteristically submissive and cooperative. While some children engage in searching behavior for means of escape, a most striking observation of the abducted child is the failure to utilize opportunities for escape. Even after the incident is over, the child often has difficulty explaining why he did not use opportunities to escape or why he picked the opportunity that he did. Whether the perceived absolute degree of control is induced by the adult captor or is attributed to the adult captor by the child hostage is not clear.

For child victims who are abducted as part of a group, obtaining food, water, and privacy during body elimination become priority times involving limited group interaction. Subgroups have been found to form around two principal characteristics: age and aggressiveness. Younger children and less aggressive children form one cluster, with older and more aggressive children in another cluster.

Child Hostage Stage 4. As disintegration or termination of captor's control begins, the child does not tend to show fear of loss of stability. Fear of death or injury during surrender is not commonly reported by children. As a child, trust of, or admiration for, the police officers remains relatively high.

Child Hostage Stage 5. In the last stage, the rescue is accomplished. Supportive physical exchanges are common between the child hostage and police officers. The child usually has a lot to say and is quite willing to talk to police at length about the incident. In fact, much greater willingness demonstrated to talk openly and at length with unknown police officers than with parents may be related to a child's fear that he has not lived up to parental expectations. Further, since the reuniting process involves a great deal of parental emotion, some children may assume responsibility for this parental emotion, feeling that the whole event was somehow their fault.

Hewitt, Beaudry, and Moran (1986) reported the reactions of four children who were abducted and two convicted abductors. The kidnapped children ranged in age from 5 to 12 years old. They were all from intact families and traditionally looked to adults for support, protection, and guidance. Two of the children were residing in small cities. The third child came from a large city, and the fourth was living in a rural town. The lengths of the kidnappings were 16 days, 6 weeks, 22 months, and 7 years.

In this series of cases, control was established by psychological, rather than physical means. All abductees were isolated initially from contact with others, and were relocated frequently, hampering the development of relations outside the now primary relationship with the abductor. Each child was given a new name to reinforce their new attachment to the abductor. The abductors would employ stories of parental rejection or lack of loving. The child would be told that the parents did not want or love him, and that loving parents don't spank or yell. The child waits for the loving parents to come and get him, which of course, does not occur. The child also remembers his parents having both spanked and yelled on occasion, and contrast this with the overtly positive, solicitous behavior of the abductor. In support of this, all of the children were given small gifts and/or taken on trips to places by the abductor. The child was constantly given the message: "I like you more than anyone else. If you leave me, I will hurt myself, return to get you, hurt your father and mother, or take you back."

The authors state that the child initially protested and resisted the statements of the abductors, while waiting for the parents to come. This, of course, does not happen. The child comes to realize that he probably could not survive on his own, and that serious consequences could occur if he rejects the abductor. In the midst of this despair stage, the abductor strengthens his hold over the child by introduction of sexual abuse, stating: "This is our special relationship. Keep this a secret or we'll both go to jail." The child's initial reaction was to wonder if he protested the sex act strongly enough, or if he was somehow guilty for just having gone through with the sex act.

III. Families of Missing Children Project: First Efforts to Understand Psychological Consequences.

This study, conducted by the Center for the Study of Trauma, University of California, San Francisco, provided the first scientific knowledge base for understanding the level of emotional distress experienced by abducted children and families (Hatcher, Barton, & Brooks, 1992). This project was conducted over a three year period at multiple sites throughout the United States. A sample of 280 families were followed prospectively with in-home interviews in a time series

measurement design from approximately one month after child disappearance to eight months after child disappearance. Three primary groups were studied: 1) child loss by non-family abduction (41 cases); 2) child loss by family abduction (104 cases); and 3) child loss by runaway status (104 cases). For comparison purposes, a separate group of families who lost a child as a result of sudden infant death syndrome (31 cases) were studied in a similar longitudinal manner.

Areas of investigation included:

(1) the type of missing experiences,
(2) the chronological experience of missing children and their families from pre-disappearance, to disappearance, to recovery or non-recovery of the missing child,
(3) the type and level of emotional distress experienced by families of missing children,
(4) the type of coping behavior used by families of missing children, and
(5) family utilization of intervention/support services.

Non-family abduction categories. One principal area of investigation of the project was to determine if there were subtypes of non-family abduction families based on differences in their experiences and to then assess for differences in distress among any such groups. Three non-family abduction categories were found:

(1) **non-family abduction with the child recovered alive** (child defined as one year of age and older),
(2) **non-family infant abduction** with the child recovered alive (infant defined as less than one year of age. All infants were recovered alive, consistent with prior data), and
(3) **non-family abduction with the child recovered deceased** (child defined as one year of age or older).

To determine distress in each of these non-family child abduction types that had now been identified in the project, parent, partner/spouse, and child distress were assessed using the Symptom Check List 90-Revised and the Frederick Trauma Reaction Index. The distress of parent, partner/spouse, and child were averaged to determine overall family distress.

These subtypes of non-family abduction families did differ in their experience of psychological distress. Some of the summary results were predictable. In non-family abductions with the child recovered deceased, clinical distress rates for family members is extremely high initially and remains at that same high level months later. In non-family infant abduction cases, clinical distress

rates are very high initially, and then decline rapidly over the following months. Since almost all abducted infants are recovered without any physical injury and within several weeks of the abduction, one could anticipate such a decline in distress. In non-family abductions with the child recovered alive, half of the families are above the clinical distress levels one month after the disappearance (some already recovered and some not). Months later, even with the child recovered alive, clinical distress rates remained for half of the families.

Characteristics of Child/Family in Non-Family Abduction with the Child Recovered Alive.

1. **Age and Sex of Missing Child.** The average age of the non-family abducted child who was later recovered alive was 9 years old for males, and 11.5 years old for females. When age and sex are considered, a pattern of pre-adolescent female non-family abduction child victims and much younger male non-family abduction child victims emerges. This latter finding is consistent with the results of the Reunification of Missing Children Project (Hatcher, Barton, & Brooks). The average age of the non-family abducted infant was 3.5 months.

2. **Racial/ethnic group identity.** Racial/ethnic group identity does not appear to increase or decrease the risk for non-family child abduction.

3. **Family Living Arrangement.** Most of the non-family abducted children and infants who were later recovered alive were living with both of their biological parents at the time of the abduction, with approximately one-third living with a single parent.There was at least one remaining child in over three-fourths of the families following a non-family abduction with the child who was later recovered alive. Approximately one-fourth of the biological fathers lived outside the home and did not have any contact with the abducted child/infant in the six months prior to the child abduction.

4. **Pre-Disappearance Traumatic Family Events.** Three-quarters of the families who lost a child to non-family abduction with the child later recovered alive reported multiple traumatic family life events prior to the child's disappearance. Families of missing children experience a range of important life events and social changes prior to child disappearance. These events, such as death of a family member or divorce, were not always seen as traumatic, and may even be viewed as positive by some family members. Yet, these same parents viewed pre-disappearance divorce as negative or traumatic for all of the children who were later abducted. Individuals assisting these families need to recognize that family distress after child abduction may be a function not only of the abduction, but also of other family events unrelated to the abduction.

5. **Physical and Sexual Abuse in the Family.** Physical abuse by one parent of another was reported in approximately one-tenth of families who lost a child to non-family abduction with the child later recovered alive. Approximately one-tenth of the abducted children were reported as sexually abused by an adult other than a parent. Sexual abuse or sexual assault is the most common motivation for non-family child abduction. Individuals assisting families, and later the recovered child, need to be aware of the existence of pre-disappearance sexual abuse. These children, if sexually abused or assaulted during the abduction, have now been victimized twice by intrusion by individuals from outside their home.

6. **Family Stress.** More than one-third of the parents in families affected by abduction with the child recovered alive reported high levels of family stress in the three month period prior to the abduction, thereby adding to the stress of the abduction event.

7. **Pre-Disappearance Child Safety Instruction.** Prior to the non-family abduction with the child later recovered alive, one-third of the families did not have instruction for the missing child nor the siblings on potential child safety dangers, such as sexual abuse or abduction by individuals outside the home. In one-third of these families, neither the missing child nor the siblings had been taught to be aware of potential dangers, such as sexual abuse or abduction by individuals outside the home.

8. **Pre-Disappearance Runaway Status.** In this project, none of the non-family abducted children who were later recovered alive had ever runaway prior to the abduction. This finding is noteworthy. All of the non-family abductions of children in this project involved abrupt seizure and detention of the victim. These victims did not have a prior history of runaway episodes, poor school performance, juvenile justice involvement, other indicators of problem behavior, nor did they seem to be engaged in other behaviors which might have placed them at risk for contact with violent non-family members.

Characteristics of Non-Family Abduction with the Infant/Child Recovered Alive: Parent's Family of Origin

In non-family abduction cases with the child later recovered alive, the parent's family of origin history is remarkable. Approximately one-sixth of the primary parents of the abducted children reported sexual abuse of themselves by a male parent figure in the family of origin. These findings illustrate the occurrence of child sexual abuse in the general population across generations, and show that families affected by non-family child abduction are not immune to such trauma. Approximately one-third of these families of origin did not teach their children

(later the parents of abducted children) to be aware of potential child dangers such as sexual assault, abduction, or other crimes against children.

Characteristics of the Abduction Event for Non-Family Abduction with the Infant/Child Recovered Alive:

1. **Initial Parent Reaction to Abduction.** Most parents who lose a child or infant to non-family abduction react initially with fear and shock. Approximately one-sixth of these parents experience later additional reactions of helplessness and report being unable to decide what to do next.

2. **Location and Time of Abduction.** In one-third of non-family abduction cases where the child was later recovered alive, the child was last seen in a residential neighborhood, with school and shopping areas as less frequent locations. While two-fifths of non-family infant abductions occurred in hospitals/health care facilities, more than one-quarter of non-family child abductions occurred in residential neighborhoods. The largest group of non-family child abductions took place between noon and 6 P.M., while the largest group of non-family infant abductions took place between 6 A.M. and noon.

3. **Child Reactions and Behavior during Abduction.** Over half of the non-family abducted children realized immediately that they were being kidnapped. Almost three-quarters of the abducted children were initially compliant during the abduction. This was followed by children who resisted physically or verbally (23.5%), called to others for help (11.8%), cried, and/or verbally tried to get the abductor to release them (5.9%). Initial compliant behavior may not, after recovery, fit with parental and peer values about active heroic physical and verbal resistance. After child recovery, individuals assisting these families need to attend to family and recovered child values about compliant/resistant child behavior during the abduction.

Abductor Behavior During the Missing Period for Infants/Children Recovered Alive:

1. Following the initial abduction, the non-family child abductor had assistance from friends or relatives in over half of the cases. This assistance is provided by individuals who actively participate in the detention of the child or who vicariously participate by knowing of the child abduction and taking no action for child return.

2. Over half of the abductors had plans to travel by car to another state, but initially drove only a short distance before stopping.

3. During the course of the abduction, most child abductors traveled frequently. Infant abductors most frequently traveled to a residence not far from the abduction location and moved infrequently.

4. During the course of the abduction, most of the children did not have adequate food, water, shelter, or personal hygiene care.

5. During the course of the abduction, approximately half of the children were physically abused or sexually abused. One-third of the non-family abducted children reported sexual abuse only.

6. In contrast to the abducted children, approximately three-quarters of the non-family abducted infants were provided with adequate basic care and no evidence of physical or sexual abuse was found.

7. By the time of child recovery, approximately half of the child abductors had achieved sufficient control over the child victim that constant, complete physical control was no longer necessary.

Child Thoughts and Beliefs During the Missing Period for Non-Family abducted Children Recovered Alive:

1. During the abduction, more than one-third of the children had frequent thoughts of rescue. Of these children, the majority did not believe that their parents were still looking for them.

2. Almost one-third of the abducted children felt responsible for the abduction in some way, and one-fourth of the children believed they were involved in some at risk behavior at the time of the abduction. While actual abduction events do not support child responsibility, parents and others assisting recovered children need to be sensitive to the child's feelings, whether they are factually supported by known abduction events or not.

3. Approximately one-third of the abducted children feared physical or sexual harm during the abduction. Many of the children feared physical harm (33.3%), sexual harm (26.7%), or some unspecified harm (13.3%). These findings indicate that children do have fears of physical or sexual harm during the abduction. However, most of the parents (73%) did not know what the child's initial fears were during the abduction. Upon recovery, both parents and child may have a somewhat predictable reluctance to share difficult details and emotions about the abduction. This barrier to communication about important emotional experiences for the child is likely to enhance, over time, child isolation from parent understanding and support.

4. Abductor Control over Child and Child Escape Attempts. Slightly more than half of the abducted children who were recovered alive experienced the complete removal of the abductor's physical control near the time of recoveries, and over one-third of these children tried unsuccessfully to escape from their abductor at some point during the abduction.

5. A significant minority of abductors were frequently rated by parents and recovered children as caring and supportive (child 23.5%, infant 28.6%) during the abduction. However, in another equally significant minority of non-family child abductions with the child recovered alive, the abductors were uniformly abusive (11.8%), evasive and secretive (11.8%), and increasingly disorganized (17.6%). Notably, in almost half of the non-family child abduction cases, parents reported not knowing about the abductor's behavior.

Post Disappearance Trauma and Coping:

1. Source of Support for Families After Abduction. For most families, the police officer in non-family child abductions with the child recovered alive is not only the central investigative figure for parents of the abducted child, but also the most important source of coping support outside the immediate family. With almost no mental health or social service support currently available for families of missing children, it is the police officer, whether by design or by default, who has been the primary source of hope and coping support to families for child recovery.

2. Parent Return to Work After Child Abduction. In families who lost a child to non-family abduction with the child later recovered alive, all working fathers had returned to their jobs within one month of child disappearance. However, at eight months after child disappearance, two-fifths of the previously employed mothers had not yet returned to work. For mothers, these unemployed rates are much higher than the national unemployment rates of 6-8%. For a sizable group of mothers, return to work may represent an as yet unexplored component of family recovery after the missing child is returned home.

3. Emotional and Behavior Changes by Family Members After Abduction. All of the parents, nine-tenths of the partners or spouses, and three-fifths of the remaining children in the family experienced emotional changes as a result of the child abduction. These emotional changes included increased fear, anger, anxiety, and helplessness, followed by behavioral changes of decreased responsiveness to the needs of other family members, withdrawal from friends, and difficulties in concentration.

Half of the children remaining at home after a non-family child abduction with the child later recovered alive had difficulty in returning to school.

4. **Child Safety Rules after Child Abduction.** After child disappearance due to non-family abduction with the child later recovered alive, approximately one-half of the families did not make any changes in their family safety rules. As noted in the project finding on family safety rules prior to child disappearance, in one-third of the families affected by non-family abduction with the child recovered alive, neither the missing child nor the siblings had been taught to be aware of potential dangers, such as sexual abuse or abduction by individuals outside the home. After child recovery, possible explanations for this parent behavior may be: (1) belief that the family safety rules were fully adequate before the abduction, (2) belief that no family safety rules can prevent an abduction, (3) need to deny that better family safety rules could have prevented this abduction, (4) belief that abduction or child crime will not strike the same family twice, (5) confusion/immobilization after the abduction, or (6) a combination of the above explanations. In any event, the issue of family safety rules and the rationales that maintain or change them needs increased exploration and understanding.

Post Disappearance Intervention and Support Services:

1. **Parents Rating of Law Enforcement Assistance.** Two-thirds of parents affected by non-family abduction with the infant/child later recovered alive rated law enforcement recovery efforts as highly competent. When parent ratings of highly competent and moderately competent are combined, this includes almost 90% of all cases, which is a substantial endorsement of law enforcement recovery efforts.

2. **Families and Mental Health Services.** Four-fifths of families affected by non-family abduction with the infant/child later recovered alive received no mental health or social support services. Three factors appear to be involved in this finding: (1) few mental health professionals are knowledgeable about child and family trauma due to child disappearance, (2) community mental health centers do not view families of missing children as a service population, and (3) many families have a belief that mental health or social support services would not be useful to them if they were available.

The Reunification Experience:

1. **Time Missing.** In non-family abduction cases, the average length of time for infant/child recovery alive was 5 days. For the 8-month data collection period of this project, most (88.2%) of non-family abduction with the children who were recovered alive were home by the first interview or within approximately 45

days of the abduction. All of the non-family abducted infants were recovered by this point in time. From comparison of this project finding with results from other projects, it appears that the closer one gets to actual case entry at the local police department level, the more short term non-family abductions are identified.

2. **Notifications to Parents of Child Recovery.** Parent notification of child recovery was made by an individual tangential to the family, such as a news reporter, in over half of the cases. Recovery notification by a police officer involved in the case is preferable both from the perspectives of providing reliable information to the family and updates on the continuing law enforcement investigation.

3. **Child Recovery Location.** More than half of non-family abducted children are recovered less than 100 miles from the abduction site, followed by approximately one-third of the children that are found between 501 and 1,000 miles from the abduction site. Nine-tenths of all non-family abducted infants are recovered less than 100 miles from the abduction site. Non-family abductors of infants typically have only one or two residences during the abduction and do not travel far from the abduction site. On the other hand, non-family abductors of children typically travel frequently with multiple residences and a minority travel significant distances.

4. **Assistance to Family for Reunification with Recovered Child.** Three-quarters of the families whose infant/child was recovered received no instructions or guidance about reunification with their child. These families must then approach the reunification meeting without any guidance as to what to say or do, what to expect in terms of child behavior, what would happen during the reunification meeting, or who to call for help after the reunification meeting. While the position could be taken that all families would benefit from such reunification information, family receptivity and ability to absorb such information is a factor as well. In this project, many families could not identify information they would like to have had prior to reunification with their child. Effective communication of reunification information will involve not only the availability of the information itself, but an assessment of the individual family receptivity of such information as well.

5. **Reunification Meeting Characteristics.** In three-quarters of the non-family abduction cases, the reunification meeting with child and family is less than thirty minutes, followed by the child and family's return home, with no guidance for post recovery assistance. Reunification meetings between parents and infants/children recovered from non-family abduction remain unsystematized, with meeting responsibility being delegated by default to the individual police officer present at the meeting.

Post Recovery Trauma and Coping:

A principal area of investigation of the project was to determine if there were subtypes of non-family abduction families based on differences in their experiences and to then assess for differences in distress (as defined by established psychological measures) among any such groups.

1. Non-family abduction consists of four distinct groups and family distress components varies by type of non-family abduction.

2. In non-family abduction infant cases, 72.9% of family members are above clinical distress levels at approximately one month post disappearance, and 36.7% are above clinical distress levels at eight months post disappearance.

3. In non-family abduction child recovered alive cases, 51.1% of family members are above clinical distress levels at approximately one month post disappearance, and 52.7% of family members are above clinical distress levels at eight months post disappearance.

4. In non-family abduction child recovered deceased cases, 90% of family members are above clinical distress levels at approximately one month post disappearance, and 94.4% of family members are above clinical distress levels at eight months post disappearance.

5. In non-family abduction child unrecovered cases, 76.6% of family members are above clinical distress levels at approximately one month post disappearance, and 66.7% of family members are above clinical distress levels at eight months post disappearance.

Adult Family Member Distress (by Type of Missing Child Family Across Time). A principal area of investigation of the project was to assess adult family distress between disappearance groups and over time.

1. In non-family abduction infant cases, 85.7% of the parents (primary respondents) are above clinical distress levels at approximately one month post disappearance and 40% are above clinical distress levels at eight months post disappearance.

2. In non-family abduction child recovered alive cases, 29.4% of the parents (primary respondents) are above clinical distress levels at

approximately one month post disappearance and 25% are above clinical distress levels at eight months post disappearance.

3. In non-family abduction child recovered deceased cases, 90% of the parents (primary respondents) are above clinical distress levels at approximately one month post disappearance and 83.3% are above clinical distress levels at eight months post disappearance.

Siblings and Missing Children Distress (Specific Psychological Trauma Symptoms). A principal area of investigation of the project was to assess clinical distress in siblings of missing children and the missing children themselves.

1. 75% of the remaining children in non-family abduction child recovered alive cases are clinically distressed at approximately one month post disappearance and 60% are clinically distressed eight months post disappearance.

2. 100% of the remaining children in the non-family abduction child recovered deceased cases are found to be clinically distressed at approximately one month post disappearance. These children are all still clinically distressed at eight months post disappearance.

3. 90% of the non-family abduction recovered alive missing children were above clinical distress levels at point of reunification (under 45 days post-disappearance) and 88.9% were above clinical distress levels at eight months post disappearance.

Additional Family/Parental Responses.

1. Parental Expectations about Child Harm during Abduction. While almost all parents felt that the non-family abducted infant/child had been recovered with less harm than expected, over one-quarter of the parents reported being less relieved than they expected to be after recovery. Child recovery alive with limited harm does not automatically equal parental relief from high stress.

2. Family Return to Normal Daily Pattern after Child Recovery. After child recovery from non-family abduction, more than half of the families returned to a normal daily pattern within one week after child recovery. Yet, this general pattern of a return to a normal daily family life obscures other very important problems for the recovered child. Specifically, parents report high rates of physical and psychological problems for recovered children, including nightmares and anxiety symptoms for three-quarters of the children and headache symptoms for one-half of the children.

3. **Difficulty in Return to School.** While half of the recovered children retruned to school within three days of recovery, nine-tenths had difficulty returning and adjusting to school.

4. **Post Recovery Coping Strategies.** The non-family child abduction primary parent reported the following ways of coping which have been helpful since the recovery: 68.8% of the parents expressed their feelings, 43.8% of the parents communicated with family members, and 43.8% of the parents learned relaxation techniques. After child recovery, the coping skills reported by the most infant abduction primary parents were expressing feelings (42.9%), and learning how to communicate with family members (42.9%).

5. **Post Recovery Professional Support.** After child recovery alive from non-family abduction, the law enforcement officer was the most frequently utilized resource outside the family for support and coping. No mental health professional, social worker, member of the clergy, or social support agency staff member was cited by any family as the primary contact for support and coping.

IV. Reunification of Missing Children Study Findings for Non-Family Abductions:

Some of these findings have already been presented in Chapter One and will not be repeated. The following results, which look at all types of abduction are presented in four major categories: (1) recovery status, (2) recovery characteristics, (3) sex of child, (4) race of child.

Recovery Status. With regard to the issue of child recovered alive/recovered deceased, recovery status is compared with type of disappearance, over 77% of all missing children in the sample were recovered alive, and slightly more than 1% of all missing children in the sample were verified as recovered deceased. However, one important issue emerges when the data are examined by individual category. When the stranger abduction category is examined by itself, it is highly significant to note 35% of the stranger abducted children were recovered deceased.

With regard to the issue of sex of missing child, it appears that within the total sample of all missing children, male and female children were recovered deceased in equal numbers.

With regard to time from disappearance to recovery, approximately 50% of all cases are reunified with their families within 90 days, and approximately 75%

are reunified with their families within one year. Recovery continues at a significant rate beyond the one-year period, with about 15% of reunifications taking place after two years time from the date of disappearance. Within the sample of recovered runaway youth, the majority had been recovered within 90 days from the date of disappearance and 90% youth had been recovered within one year from the date of disappearance.

Age of Child at Time of Disappearance. With regard to the issue of the child's age at time of disappearance, parental abductions are primarily focused on younger children with more than half of these cases occurring with children under 9 years of age and with 80% of these cases occurring with children under 13 years of age. However, it is more surprising to note that some parents do abduct older children, with some incidents occurring even in the later teenage years. As adolescents are more independent and socially aware than younger children, one would predict that the circumstances of these parental abductions would have unique characteristics. In a similar way the results confirm to the commonly held impression that adolescents constitute the majority of runaways. However, there is a significant minority of very young children who were reported to have run away or disappeared from their parents. And the circumstances of both of these type of cases is not yet understood.

Sex of Child. With regard to the child's age at time missing and sex of child, the results indicate that at younger ages, when presumably children have less control over their lives, the numbers of missing male and female children is similar. As children mature to age 14, almost three times as many girls as boys are noted to be missing.

Race of Child. With regard to race of child and type of disappearance, black children are less represented than the proportion of these children in the general population. Data were reviewed for possible systematic bias within the variables of (1) age of children, and (2) and length of time missing, which might point to a differential reunification process for members of racial groups. There do not appear to be differences that can be assigned to race. In fact, statistical analyses were conducted to ascertain whether race of child interacted with any other characteristics of children to produce any type of systemic difference in these data. None were statistically significant.

In this investigation of reunification of missing children, all records of families reunified in 1987 as present in NCMEC data base were reviewed. The general characteristics of the sample were:

- 3,136 cases were recovered alive
- 45 cases were recovered deceased

- 839 cases were administratively closed
- 4,020 cases in total were reviewed

For reunified cases, the case distribution by missing child category was:

- 1.2% of reunified cases were stranger abductions
- 26.4% of reunified cases were parental abductions
- 67.7% of reunified cases were runaways

For stranger abducted, recovered alive cases, the following conclusions are noted:

- Stranger abducted, recovered alive female children are significantly older (average age = 10.3 years) than stranger abducted recovered alive male children (average age = 5.5 years).
- 78% of stranger abducted, recovered alive male and female children are home within 90 days.
- 96% of stranger abducted, recovered alive male and female children are home within 1 year.

For stranger abducted, deceased cases, the following conclusions are noted:

- There are 2 times as many female children as male children in the stranger abducted, deceased category.
- Stranger abducted, recovered deceased children are significantly older (average age = 10.6 years) than recovered alive children (average age = 8.7 years).
- Stranger abducted, recovered deceased female children are significantly older (average age = 12.15 years) than stranger abducted, recovered deceased male children (average age = 7.57 years).
- Stranger abducted recovered deceased children are recovered significantly later (average time missing = 145 days) than stranger abducted, recovered alive children (average time missing = 136 days).
- 100% of stranger abducted, recovered deceased male children were found within 90 days.
- 64% of stranger abducted, recovered female children were found within 90 days, and 79% of these children were found within 1 year.

Summary of Survey Interview of Families of Missing Children

- Missing child reunification meetings are extremely brief, with no evident set of goals or plans.

- Mental health professionals have virtually no involvement in missing child reunification.
- Police officers are the most common non-family member present at missing child reunification meetings.
- Police officers are required to manage missing child reunification meetings without technical support training or technical support personnel.
- Future missing child reunification programs need to: (1) increase reunification technical support training provided to police officers, and (2) increase the availability of mental health and social service personnel with specific reunification training.

V. Overall Chapter Summary of the Effects of Non-Family Abduction on Children:

(1) The abduction experience results in adverse psychological consequences particular to children, and can be observed both in their immediate responses as well as up to 4 to 5 years post trauma. Such responses include: hallucinations, specific fears that can reach panic proportions, misperceptions, belief in omens, recurrent dreams of terror and personal death, compensatory fantasies, time skew, time distortion, repetitive monotonous play that fails to relieve anxiety, school decline, survivor guilt, and psychophysiological disturbances. Fantasy of taking action has been found to be an important defense mechanism both during and after the event. Dreams of vulnerability and mastery are very common among child victims.

(2) Symptoms range in frequency and severity, with the more severely disturbed children:

(a) having preexisting physical or emotional disturbances,
(b) coming from families with preexisting psychopathology, and
(c) having fewer extended family in the community.

(3) No specific age differences emerge relative to the presence, type, or differences appear to be a function of the degree of community bonding rather than representing inherent increased vulnerability among boys.

(4) Long-term traumatic effects in children may not be observed by parents for six months to one year post trauma.

(5) The interpersonal relationship between victim and abductor has been shown to be a key variable in establishing psychological control during the abduction. The process by which this relationship develops may

be critical in terms of understanding the child's psychological response post abduction.

(6) Families of abducted children do not perceive themselves as "sick" and therefore do not actively seek the help of mental health professionals.

(7) Families themselves experience post-traumatic stress symptoms similar to the child victim, although frequently of lesser intensity.

(8) The child victim's post-traumatic symptoms may be uniquely different from those of adults. These differences include: (a) event amnesia not observed, (b) psychic numbing not observed, (c) voluntary recollections of the event rather than intrusive flashbacks, (d) the presence of post-traumatic themes in child play, (e) time skew and distortion, and (f) a pessimistic view of the future.

APPENDIX B - FAMILY ABDUCTION RESEARCH/LITERATURE REVIEW

Family Abduction Literature Review. Family abduction (also referred to as parental abduction, child stealing, parental kidnapping, or child-snatching) is a social phenomenon that has only recently drawn the attention of social scientists and mental health practitioners.

Although definitions of family abduction vary in the social science literature, there is a general consensus that a family abduction has occurred when a parent or guardian who has a legal custody or right of access to a child is deprived of that access by the actions of the other parent (Agopian, 1981; Gridner & Hoff, 1994; Finkelhor, Hotaling, & Sedlak, 1990; Hegar & Grief, 1991). Family abduction is often an extension of parental conflict associated with the termination of a marital or quasi-marital relationship. It has also been associated with custody determinations necessitated by parental divorce or separation (Agopian, 1981). For this reason, there has been some tendency to treat the abduction of a child by a parent as a family or domestic matter, rather than as a significant social problem warranting the attention of mental health professionals and social scientists, as well as the general public.

Increased awareness of family abduction as a problem of significance has come from three sources: (1) concern about rising divorce rates and increased interest on the part of fathers in custody rights, which has put increasing numbers of children "at risk" for experiencing a family abduction (Agopian & Anderson, 1981; Finkelhor, Hotaling, & Sedlak, 1990), (2) estimates of the incidence of family abduction that show family abduction to be a problem of much greater magnitude than previously believed (Finkelhor, Hotaling, & Sedlak, 1990), and (3) an accumulation of anecdotal evidence that family abduction can produce negative psychological problems in children and remaining parents (Agopian, 1984; Forehand, Long, Zogg, & Parrish, 1989; Schetky, & Haller, 1983; Senior, Gladstone, & Nurcombe, 1982; Terr, 1983; LeWall, 1993; Hart; 1993; Klain, 1995).

With this increased awareness of the incidence and the traumatic impact of family abduction, many states have now passed stricter laws. These laws are clearer in their definitions of unlawful taking of a child by a parent and have criminalized parental abduction. Many of these laws have also defined sentencing guidelines for the judiciary (Klain, 1995). A recent OJJDP funded project, Model Sentencing Guidelines also completed in 1995, was designed to provide sentencing guidelines in an attempt to create more uniform sentencing for parents who abduct and to provide the judiciary with guidelines for sentencing these parents.

Early Family/Parental Abduction Case of Historical Interest. One of the earliest documented parental abductions in the U.S. is referenced in a letter dated February 27, 1885 to the sheriff of Santa Barbara, California, from W. A. Pinkerton, of the famous Pinkerton National Detective Agency in Chicago, Illinois. The letter tells of the agency's involvement in aiding a mother to secure the return of her daughter, a child named Mary Reeves. The information relayed to the sheriff from Mr. Pinkerton relates that the child was abducted by her father, from her mother, in New Haven, Connecticut about eight months prior to the date of the letter. The father, described as "a man about 5 feet 8 inches high, heavy built, rather sallow complexion, dark eyes and dark hair, and one shoulder higher than the other," is characterized as a "very pleasant talker." At the time of the correspondence, the whereabouts of the girl are unknown, although the father is described as being incarcerated in Chicago. Mr. Pinkerton is writing from Chicago and states that the mother has had an "intimation" that the girl is with a banker or his relatives in Santa Barbara, most likely taken there by friends of the father. A photograph of the child was sent to the sheriff. The outcome of the case has not been verified.

Child Custody and Divorce

Contemporary Changes in Family Systems. Family abduction is a phenomenon linked to post-divorce or post-separation marital conflict. Therefore, changes in the divorce rate directly affect the number of children at risk for family abduction. Population statistics indicate that there was an increase in the divorce rate from 3.5 per 1,000 to 5.2 per 1,000 population during the decade from 1970 to 1980. While the divorce rate declined slightly during the 1980's (from 5.2 in 1980, to 4.8 in 1988), the absolute number of families involved in divorce has continued to rise. Over one million divorces occur annually in the U.S. (U.S. Bureau of the Census, 1990). As more than a million children are involved in a parental divorce annually (U.S. Department of Health and Human Services, 1986), the number of children potentially at risk for family abduction is substantial.

Trends in Child Custody Determination. Few areas of U.S. law or social policy have been characterized by the extreme changes which have occurred in the awarding of child custody. Child custody standards evolved from an early standard of paternal preference, to a maternal preference standard, and most recently, to a "gender neutral" standard that looks to the child's best interests.

Paternal Preference Doctrine. Prior to the 20th century, the legal standard for child custody was sole paternal custody unless the child was a nursing infant, or it was determined that the father was unfit. For most mothers, access to children of the marriage was terminated with the marriage. As the fathers were

legally responsible for the care and maintenance of their children, they were also deemed to be the appropriate custodians and beneficiaries of the children's labor.

Tender-Years Doctrine. During the time that the paternal preference doctrine was giving way to the granting of custody to the "innocent" party in divorce proceedings, mothers gained an advantage in the retention of custody as husbands more often were designated as the party "at fault" in the failure of the marriage. It came to be presumed that mothers were the natural caretakers of children following divorce, particularly where the children were of a "tender age." For the major part of the 20th century, the tender-years doctrine was in common use in most states.

The tender years doctrine held that a young child, generally under the age of 10, should be in the care of the mother, unless she was shown to be unfit. Unfitness for motherhood was judged against moral criteria, of which adultery and alcoholism were the primary transgressions (Derdeyn, 1976).

Although mothers are still awarded custody in approximately 90% of divorce cases, a preference for maternal custody is no longer automatic (Weitzman, 1985). The greater frequency of mothers employed full time and changes in social attitudes toward greater involvement on the part of fathers in day-to-day care giving activities have resulted in the assertion by some fathers that paternal custody will serve the child's best interests (Weitzman, 1985). Some fathers have used their generally greater earning power, and greater likelihood of remarriage, to make the case that they are better prepared to provide an optimal environment for their children. Child custody also remains a bargaining chip in the settlement of divorce issues (especially support issues), as joint custody or sole custody can relieve a parent of the burden of child support to be paid out to the other parent.

Another expression of a change in attitude toward more father involvement in custody following divorce has been the growth of Father's Rights organizations which have lobbied for the elimination of sex bias in legal proceedings and have provided information and support to fathers choosing to assert custody rights in divorce actions.

Best Interests of the Child Doctrine. In the past 15 years there has been a distinct legal trend away from a formal maternal preference standard in the determination of custody, toward a "best interests of the child" standard. Today, most states have "gender neutral" child custody statutes.

Options other than maternal custody are more actively encouraged, as there is an assumption based on research findings, that the best interests of children are served through maintaining close contact with both parents following marital

separation. Preference, therefore, may be given to joint custody, or to the parent who is willing to insure ample visitation with the other parent.

For mothers, the changes in societal attitudes have not been parallel to those taking place for fathers. While there has been some change of attitude toward non-custodial mothers, based on an understanding that mothers do not have to be "unfit" in order to lose a custody battle, women who do not fight for custody of their children are still likely to experience strong social censure and a judicial attitude that assumes the worst about them (Grief & Pabst, 1988; Grief & Hegar, 1992; Grief & Hegar, 1993).

Major social and legal changes in the 1970s resulted not only in an increasing number of mothers in full-time employment, but also in divorce reforms, which made it possible for marital partners to terminate a marriage with greater ease. As no-fault divorce laws, equitable distribution of marital property statutes and actuarial divorces became more common, the division of property was no longer an accepted mechanism for rewarding a "virtuous" marriage partner or punishing an errant spouse (Weitzman, 1985). Child custody, however, remained a stage upon which marital conflict and hostility could continue to be played out. This dynamic, combined with a lack of objective information regarding what constitutes the best interests of an individual child, has set the stage for a system often characterized by confusion and strife.

Child Custody and the Social Sciences. As most family abducted children are children whose parents have divorced or separated, the issues of divorce, child custody and abduction are inexorably linked. Children of divorce, therefore, constitute the target population of children likely to be the victims of a family abduction. It is estimated that 40% of the children in the United States will experience a parental divorce before they reach the age of majority, and for many children the experience of divorce will be a repeated one (Hetherington & Martin, 1986).

The 1980s was a decade that generated much interest on the part of social scientists seeking to study the effects of family dissolution on developing children. The seminal work of Wallerstein and Kelly (1980) focused on the aftermath of divorce for children and parents and documented post-divorce adjustment problems in significant numbers of families studied. Children seemed denied the positive aspects of divorce reported by their parents and were vulnerable to stresses subsequent to the divorce that were different from those experienced by their parents. Much of the subsequent divorce research, therefore, has focused on the post-divorce adjustment of children.

While several studies have found problem behaviors in children following divorce, there have been fewer studies which have specifically examined the relationship between custody arrangements and children's post-divorce adjustment.

Given the hostile nature of most custody disputes and the known negative impact of parental conflict on children, custody litigation can constitute a crisis for both parents and children. As family abduction is largely a consequence of post-divorce parental conflict, custody arrangements constitute an important factor in the study of family abduction.

Social Policy and Parental Abduction. Greif and Hegar (1993) view parental abduction as stemming from several sources: fear for the safety or welfare of the child; fear of losing a relationship or contact with a child; the need of the parent to be in control; anger or a wish to hurt the other parent. Efforts at prevention must address the roots of the problem which are legal and social. The present legal system is not adequately dealing with domestic problems, nor adequately protecting children involved in divorce or parental disputes.

Custody arrangements and marital status need to be taken into account in developing laws which cover a wide variety of family circumstances. The rights of unmarried parents and single fathers need to be equally protected under the law. States should consider enacting laws which define different offenses and/or prescribe varying penalties for interfering with different custody interests through abduction.

Joint Custody vs. Sole Custody. The effects of joint custody arrangements have been studied by social science researchers in an attempt to determine whether joint custody serves the best interests of the child to a greater extent than other custody arrangements. Joint custody has been touted as beneficial for children as it can offer the frequent contact with both parents that is available to children raised in intact families. Negative concerns have also been expressed, as former spouses are required to cooperate and interact around the needs of the children. In exploratory studies, Ahrons (1981) and Greif and Pabst (1988) found that parents participating in a joint custody arrangement could separate the children's interest from their own relationship conflicts.

Observations on the effects of joint custody on child development has produced mixed results. Increased competence and self-esteem and a diminished sense of loss following divorce were found to be positive outcomes of joint custody. In other cases, no differences in symptomatology have been seen between children from joint or sole custody families.

Kline, Tschann, Johnston, and Wallerstein (1988) examined custody arrangements and their relationship to the social, emotional and behavioral adjustment of 93 children in divorcing families. Custody arrangements were not found to be significantly related to parent and clinician ratings of children's adjustment during the first year following divorce or at 1 or 2 year post-divorce follow-up. The psychological adjustment of children was explained by a combination of age, gender, parental conflict at 1 year post-divorce, and parental emotional functioning at the time of divorce filing. The Kline, Tschann, Johnston and Wallerstein results support the findings of earlier divorce studies by Rutter (1979) in which greater vulnerability was found in boys and latency-age children, regardless of the type of custody arrangement.

The variable findings from custody studies indicate that custody is only one factor in a complex group of factors that affect post-divorce adjustment in children. As stated by Kline, Tschann, Johnston, and Wallerstein (1988), "Children whose parents are less severely distressed and in less conflict with each other may fare well in either sort of time-sharing arrangement—joint or sole custody. Finding out who these children are and what factors promote their adjustment might best be accomplished by studies that explore the quality of parental and family functioning rather than the structural aspects of the arrangements themselves" (p.437). Children from families in which a parent abduction occurs may therefore already be at increased risk for stress-related symptoms secondary to ongoing parental conflict.

The Effects of Post-Divorce Parental Conflict on Children. In a series of studies, Johnson and Campbell (1988) have sought to examine the contribution of high levels of ongoing parental conflict following divorce, to children's post-divorce adjustment. The studies will be reviewed in this section, as ongoing parental conflict in the post-divorce period has been considered to be a factor associated with post-divorce family abduction (Agopian, 1982).

In studying the effects of post-divorce parental conflict on latency-age children, Johnson, Campbell, and Mayas (1985) reported parental conflict behaviors frequently witnessed by children from high-conflict families. High-conflict parents were described as going out of their way to avoid contact with the other parent, often communicating through their children or an intermediary. Parents rarely discussed the needs of the children or attempted to coordinate plans for the children. Their contacts were largely limited to accusations and complaints directed to the other parent. In only 13% of the families were there even intermittent, friendly contacts between the parents. The major topic of dispute between parents was custody. Unwillingness to communicate about the children, dissatisfaction with visitation arrangements, complaints about inadequate care of the child and involvement of the child in the conflict occurred somewhat less frequently as topics of dispute.

In 88% of these high-conflict couples, the partners had been physically aggressive toward each other in the past, and in 71% of the couples, the aggression had occurred within the last year. Aggressive acts included slapping, pushing, shoving, spitting, biting, throwing objects and threatening with knives and guns. Threats of physical violence reportedly occurred more often than once a month. Verbal attacks on the other parent in the form of insults, name calling, or swearing, occurred on the average more than once a week.

Children were often witness to the aforementioned aggressive incidents, and were, in some cases, endangered by the aggressing parent. An example is the report by Johnson, Campbell, & Mayes of three instances in which women rammed the cars of their ex-spouses with their children in their cars as passengers. In one instance, a child was injured. Only 5% of the high-conflict parents studied protected their children consistently from witnessing conflict with the other parent. In these couples, the desire to injure the other parent took precedence over the needs and interests of the children.

Children of high-conflict couples were found to show extreme distress during the transition from one parental home to the other, as any contact between the parents was characterized by hostility and conflict. The transition was found to be aided by having the exchange take place at a neutral drop-off and pick-up place where the parents would not have to meet.

Johnston, Campbell, and Mayes described six coping patterns employed by children of high-conflict, post-divorce couples: (1) strong alliance with one parent; (2) moderate alignment with one parent, while protecting the feeling of the other parent; (3) loyalty conflict with distress about hurting or being rejected by the other parent; (4) shifting allegiances with inconsistent preference for one and then the other parent; (5) acceptance of both parents with avoidance of preference or choice of one parent over the other; (6) rejection of both with both parents regarded in a negative manner by the child.

About one-half of the children in the study were described as having mixed responses where they would move among the different response categories. Shifting allegiances and loyalty conflicts were found to be more characteristic of younger latency-age children. Where strong alliances were formed between parent and child, the excluded parent was rendered relatively powerless. In all of the response patterns described above, the child's capacity for a secure, autonomous relationship with at least one parent was compromised.

In general, ongoing parental discord is associated with signs of behavioral disturbance in children. Among children from families where there was

ongoing post-divorce conflict, more extensive visitation and more frequent moves between parental homes frequently increases symptoms of emotional and behavioral disturbance.

Family abduction attempts were reported in at least 10 (23%) of the families studied by Johnston, Campbell, & Mayes. In two instances, children were objects in a physical tug-of-war between the parents. Another 3 children were not returned after visitation periods, and 5 children were kidnapped and secreted from the other parent. The Johnston, Campbell and Mayes findings suggest that children in families which have high levels of ongoing parental conflict, involving re litigation of custody, physical or verbal aggression directed toward the other parent, or the formation of a parent-child alliance which excludes the other parent, may be at greater risk for family abduction, even with frequent parental visitation or joint custody agreements.

In analyzing the characteristics of couples entrenched in post-divorce disputes, Johnston, Campbell, and Mayes (1985), formulated the concept of divorce-transition impasse. The inability of the couple to settle disputes constitutes the post-divorce impasse. The post-divorce impasse is symptomatic of resistance to needed change and indicative of predominance of homeostatic mechanisms considered to serve a protective intrapsychic function.

Factors that have been proposed as contributing to ongoing post-divorce conflict are long-term destructive marital transactions and traumatic or ambivalent separations. In some couples, intolerable levels of anger, helplessness, loneliness or guilt had been generated by the separation. The divorce-transition impasse is considered by the authors to provide a defense against these overwhelming feelings. In more than two-thirds of the families studied by Johnston, Campbell, and Mayes (1885), the dispute involved an only child who served to fill an important emotional need for the parent. For some the child was considered to be an important source of emotional support or companionship, while for others, the child represented their only achievement in life and the primary source of their identity.

It has also been observed that the degree of familial conflict may accelerate following divorce and that continuing conflict may serve to maintain an emotional relationship with the former spouse. Where the parent has preserved bonds of attachment to the former spouse, a difficult choice may be present between conflict versus indifference.

Levy (1987) provides anecdotal case materials to support the observations that threatened custody loss can trigger extreme emotional and/or

behavioral responses in parents that differ in intensity and degree from previous behavioral patterns of the parents.

Custody loss has been described as: (1) containing a quality of anger which is rare in other human contacts, (2) a direct assault on one's status as a parent, and (3) a threat to enmesh divorcing parents, judges, psychiatrists and attorneys in a lengthy legal process. Along with professionals, extended family members and new spouses can be enlisted in the conflict against the other parent.

The findings discussed have relevance for the study of families in which a family abduction has been attempted or has occurred. Both abducting and left-behind parents may already be veterans not only of divorce, but also of custody battles waged over their children. The effects of the divorce process on individuals and families has been found to be variable. There is presently some evidence that most people adjust to post-divorce life after a limited period of turmoil and disruption. For some individuals, the process is much more protracted and/or intense (Johnston & Campbell, 1988). Whether this is a result of individual or systemic factors has not been clearly established.

Family Abduction Research

Age of Family-Abducted Child. There has been a consistent finding that the majority of abducted children are under the age of eight. Agopian (1981) reported 56% of the child victims to be under the age of 8 and 87% to be under the age of 11. Agopian further reported that children between the ages of 3 and 5 were the most likely to be abducted and infants and adolescents were the least likely to be taken. Of the 18 child victims evaluated by Terr (1983) between 1976 and 1982, only one was over the age of eight. Janvier, McCormick, and Donaldson (1990) found 77% of abducted children were under 8 and 96% were under eleven. Greif and Hegar (1992; 1993) found that only 6% of the abducted children from their study were over the age of 12. In the study based on the largest sample size to date, Finkelhor, Hotaling, and Sedlak (1990) reported that 52% of the family abductions involved children under the age of 8 and in almost a quarter of the abductions (23%) the child victim was under the age of four. There have been no studies which have systematically examined the relationship between the age of the child and other factors such as recovery success.

Sex of the Family Abducted Child. There is no clear preference for male or female child victims emerging from studies with limited, small samples of family abduction samples (Janvier, McCormick, and Donaldson, 1990; Forehand, Long, & Zogg, 1989; Forehand, Long, Zogg, & Parrish, 1989; Greif & Hegar, 1992; Greif & Hegar, 1993). Based on their use of a nationwide, representative sample, Finkelhor, Hotaling, and Sedlak (1990) reported that there were a larger percentage

of male children reported as victims of abduction (58%), compared to females (42%), but that the difference was not statistically significant. It is not presently known whether the sex of the child plays a role in the successful recovery of the child by the remaining parent, in the coping responses of the child, or in manifestations of post-recovery symptoms. As with the age of the child, no information is currently available on the relationship between the sex of the child and other factors such as recovery success.

Ethnicity of the Parentally Abducted Child. Information on the ethnicity of abducted children has been reported only by Agopian (1984) and Finkelhor, Hotaling, and Sedlak (1990). Agopian, using data from Los Angeles, reported that 74% of the child victims were Caucasian, 11% were Black, 11% Mexican-American, and 5% Asian. Finkelhor, Hotaling, and Sedlak (1990) reported that 80% of the abducted children in their nationwide study were Caucasian, 17% were Black, and 3% were Hispanic. There were no reports of abducted children in their sample which fell outside of these three groups. The significantly lower than expected rates for Hispanics and the absence of Asians in the sample, indicate that Hispanics, Asians, and possibly other non-specified ethnic groups may be under-represented as victims of family abduction.

At the present, it is not known if the ethnicity of the child is a factor in the ability to locate and recover an abducted child, as it is not known whether police, school officials, health care providers, and others who are likely to encounter an abducted child respond similarly to reported missing children from different ethnic backgrounds.

Number Of Children Abducted per Incident. Most abductions (approximately two-thirds) reportedly involved a single child (Agopian, 1984; Forehand, Long, & Zogg, 1989; Greif & Hegar, 1992).

Age of the Abductor. Both abducting (Agopian, 1981; Finkelhor, Hotaling, & Sedlak, 1990) and custodial parents (Agopian, 1981) tend to be under 40 years of age. The mean age Agopian found was 34 years of age for abducting parents and 33 years for custodial parents. Approximately two-thirds of the parents involved in a family abduction were under the age of 36, with the largest group being between 27 and 31 years of age. The Finkelhor, Hotaling, & Sedlak (1990) study found the largest number of abducting parents to be between the ages of 31 and 40 (46%) with another 30% under the age of 30.

Sex of the Abductor. Early studies have not clearly established male or female parents as the primary abductors. In one early study, Terr's (1983) sample of 16 families contained 75% male abducting parents. In two other cases, the children had been abducted on occasion by both parents.

Agopian (1981) reported that fathers were abductors twice as often as mothers. Other studies have reported varying proportions of abductions by mothers and fathers, but data have been based on questionnaires voluntarily returned, which could bias the results (Forehand, Long, Zogg, and Parrish, 1989; Greif and Hegar, 1992; Janvier, McCormick, & Donaldson, 1990).

In another study, a non-profit agency, the Florida Project, received anonymous telephone calls from parents who were either contemplating abduction or "in flight." Project data reported nearly equal numbers of males and females "in flight" with abducted children, but twice as many calls from males who were contemplating abduction (Forehand, Long, Zogg, and Parrish, 1989).

The best current estimate of the frequencies of abduction for males and females is likely to be from the NISMART study (Finkelhor, Hotaling, & Sedlak 1990). The data suggest a higher number of male abductors (73%) than female abductors, with former husbands/boyfriends comprising the largest group (42%) followed by current husbands/boyfriends (21%). All categories of female abductors accounted for only 26% of the abductions.

Even though fathers abduct more often than mothers, mothers may be considered over-represented, as typically, only 10% of fathers have custody of their children following divorce (Hetherington & Martin, 1986; Santilli & Roberts, 1990).

Ethnicity of the Abductor. The majority of abducting parents are Caucasian. In Los Angeles County, Agopian (1981) found that a majority of abducting parents were Caucasian (68%) which was representative of the percentage of Caucasians as custodial parents in Los Angeles County (69%). Blacks and Hispanics represented a higher proportion of the total number of abductions than their numbers in the population of custodial parents, while Asians were slightly under-represented. Asians represented 6% of the custodial parents in Los Angeles, but accounted for only 1% of the family abductions. Parents from interracial relationships seemed to abduct at a higher rate (11%) than would be expected, based on known rates of intermarriage in the U.S., which are between 1% and 2% (U.S. Department of Commerce, 1990). This finding, combined with the reports of relatively high numbers of foreign-born fathers who abduct (Janvier, McCormick, & Donaldson, 1990), suggests that children from cross-cultural or interracial marriages may be at increased risk for abduction.

Previous Criminal History. Agopian (1981) speculates that the characteristics of the typical abductor (Caucasian, young, employed, with a crime-free history) may serve to insulate the abductor from contact with law enforcement

authorities. As abductors appear to be conventional and may avoid calling attention to themselves, it may be only through a minor offense, such as a vehicle violation, that the abductor would be likely to attract attention of the law enforcement system.

Marital Status. As mental health professionals have played a direct role in the evaluation of custody disputes, early case histories most often depict family abductions that occur in the course of a separation or the settlement of a divorce (Senior, 1982; Schetky & Haller, 1983). In most quantitative studies of family abduction, it has been found that the majority of parents are divorced or separated at the time of the abduction and there has been a custody determination made by a court (Agopian, 1981, Forehand, Long, Zogg, and Parrish, 1989; Janvier, McCormick, & Donaldson, 1989).

In Agopian's 1981 study of family abduction cases in Los Angeles County, 85% of the cases involved divorced parents, but it was not determined what percentage of these involved a written custody order. In 60% of the situations occurring in the NISMART study (Finkelhor, Hotaling, & Sedlak, 1990), there reportedly was a written custody order. Thirty-nine percent of the NISMART respondents indicated a mutual understanding between the parents, but no written custody order.

Marital status is an important factor in the ability of the parent to recover an abducted child, as an enforceable custody order will allow the parent to take legal action against the abducting parent for violation of the custody order.

Type of Abduction. As it is often unclear when an unauthorized extension of visitation or the minor violation of a custody agreement becomes a family abduction, there has been interest in classifying abductions as intent and duration. There have been two formulations of type of abduction based on anecdotal observations. Terr (1983) gave an anecdotal accounting of violations of custody agreements in which there was an intent to return the child, calling them "vacations," compared with situations in which children were successfully snatched and hidden. Terr (1983) reported psychological consequences to the child regardless of the legal issues raised by the intent of the abducting parent or the duration of the child's absence. In contrast, Agopian (1984) listed the length of time the child was under the control of the abducting parent as a factor related to the severity of harm to the child.

As previously referenced, the NISMART study defined one type of parental abductions as less serious, Broad Scope abductions, as those situations in which a family member: (1) took a child in violation of an existing custody agreement or decree, of (2) failed to return a child at the end of a court-sanctioned or agreed-

upon visit (with the child being away at least overnight), in violation of a custody agreement or decree. In this study, this type represented the greater number of cases.

A more serious type of family abduction was defined by NISMART as a Policy Focal case. Conditions such as: (1) transporting the child out of state; (2) attempting to prevent contact between the other parent and the child; or concealing the abduction or whereabouts of the child; or (3) intending to keep the child indefinitely, or to permanently alter the custodial arrangement, were considered to increase the seriousness of the event. The 163,200 Policy Focal family abductions estimated for 1988 represent 46% of the total annual incidence (Broad Scope & Policy Focal) in the study. This two-type definition was designed to differentiate cases which may seem relatively minor, but may be upsetting to the participants, and cases in which the child is more likely to be at risk, requiring possible intervention by the police or other social service agencies.

Site and Time of Abduction. Published information on the site and time of abduction is limited. In an early case history, Senior, Gladstone, and Nurcombe (1982) describe the snatching of a two-year old from the home of the child's father (the custodial parent) and stepmother, while the child's stepmother was in an adjacent room. The natural mother, who was visiting the child, ran from the house to a waiting vehicle. Not all children are taken from the custodial parent, as Palmer and Noble (1984) describe abductions in which the child is taken from an institutional setting or the home of a relative who is the child's legal guardian.

Similarly, Terr (1983) describes four sites from which children were taken. One child was abducted from her schoolyard by her mother after the father was granted custody of the child. Another 4-year-old girl and her 7-year-old brother were taken from their backyard when the father was denied visitation by the mother. The father did not return the children and moved with them to another state to start a new life. A third account was given of a child being taken from a friend's house where she had gone to play.

Agopian (1981) reported that the home was found to be the most frequent site (67%) for an abduction, a public setting such as an outdoor area was the second most common site, and the child's school was the third most common setting. 17% of the children studied were taken from day care and 8% during a denial of visitation.

Agopian and Anderson (1981) found that a majority (55%) of the abductions studied occurred within 18 months of the divorce action or custody agreement, 7% occurred 18 months to 2 years after the divorce, and 37% occurred more than 2 years following the order.

Weekend days (Fridays, Saturdays, and Sundays) were found to account for the majority (55%) of family abductions while the fewest numbers of abductions took place on Tuesdays and Thursdays. The large number of abductions taking place on weekends may reflect both opportunity and the desire to maintain the parents role as full-time parent (Agopian & Anderson 1981). One-third of abductions studied took place during the weekend visitations and only 10% during summer visitations.

Physical force was rarely a factor, and was usually limited to restraint. Threats of force were reported in an additional 8% of the abductions studied by Agopian and Anderson (1981). Using information from a national sample, Finkelhor, Hotaling, & Sedlak (1990), reported force used in 14% of family abductions, and the use of coercive threats or demands in 17% of the situations. No physical harm to the child was reported by 89% of the interviewed parents and physical abuse was reported to have occurred in less than 5% of the cases. Not more than 1% of the abducted children were reported as sexually abused by the abducting parent. Family abduction appears to be a crime of convenience, not a crime of violence.

The NISMART study (Finkelhor, Hotaling, & Sedlak, 1990), indicated that children were taken by unauthorized removal from the custodial parent's home in one half of the cases, or in the other half of the cases, by failing to return the child(ren) after an authorized visitation. There is no information which reveals possible methods of enticement used by a parent to abduct a child and there are only case histories of explanations which may have been given to a child to enlist the child's cooperation (Palmer & Noble, 1984).

As previously stated, the NISMART study divided abductions into Broad Scope or Policy Focal categories based on the abducting parent's intent not to return the child and the custodial parent being denied access to the child. In one out of 10 cases fitting the Broad Scope definition, the child was removed from the state (Finkelhor, Hotaling, & Sedlak, 1990). There was an attempt to conceal the child's whereabouts in one-third of the Broad Scope cases, and in one-half of the cases, the custodial parent did know where the child was, but was not able to retrieve the child. This finding indicates that a lack of knowledge of the child's whereabouts may not be the primary factor in failure to recover the abducted child. More extensive study is needed to determine what additional factors may constitute obstacles to recovery, especially in cases where the location of the child is known. In some instances, parents may detain a child with the intent of returning the child to the custodial parent once the purposes of the abduction have been served. Such cases may fit the definition of family abduction, these short-term abductions may be difficult to separate from cases of non-compliance of visitation orders.

Short-term retention of the child may be unimportant, however, it may serve as a means of "testing the waters" before an abduction. Custodial parents may then become "desensitized" to violations of visitation agreements and less vigilant about the possibility that their child has been taken. This conclusion is supported by the finding of Janvier, McCormick, & Rose (1990) that prior threats of abduction had been made in 46-48% of abductions in their study.

The Use of an Accomplice. Extended family members have been described as playing an active role in facilitating an abduction (including acting in the role of an accomplice) or offering support to the abducting parent. Janvier, McCormick, & Rose (1990), found that aid by an accomplice was present in 76% of the international situations and 84% of domestic family abduction situations studied. This infers that abduction in both domestic and international situations may be more premeditated than an impulsive act.

The NISMART study reported that 25% of the abductions were perpetrated by persons other than the former or current husband/boyfriend of the respondent or the former or current wife/girlfriend of the respondent. Other relationships designated for abductors included the husband/boyfriend of the ex-wife, the wife/girlfriend of the ex-husband, in-laws and unrelated persons. It is not known how often these individuals were acting of their own accord and how often they may have been acting in the role of an accomplice carrying out the wishes of the child's parent.

Motivation of the Abducting Parent. Family abduction is an event planned in advance of the actual child snatching and abducting parents are motivated by a variety of pre-abduction factors (Agopian, 1984; Palmer & Noble, 1984).

Agopian (1981) found parental child abduction to be a phenomenon, related to divorce and custody determination, which occurred after a period of compliance with a court ordered custody agreement. The abduction was an attempt by the non-custodial parent to regain full-time possession of the child, or as an attempt to influence or intimidate the custodial parent.

Palmer & Noble (1984) divide abductor motivation into two types: self-focused and child-focused. In self-focused abductions, the abducting parent is motivated by a strong desire to meet a parental need, even if this conflicts with the best interest of the child. A parent may desire to hurt or manipulate the custodial parent by removing the child, or may be reacting to the perceived loss of the child in a custody dispute. The abducting parent then sees him/herself as being vindicated by the abduction of the child from the custodial parent. Conflicts of values and/or child-rearing practices may create a desire to remove the child from

the influences of the other parent, even if the quality of the relationship with the child is positive. Alternatively, a parent may simply enjoy the child's presence and want to be a full-time parent. Parents have also used abduction as a way of gaining the attention of the custodial parent in situations where a reconciliation is desired.

Parents in child-focused abductions express some concern about the well-being of the child in the care of the custodial parent. Concerns may stem from objections to the other parent's values or life style, which are felt to be damaging to the child, or from concerns about the health and safety of the child. This is especially true in cases where physical and/or sexual abuse to the child is suspected. The motivation for parental child abduction was most often seen as growing out of a lengthy conflict related to the separation and divorce of the parents.

Agopian (1982) listed four primary motives for child abduction by a parent: (1) belief that the child is subject to neglect, (2) a desire to blame and punish the other parent for the failure of the marriage, (3) a desire to continue in a full-time parenting role, and (4) an effort to initiate a reconciliation or effect a withdrawal of the divorce action. In adversarial divorce proceedings, custody can be viewed as a "prize" awarded to one parent, with the other parent defined as the "loser" in the battle for custody. Anger from the loss of a custody battle may be a primary motivating factor for fathers who may feel cheated and resent losing control over their children. Non-custodial fathers may use child stealing as an "adjustment" to the divorce decree, especially when they think the mother was favored in the custody determination (Agopian, 1981).

Motivation for abduction was considered to be different for male and female parents. Females were to be susceptible to negative opinion from others for losing custody of her children, as only under the most severe conditions would custody be given to the father. Custody to the father would then be an insult to the mother. For males, abduction was seen as caused by anger from the loss of a custody battle. Fathers feel cheated and unfairly cut off from their children. The custody award is viewed as an unfair decision, which results from a tradition of awarding custody to women even in situations where the father may be an equal or better provider. Male abductors may act to recover what they feel is rightly theirs, which they feel has been unfairly taken from them.

There is virtually no information on the overall quality of family life or stresses prior to the abduction of their child, other than the pre-existing mental health problems in the abducting parent (Schetky & Haller, 1983) or problems of substance abuse or domestic violence (Janvier, McCormick, & Donaldson, 1990).

Greif and Hegar (1994) had parents rate their mood prior to the abduction. 40% rated themselves as "happy" at that time, 40% as "mixed," and 19% as "sad." Parent ratings of their own self-esteem, prior to the abduction, were presented as no higher or lower than what would be found in the general population.

Other Family Stressors

Limited references are available to relocation, domestic violence, and out-of-wedlock pregnancy in abduction family (Schetky & Haller, 1983; Terr, 1983). Such reports include Schetky & Haller's (1983) account of a mother abducting a child when she feared that her husband's plans to relocate to another state would be followed by a divorce action, and Terr's (1983) account of a mother losing custody of her child after the father initiated a court action, complaining that the mother had given birth to an illegitimate baby.

Studies by Greif and Hegar (1994), and Janiver, McCormick, & Donaldson (1990) indicate that domestic violence, mental abuse, and/or substance abuse occurred in more than one-half of the respondent families prior to separation or divorce, and child abuse was reportedly a factor in one-quarter to two-thirds of the families.

Relationship changes were further documented by the NISMART study. In 53% of the family abductions, the left-behind parent was a single parent, not living with a partner at the time the child was taken. In 24% of the reported situations, the left-behind parent was residing with a new partner.

In summary, studies on family stressors prior to abduction indicate that: (1) more than half of parental abduction cases involve a single parent, not living with any partner, (2) there is limited support for the presence of domestic violence, mental abuse, and substance abuse prior to abduction, and (3) overall pre-abduction family stressors remain largely unmeasured.

Pre-Abduction Family Resources

The socio-economic status of families prior to family abduction has not been thoroughly studied. In general it has been determined that female-headed households generally experience a decline in income and standard of living following divorce (Weitzman, 1985).

There is no published information regarding the use of support networks or organizations by parents, other than missing children's organizations and government or law enforcement agencies. There is some indication that attempts to elicit help from friends and relatives may not always be beneficial, as 33% of the

custodial parents reported being told by friends and family that they were overreacting when they revealed threats of abduction (Janvier, McCormick, & Donaldson, 1990).Pre-abduction family crisis resources indicated that women are the most likely searching parent.

Post-Abduction Resources

Post-Abduction Earned Income. Family income may be a critical factor for some families in recovering their child. The dollar cost may hamper the efforts of families, as the mean cost of searching for a child was found to be over $8,000 in domestic cases and more than $27,000 in cases of international abduction (Janvier, McCormick, & Donaldson, 1990). It is presently not known how most parents finance the cost of searching for their children or what the long-term effects of conducting an expensive search are for other family members.

Agopian (1981) reported an employment rate of close to 70% for both abducting and remaining parents. More than one-third of parents in the NISMART study reported being in managerial or professional occupations with incomes over $30,000 per year. Sixty percent of respondents in the Greif and Hegar (1994) study had more than 12 years of education and 38% were in professional or managerial positions.

Help-Seeking Behavior. Information regarding the remaining parent's use of legal or law enforcement resources is limited as no study has looked at the family's use of social service, legal and law enforcement resources. The anecdotal family abduction literature contains descriptions of actions taken by attorneys on behalf of left-behind parents, such as filing criminal charges, civil charges and suits for financial damages (Noble & Palmer, 1984; Palmer & Noble, 1984). Terr (1983) mentions a case in which a child was abducted on the advice of the parent's attorney.

Forehand, Long, & Zogg (1989) reported that a warrant had been issued in 71% of the cases studied. One-half of the left-behind parents in the NISMART study reportedly contacted an attorney, while slightly fewer (44%) reported contacting the police (Finkelhor, Hotaling, & Sedlak, 1990).

Although the use of a bond or restraining order can be a method of preventing abduction, and it was employed in less than one-quarter of the cases studied, their use was mentioned in only one study (Janvier, McCormick, & Donaldson, 1990). There were no other references to coping strategies parents used to prevent abduction other than discussing the threat of abduction with relatives.

Problem-Focused Coping Strategies. Little has been written about the ways in which families cope with the abduction of a child. Data from the NISMART study (Finkelhor, Hotaling, & Sedlak, 1990), reported two types of actions taken by parents, contacting an attorney (50% of the respondents) and seeking help from the police department (40% of the respondents).

Agopian (1981) examined the relationship of a specific parental action following the abduction (reporting the incidence to law enforcement personnel) and recovery of the missing child. Most parents whose children had been returned had notified authorities within one week of the child's disappearance. Only 2% of children had been returned in families where notification was made more than one month after the abduction.

Outside Family Support. Schetky & Haller (1983) discussed a case in which outside family support played a key role following a child's reunification with her father. The abducting parent, the child's mother, was reported to have a history of psychiatric problems which impaired her ability to adequately care for the child. Under the care of the grandmother and father, the child was reported to make a good adjustment and psychological treatment was not considered necessary.

Extended families have been mentioned more often in the role of accomplice to the abduction than support to the remaining parent (Noble & Palmer, 1984; Terr, 1983). The only mention of family support in a quantitative study was a reference to family members discounting the seriousness of reported threats of abduction when disclosed by the custodial parent (Janvier, McCormick, & Donaldson, 1990).

Drug and Alcohol Use as Coping Mechanisms. Reported rates of alcohol and drug abuse would suggest that many of the families in which an abduction occurs may have used alcohol or drugs as a method of coping with stress prior to the abduction (Janvier, McCormick, & Donaldson, 1990). It is not presently know if there are changes in patterns of drinking and/or drug use subsequent to an abduction.

Parental Perceptions of Agency Response to Family Abduction. Janvier, McCormick, & Donaldson (1990) assessed the perception the remaining parent had of government and agency response to family abduction. Response of law enforcement and court personnel to reported threats of abduction were rated as not helpful by two-thirds of reporting parents. Over one-half of the left-behind parents described the following agencies as "not helpful": FBI (79%); District Attorney (73); local police (67%); courts (58%). Both family members and attorneys were rated as "not helpful" by approximately one-half of the responding parents.

There was a general perception on the part of parents that the professional community, government, service agencies and the public were lacking in awareness and skills to respond appropriately and effectively to families whose child(ren) had been abducted. There was also wide-spread belief on the part of parents that the lack of responsiveness on the part of law enforcement agencies stemmed from a general perception that the child who is abducted by a parent is in less jeopardy than a stranger-abducted child. Reporting parents had the perception that family abduction was often considered to be a "domestic matter" in which the involvement of law enforcement is discretionary (Janvier, McCormick, & Donaldson, 1990).

When asked to rank the five most pressing problems encountered in trying to obtain the return of the missing child(ren) in international abductions, parents listed: (1) failure to receive help from the U.S. Department of State; (2) lack of cooperation from foreign governments; (3) low priority given to family abduction by law enforcement; (4) absence of clues to the child's whereabouts; and (5) inconsistencies in state laws. Parents in domestic situations cited: (1) absence of clues to the child's whereabouts; (2) lack of funds to conduct a private search; (3) low priority given to family abduction by law enforcement; (4) lack of police search efforts; and (5) inconsistencies in state laws. In the instances where parents have reported turning to law enforcement and/or specialized resources for assistance with international abductions, they have reported high rates of dissatisfaction.

In summary, studies on post-abduction family crisis resources indicate that: (1) post-abduction income data is unclear, (2) approximately one-half of left-behind parents contacted the police and an attorney, (3) police were generally notified within one week of the child's disappearance, (4) extended family mentioned more often as accomplice to abduction than support to left-behind parent, (5) relatives sometimes discount threats of abduction, and (6) the majority of left-behind parents report negative evaluations of existing law enforcement and government services.

The Parent's Abduction Experience

There is no information at the present time regarding family members pre-crisis perception of family abduction other than the reported finding by Janvier, McCormick, & Donaldson (1990) that in 48% of the domestic situations and 46% of the international situations, threats of abduction had been made prior to the completed abduction. Some parents, therefore, may have an awareness that an abduction may be possible.

Early reports (Schetky & Haller, 1983; Palmer & Noble, 1984) indicated that the abduction of a child for most parents is an unplanned for event, leaving the custodial parent with no information about the location of the child, the child's emotional state, the type of care the child is receiving, or the potential risks to the child.

Likelihood of Return. Higher rates of recovery have been found in international abductions than in domestic abductions (Janvier, McCormick, & Donaldson, 1990). The children had been recovered in only 8% of the domestic cases and in 19% of the international cases. The authors account for this discrepancy by proposing that parents in an international abduction may be more likely to return to the family's country and community of origin. Consequently, the location of the child might be more readily determined. In domestic abductions, the remaining parent is less knowledgeable as to the whereabouts of the abducting parent and child(ren).

The NISMART study found that children had been returned or recovered in 99% of the Broad Scope (less serious) episodes of parental abduction at the time the family was contacted.

Perceptions of the Abductor. When left-behind parents were asked to select characteristics from a list of 125 traits describing both the abducting parent and themselves, positive and negative traits were identified for both parents (Janvier, McCormick, & Donaldson, 1990). Abducting parents were viewed by left-behind parents as impulsive, revengeful, manipulative, controlling, and unpredictable. 80% of the domestic abducting parents were seen as coming from dysfunctional families with 60-70% for international abductors. Over 50% of the abducting parents were described by left-behind parents as having "undiagnosed emotional problems."

Child abuse by the abducting parent was reported to have occurred in as many as 66% of the domestic cases, but in no more than 23% of the international cases. These reports give a different picture of domestic and international abducting parents. Domestic abductors seem to have more signs of violent behavior, poor impulse control, and emotional disturbance.

Length of Abduction. Agopian (1984) identified two types of family abduction: short-term abductions where the abducting parent's interest was to detain or hold the child temporarily, and long-term abductions, where the child's life style and treatment are directed by the abducting parent's efforts to retain custody and evade detection by law enforcement personnel. In short-term abductions, the child's name and appearance are not altered and the child is usually transported to a specific location. Long-term abductions are characterized by

attempts to disguise the child's identity, frequent changes of location, and deprivation of peer and social interaction. Long-term abductions frequently involve interstate flight and a less stable and safe environment.

At the present time there is no good estimate of the length of time most abducted children are away from their custodial parent. The length of time reported in a few clinical studies ranged from several days to 3 years (Schetky & Haller, 1983; Terr, 1983). Most "in-flight" abducting parents reported to a telephone "hotline" service that they had been gone between 3 and 7 months (Forehand, Long, & Zogg, 1989). A survey of parents registered with a national child find organization (Forehand, Long, Zogg, and Parrish, 1989) found the mean length of abduction to be 30 months. The majority of episodes in the NISMART study lasted between 2 days and 1 week and 10% lasted more than a month.

Accurate data regarding the length of abduction are difficult to obtain due to a lack of agreement as to what constitutes a family abduction, with less serious abductions accounting for the majority of cases.

Methods of Recovery. In Janvier, McCormick, & Donaldson's 1990 study, the methods of recovering children were listed as follows: 8 children were located by police or legal authorities; 5 children were located by a missing children's agency; 3 children were located by the searching parent; and 1 child was returned by the abducting parent. The greatest number of children were located by police or legal authorities and the smallest number were returned by the abducting parent. Agopian (1981) further indicated that recovery of the child was related to the speed in reporting the child's disappearance to law enforcement. These findings suggest that the parent who does not use law enforcement and waits for the abducting parent to return the child may be at a distinct disadvantage for child recovery.

In summary, studies indicate that: (1) left-behind parents view more than three-quarters of abducting as coming from dysfunctional families, (2) left-behind parents report more child abuse by abducting parent in domestic vs. international cases, (3) the majority of left-behind parents perceive law enforcement and governmental services to be inadequate, and (4) many left-behind parents believe that law enforcement does not see parental abductions as a felony crime.

Experience of Stress Due to Family Abduction

In general, the experience of stress is related to: (1) the hardship of the original crisis, (2) family life changes that occur at the same time as the original crisis, and (3) stress of the family's efforts to cope with the crisis.

Most of what is known about the immediate and short-term response of families to the abduction of a child has been learned by asking left-behind parents about how they coped with the experience of having their child abducted.

For some parents, fear of abduction was something they lived with prior to the abduction. The abducting parent had made previous threats of abduction to the custodial parent. When custodial parents reported these threats to friends or relatives, their claims were frequently met with disbelief or were discounted as overreactions.

When asked how they coped with the abduction, most parents reported using a problem-focused style of coping rather than an emotion-focused style (Forehand, Long, Zogg, and Parrish, 1989). This suggests that most parents would turn to resources that would provide direct assistance with locating or recovering their child, such as law enforcement, investigating agencies or publicity generating resources. Contact with mental health resources may not be seen as helpful or important during the period immediately following the abduction.

A 1990, research study focused on the experiences of parents while their children were abducted (Greif and Hegar, 1990). Parents in the study were asked to complete a questionnaire designed to assess their sense of well being, by describing their mood and self-esteem prior to and since the abduction, their use of mental health services and any health problems they experienced.

Half of the parents in the study reported needing mental health services to cope with the loss of their child. One-quarter of the parents were treated for depression, and one-quarter were treated for anxiety and other problems. Three-quarters of the parents reported feelings of loss, rage and impaired sleep; half reported feelings of loneliness, fear, loss of appetite or severe depression.

Information regarding the psychological consequences of family abduction for child victims comes from clinical case studies reported by a few mental health professionals and limited research findings. Schetky & Haller (1983) summarized the effect of parental abduction by stating that parental kidnapping undermines the child's trust in the abducting parent and the child may blame the left-behind parent for not rescuing him. The child is left feeling vulnerable and without protection. Psychological consequences to the child, therefore, may begin immediately and continue throughout the reunification and post-reunification periods.

The degree of social trauma exhibited by the child after reunification has been related to five factors: (1) the age of the child at the time of abduction, (2) the type of treatment received by the child during the abduction, (3) the length of time the child was under the control of the abducting parent, (4) the child's experience

and life style while kept by the abducting parent, and (5) the type of support and therapy received by the child after recovery (Agopian (1984).

Agopian (1984) related the severity of the child's reaction to the length of time the child was kept away from the custodial parent. Children held for short periods did not lose hope of being reunited with the other parent, and did not develop an intense loyalty of identification with the abducting parent. Children taken for short periods of time were often lavishly entertained and when well cared for, tended to view their experience as an adventure. They felt concern, however, for the left-behind parent and were confused and fearful if told the left-behind parent approved of the trip.

Clinical case studies have described a variety of reactions shown by children following an abduction. Following reunification with her mother, one child studied experienced frequent nightmares with visions of monsters. She was fearful of another abduction and did not like being left alone. She was suspicious and fearful of strangers, but with regular psychotherapy and supportive maternal care, she was described as able to return to being a relaxed and happy child (Agopian, 1984).

In another case, a 3-year-old child had been abducted by her mother for a 2-week period. The mother abducted the child after she became fearful that the father's plans to move to another state would precipitate a divorce and custody dispute. After reunification, the child was evaluated, but not treated. The father obtained legal custody. The child's clinging behavior and fearfulness reportedly subsided after taking up residence with the father and paternal grandmother.

Parents asked to rate their children following reunification reported significantly more conduct problems, learning problems, psychosomatic symptoms and anxiety compared with the children's pre-abduction behavior. The only behavior on which parents did not rate the children as significantly different after the abduction was impulsive, hyperactive behavior. For the most part the reported negative effects of the abduction were not found to be related to the length of the abduction, the age of the child, the time since return, or the psychological adjustment of the parent with whom the child was reunited. One exception was a positive relationship between length of abduction and post-abduction learning problems. Children's symptoms decreased over time but did not return to the pre-abduction levels reported by the parent (Forehand, Long, Zogg, and Parrish, 1989). For most families, the overall effects of the abduction on the parent or child were neither extreme nor permanent, suggesting that parents and children have ways of adapting to extreme stress.

While most parent reports indicate only moderate and transient symptoms in children following abduction, one-third of custodial parents reported observing

signs of serious or mild mental harm to the abducted child (Finkelhor, Hotaling, & Sedlak, 1990). To date there are no published findings based on long-term follow-up in populations of parentally abducted children or their other family members.

There is also little information about the recovery process, which sometimes involves reabducting the child and possibly exposing the child to further trauma in the process. While the age of the child at the time of abduction, the duration of the abduction, and living conditions during the child's absence from the custodial parent have been suggested as factors contributing to psychological outcome, information on their role in determining psychological outcome is not presently known.

In summary, studies on the immediate and short-term experience of parental abduction stress study indicate that: (1) children may perceive the left-behind parent as having failed to protect them, (2) children may react to the left-behind parent with anger/rejection, (3) one-half of left-behind parents report needing mental health services, (4) experience of stress may be related to abduction motives, including need to possess child, and need to protect child, (5) mild to moderate psychological trauma symptoms have been reported for left-behind parents, and (6) significant psychological trauma symptoms have been reported for the recovered child.

Intermediate & Long-Term Experience of Stress Due to Family Abduction

The following summaries of case studies illustrate some of the intermediate to long-term experiences of stress found in family abducted children.

A case study of a 2-year-old boy abducted from his father and stepmother by his natural mother reported the child's subsequent course of treatment through individual psychotherapy and gave a description of the post-traumatic symptoms exhibited by the child. The boy had been abducted for a 5-week period, during which time he was taken to another state, which did not recognize the custody laws of the child's original state of residence. The child was reunited with his father and stepmother after his natural mother reportedly had problems managing the child's behavior and contacted the father agreeing to return the child. Treatment began approximately 2 months after the reunification (Senior, Gladstone, and Nurcombe, 1982). The child's symptoms included: disordered sleep, food refusal, violent behavior toward his stepmother and brother, uncontrolled crying, fearfulness, and separation difficulties.

The initial intervention involved medication for sleep disturbance along with reassurance of the parents. The family returned to treatment 10 months later, as the child's symptoms had increased and a more intensive course of treatment was

begun. The child's symptoms abated over the course of treatment with the exception of reaction observed by the stepmother on the first anniversary of the abduction.

Terr (1983) reported on the effects of threatened, aborted, and "successful" abductions by parents on children seen in her psychiatric practice over a 7-year period.

Eight of the children had been successfully abducted and kept for 2 weeks to 3 years by the abducting parent. There was a threat of an abduction, an abortive attempt, or the child was taken on an incommunicado "vacation" without the permission of the custodial parent in 10 reported cases. While the children were helped to cope with the trauma of their abduction, some permanent psychological effects remained. This was true even in cases where abductions were attempted, but unsuccessful in their completion.

Immediate responses, as well as 4-5 years post-trauma were observed. Responses were classified into five areas of functional changes: (1) the after effects of extreme fright or psychic trauma; (2) the effects of mental indoctrination; (3) rage or grief about parental abandonment; (4) rejection of the offending parent, and (5) exaggerated wish fulfillment or identification with a parent (Terr, 1983).

In another case study, a child was brought to a mental health clinic for evaluation after her adoptive mother's separation from her second husband, who had been psychologically abusive to both mother and daughter during the course of the marriage. Treatment was recommended to help the child deal with the divorce. During the course of her treatment, her adoptive father reentered the picture and arranged to take her for a weekend visit. He kept her for 7 weeks during which time he petitioned the court for custody. During the time the child was with the adoptive father, he refused to let the child contact her mother and hired a security guard to protect the house.

The father's attempts to gain custody were unsuccessful and the court ordered the child returned to her mother. A prolonged battle ensued in which the therapist assumed the role of advocate for the child's interests. The custody issue was resolved with the mother retaining custody and the adoptive father having regularly scheduled visitation. There was no punitive action taken against the father in response to the abduction. Following reunification with her mother, the child was treated for fears and emotional problems seen as resulting from the abduction.

The impact of family abduction on child victims was examined by conducting interviews with 5 children ranging in age from 6 to 11 years (Agopian,

1984). One child had remained in the state of residence, three were taken out of the state, and one was taken out of the country. The children were missing for periods ranging from 6 months to 2-1/2 years. The author found a transitory response to the abduction, characterized primarily by worry, fear, or crying in children who were held by their captors for a short period and were well treated.

Children detained for periods over 6 months displayed signs of severe psychological trauma and profound social disorders. As most had been quite young when abducted, they often had no recollection of the custodial parent. They had developed an affection for the abductor and accepted their fugitive life style as normal. The children were secretive, lied, and were untrusting of others. They tended to remain isolated from peers, preferring the company of adults. They assumed adult roles early and had a "pseudo mature" quality. After recovery, the children may remain loyal to the abducting parent and may become confused, distraught, and resentful when taken from the abductor's care.

Agopian proposed that the degree of emotional or social trauma to the child was affected by five factors: (1) the age of the child at the time of abduction; (2) the type of treatment the child received from the abducting parent; (3) the length of time the child was gone; (4) the events and life style to which the child was exposed during the abduction; and (5) the type of therapy and support received by the child upon recovery.

Children in long-term abductions have been found to show resentment toward both parents (Agopian, 1984; Terr, 1983). They may feel betrayed by the abducting parent and feel anger toward the left-behind parent for not coming to their rescue more rapidly.

In contrast to some children's perception of a brief abduction as a "vacation" children in long-term abductions experienced a life of deception and flight. Long-term abductions were more likely to be characterized by (1) many changes of residence directed at avoiding detection; (2) deprivation of social contacts (3) attempts to change or disguise the child's identity and generally less stable and safe life style than that experienced by children who were gone a relatively short period of time.

While the clinical literature would suggest that psychological intervention is warranted in cases of family abduction, it is not yet clear what services would be welcomed and utilized by families.

In summary, studies on the intermediate and long-term experience of parental abduction stress study indicate that: (1) significant psychological trauma

symptoms have been reported for the recovered child, and (2) mild to moderate psychological trauma symptoms have been reported for left-behind parents.

Although there are currently no available data on the combination of immediate, short-term, intermediate, and long-term experiences of stress resulting from family abduction, the preponderance of the professional literature on childhood trauma indicates that children experience significant psychological and behavioral reactions both immediately following, and long-after the traumatic event. Such reactions include psychophysiological disturbance (i.e., eating/sleeping difficulties), symptoms of avoidance and withdrawal (i.e., excessive fears, depression, and life-threatening behavior), and alternately symptoms of aggressive, acting out (Eth and Pynoos, 1985).

Evidence of emotional distress may not be immediately apparent, as there is indication of an "incubation period" of symptoms among traumatized children. When symptoms are present, they have been shown to be persistent and long lasting (Terr, 1991). There is no clear consensus on age and sex differences in children with regard to the duration, frequency, or intensity of psychological symptoms post-trauma.

Factors known to increase vulnerability to psychological distress following trauma include: prior existing psychological disturbance, degree of family organization, extent of immediate and extended family community support, use of force or coercion, presence of sexual exploitation, length of trauma, direct exposure to trauma source, and particular nature of abductor/victim relationship.

Factors known to reduce or minimize risk and adverse psychological consequences include: stable and emotionally supportive family environment, absence of preexisting psychological disturbance in child victim or family members, extended family and community support, and psychological intervention.

In summary, studies on the combination of immediate and long-term parental abduction stress study indicate that: (1) no reliable data is available on combination stress effects on children and families coping with parental abduction and its aftermath, and (2) data on combination stress effects on children and families coping with other severe traumas indicate that: (a) significant psychological and behavioral reactions exist in both following and long after the trauma, (b) some reactions may not be immediately apparent, but appear over time, and (c) previous life experiences can increase or reduce risk of adverse reactions.

Conclusions

As parents responses in the Janvier, McCormick, & Donaldson (1990) study suggest, the problem of family abduction is not independent of other major social problems impacting family life in the U.S., namely divorce, domestic violence, and drug and alcohol abuse. Obstacles to the recovery of a family abducted child may take many forms for a left-behind parent. The divorce process, and more specifically, determination of custody may have left a residue of impressions, experiences, and expectations related to the effectiveness of the legal system in resolving family disputes. The way that parents and other family members perceive the abduction, and the response of the left-behind parent are likely to be influenced by issues arising during the divorce and post-divorce adjustment periods.

As demonstrated by the information present in the social science literature on family abduction, the risk to children and parents is not minimal, as children are likely to remain away from custodial parents for extended periods of time and are likely to experience a wide range of psychological symptoms upon return, and in some cases for extended periods of time after recovery. There is even some speculation that the residual effects of severe fright may be permanent and may detrimentally become part of the child's overall personality structure (Terr, 1990).

References in the social sciences literature show the abduction of a dependent child is likely to be a sudden and unanticipated event for which the parent needs to rapidly develop an effective coping strategy. When the abductor has previously been abusive, or is known to abuse drugs or alcohol, or have a criminal record, the remaining parent may be greatly concerned about the child's well being and/or safety. This concern may be augmented for parents and is of substantial concern for society in general because of (1) vulnerability of young children who are most likely to be the targets of abduction; (2) the associated stressors faced by families experiencing a family abduction (such as extreme psychological stress, financial problems, and a lack of responsive support agencies and services); and (3) the enormous scope of the problem, documented by recent estimates of the incidence of family abductions over 150,000 cases annually, in which the intent of the abduction was to permanently detain the child and/or prevent the child from having contact with the remaining parent.

Although set in the context of a growing concern for missing children, the problem of family abduction needs to be examined as a significant social and legal problem in its own right. Family abduction might be viewed as a non-hazardous form of abduction as compared to some stranger abduction cases. However, family abduction represents one of the most extreme expressions of marital hostility and family conflict in which the needs of the dependent child are ignored. Parental abduction of children in the marital and post-marital battles can result in severe and long-lasting consequences for all.

Families of Missing Children Project Findings

This study, conducted by the Center for the Study of Trauma, University of California, San Francisco, provided the first scientific knowledge base for understanding the level of emotional distress experienced by these children and families (Hatcher, Barton, & Brooks, 1992). This project was conducted over a three year period at multiple sites throughout the United States. A sample of 280 families were followed prospectively with in-home interviews in a time series measurement design from approximately one month after child disappearance to eight months after child disappearance. Three primary groups were studied: (1) child loss by non-family abduction (41 cases), (2) child loss by family abduction (104 cases), and (3) child loss by runaway status (104 cases). For comparison purposes, a separate group of families who lost a child as a result of sudden infant death syndrome (31 cases) were studied in a similar longitudinal manner.

Areas of investigation included: (1) the chronological experience of missing children and their families from pre-disappearance events to disappearance events to recovery/non-recovery events, (2) the type and level of emotional distress experienced by families of missing children, (3) the type of coping behavior used by families of missing children, and (4) family utilization of intervention/support services.

Descriptive Results

Age and Number of Abducted Children. The average age for the family abducted child was five years old for both males and females. In comparison to non-family abductions, it is noteworthy that a substantial minority of family abductions involve more than one child.

Pre-Abduction Family Composition. While slightly more than half of the family abduction cases involved single parent households, it is more noteworthy to find that almost half of the cases involved the custodial parent plus a new step-parent or live-in adult partner. The impact of the entry and later behavior of the new step-parent or live-in adult partner upon the non-custodial parent's decision to abduct is presently unstudied, but clearly worthy of attention.

Children Left Behind in Family Abductions. Family abductors leave children behind in almost one-third of cases. There are important implications from this act, including the potential impact of: (1) abducting favored over less favored children, (2) the interruption of relationships among abducted and non-abducted children in the same family, and (3) the stress of the family abduction upon the left behind child and the left behind parent.

Pre-Abduction Family Traumatic Events. Over half of the families who later lost a child to family abduction reported multiple traumatic family life events prior to the child's disappearance. When a divorce occurred prior to child family abduction, the divorce was viewed as a positive event for one-quarter of the custodial parents, but negative or traumatic for almost one-half of the children who would later be abducted.

Pre-Abduction Physical and Sexual Abuse. Prior to child abduction by a family member, physical or sexual abuse of a family member was reported in almost half of the families. These reported rates of physical or sexual abuse, prior to child disappearance, are substantially higher than for other missing child groups. However, upon examination, almost all of the reported abuse is physical abuse of one parent by another parent or physical abuse of a subsequently abducted male child by the male parent.

Prior to family abduction, family sexual abuse reports are less than 4% and non-family sexual abuse rates are 8%. These findings are at variance with frequent media portrayals of family abduction cases where reports of pre-disappearance sexual abuse by a parent are very frequent.

Pre-Disappearance Mental Health/Support Services Use. In the one year period prior to the family abduction, almost one-fifth of the parents who would later be left-behind by the abduction were participating in family counseling services. This rate of utilization of mental health services is above average, and is probably reflective of ongoing family conflict prior to child disappearance.

Pre-Child Abduction Family Stress. Almost half of the left-behind parents affected by family abduction reported high levels of stress in the three month period prior to the abduction, thereby adding to the stress of the abduction event. Almost half of the children who would be later abducted and their siblings reported low levels of stress in the three month period prior to the abduction. This finding may indicate that some children in these families may be somewhat insulated from non-custodial vs. custodial parent conflict prior to the abduction.

Pre-Abduction Child Safety Instruction. Prior to the family abduction, one-fifth of the parents had not taught their children to be aware of potential dangers, such as sexual abuse or abduction by individuals outside the home. In comparison, one third of parents in non-family abduction cases with the child recovered alive and no parent in non-family abduction cases, with the child recovered deceased, had not taught their children to be aware of such potential dangers. These findings about safety instruction from parent to child are very dissimilar across different types of parents of missing children. Actual parent to child safety instruction versus potential parent need, after child disappearance, to

be perceived as having provided child safety instruction is an important area for further study.

Pre-Abduction Custody and Visitation Arrangements. Prior to the family abduction, legal custody of the child had been granted to the left-behind parent prior to the disappearance in slightly more than half of the cases. In the remainder of the cases, the child was abducted before custody was resolved.

Approximately half of the family abductions took place during scheduled visitation and approximately half involved taking the child without notice. When the abduction occurred during a visitation, the abducting parent was noted to have previously exceeded visitation limits, but the amounts of time over the visitation limits were generally small. Further, level of cooperation with visitation arrangements did not seem to be associated with family abduction.

The above findings indicate that pre-family abduction events, such as visitation, custody changes, abductor attitude changes, etc., may not be practically associated with families at risk for family abduction. Advances in the prediction of family abduction are more likely to come from detailed direct interview studies of family abductors themselves.

Family of Origin Physical and Sexual Abuse. In family abduction cases, one-quarter of these families of origin experienced physical abuse by one parent against the other parent or of a sibling by a male parent. These rates of family of origin physical abuse are apparently higher than in the families of origin of all other missing child groups, including runaways. Further, reported rates of physical abuse in family abduction cases are also apparently higher than in all other missing child groups, including runways. Physical expression of anger and resentment in domestic situations, or fear of such events, may be associated with the action oriented physical taking of the child in family abduction. It would be important to look more closely at parental values and attitudes toward retaliatory physical violence and other action oriented physical solutions to domestic problems.

Family of Origin Child Safety Instruction. Approximately one-quarter of these families of origin did not teach their children (later, the parents of abducted children) to be aware of potential child dangers such as sexual assault, abduction, or other crimes against children. Further, approximately two-fifths of the family of origin parents did not communicate information about incest, sexual abuse, or physical abuse. These findings identify an important area for further learning to determine the attitudes or values that may preclude/enhance the communication of child safety/child risk information within families of missing children.

Child Location and Time of Abduction. In just over one-third of the family abduction cases, the child was last seen in the left-behind parent's home. Less frequent last known child locations included a local neighborhood, the non-custodial parent's home, or a relative's home. Almost half of all family abductions took place between noon and 6 P.M.

Child Comprehension of Abduction Occurring. Less than one-tenth of the family abducted children initially realized that they were being abducted, apparently due to the effectiveness of abducting parent's explanation for the failure to return the child to the custodial parent's home. The most common explanation given to the child was that they were going on a "surprise trip or vacation" (14.3%), followed by reported disinterest/rejection by custodial parent (7.8%), "I am your new family" (7.8%), and custodial parent "told me to keep you" (9.1%). However notably, 43.8% of recovering parents did not know what explanation the abductor had given to the child.

Parent Knowledge of Child's Reactions to Abduction. After the child's recovery from family abduction, almost half of the recovering parents did not know about their child's initial reactions during the abduction, and four-fifths of the recovering parents did not know if their child had any initial fears. The above findings are likely to be indicative of the post recovery difficulties in communication between recovered child and left-behind parent. Such communication difficulties may initially serve a protective function for the recovering from having to respond to potentially painful events too soon after recovery. However, this initial protective function, maintained over time, is likely to serve to isolate and distance family members from each other.

As noted in prior project findings, there is a gap of knowledge between returned child and recovering parent about the circumstances of the abduction as well as the child's internal thoughts and feelings about the abduction. These findings are likely to be indicative of the post reunification difficulties in communication between recovered child and left behind parent. Such communication difficulties may initially serve a protective function for the recovering parent from having to deal with potentially emotionally painful events too soon after recovery. However, this protective function, over time characteristically changes, now serving to isolate and distance family members from each other.

Assistance to Abductor. Three-quarters of family abductors had assistance from relatives, friends, or a new spouse/partner. For a number of family abductions, it may be questionable as to whether the abduction could have been successfully carried out in the absence of this external assistance. Based upon the above project finding, direct study of the values and attitudes that these active or

vicarious (defined as knowing of the child abduction and taking no action to assist child return) accomplices to family abduction may be the most productive avenue to the prevention or early resolution of family abductions. Slightly more than one-third of family abductors had plans to travel by car to a distant state.

Physical and Sexual Abuse During the Abduction. During the family abduction, one-tenth of the family abducted children were reported as having been physically abused and 1% were reported as having been sexually abused or exploited. Four-fifths of the family abducted children were provided with adequate basic care.

Abducted Child Attendance at School. Of school-aged children, almost half were enrolled in school at some point during the family abduction. This finding points to the importance of school district involvement in obtaining copies of the newly enrolled child's prior school records, which would have identified many of the children in this project as family abducted.

Abductor Behavior. Over one-third of the family abductors were reported to be frequently caring and supportive (39.5%), followed by range of alternating supportive, evasive, and disorganized behavior. Such caring and supportive behavior by family abductors is likely to create confusion and mixed emotions/attitudes toward the abducting parent after the child has been returned home. Notably, 44.7% of the recovering parents did not know anything about the abductor's behavior toward the child during the abduction.

Emotional Distress for Left Behind Parents after Abduction. In family abduction cases, 68% of the left behind parents are above clinical distress levels at approximately one month after disappearance and 36.6% are above clinical distress levels at eight months after disappearance (The clinical distress, expressed in general psychological/physical symptoms, was measured by the Symptom Check List 90-Revised).

Primary Source of Support for Left Behind Parent During Abduction. For more than one-third of left-behind parents, the police officer is not only the central investigative figure, but also the most important source of coping support outside of the family. As noted in prior project findings on non-family abductions, the police officer's actions and behaviors continue to be viewed as a principal source of hope and encouragement to left-behind parents for child recovery.

Missing Child Center Services for Left Behind Parents. In family abduction cases, almost one-third of left-behind parents received some form of missing child center services.

Parent Return to Work After Abduction. Four-fifths of left-behind working parents and four-fifths of new partners/spouses had returned to their jobs within ten days of child disappearance.

Family Member Emotional Changes After Abduction. Ninety-four percent of the left-behind parents, four-fifths of the new partners/spouses (where present) and almost two-thirds of the remaining children in the family experienced emotional changes as a result of the child loss.

Child Safety Rule Changes After Abduction. After child disappearance due to family abduction, four-fifths of the left-behind parents did not make any changes in their family safety rules. In this case, few families may have made such changes as child loss was due to a known quantity, the former partner/non-custodial parent. For families with other children remaining in the home, the assumption of the left-behind parent may have been that there was no need to alter child safety rules, as the non-custodial parent had already taken the child intended for abduction, and would have taken other children in the family at that time if intended.

Family Value and Relationship Changes After Abduction. Left-behind parents maintained some of their beliefs in traditional family values after the family abduction, but their belief in predictability and control in their lives was substantially decreased.

Notably, more than half of the left-behind parents reported that their level of relationship satisfaction with the unabducted children increased. This increase in left-behind parent attention and affection is likely to be positively received by the remaining children. Other than minor anecdotal accounts, little is known about the experience of the unabducted children after a family abduction. This finding may indicate that left-behind parent attention and affection may increase to remaining children after the abduction. This increase in attention and affection is likely to be positively received by the remaining children, but a degree of emotional confusion or conflict may arise as well as these increases occur only with the sibling's abduction. There are important implications for left behind children, including the potential impact of: (1) the abductor taking favored over less favored children, (2) the interruption of relationships among abducted and non-abducted children in the same family, and (3) the stress of the family abduction upon the left behind child and the left behind parent. As in non-family abduction, the left at home siblings of family abducted children have been largely unattended to and forgotten as parent, police, and public policy has, understandably, been focused upon the abducted child. It is now clear that left at home siblings of family abducted children warrant attention and concern as well.

Parent Ratings of Law Enforcement Competence in Family Abduction. Slightly less than one-third of left-behind parents rated law enforcement recovery efforts as highly competent. When left-behind parent ratings of highly competent and moderately competent are combined, this includes almost two-thirds of all cases. As contrasted with parents who lost a child to non-family abduction (who provided overall favorable ratings of law enforcement competence), left-behind parents in family abductions rated over one-third of law enforcement recovery efforts as incompetent. The above finding indicates a substantial group of left-behind parents whose dissatisfaction may be due to varying degrees of investigative priority among agencies, and/or varying degrees of individual investigator knowledge about avenues through which to pursue child recovery.

Mental Health Services After Family Abduction. Following family abduction, nine-tenths of the families received no mental health services. The most frequently used social support service, missing child agencies, was received by just over one-quarter of all families. As noted in previously reported project findings on non-family abduction, the majority of families affected by family abduction must cope with this event without mental health or social service support.

Length of Time Missing in Family Abduction. In family abduction cases, the average length of time for child recovery 66 days, with the amount of time missing ranging from 1 day to 240 days. One-quarter of the family abducted children had not been returned by the conclusion of this project (eight months after child disappearance). From comparison of these project findings with results from other projects, it appears that the closer one gets to the local police department level, the more short term family abductions are identified.

The length of time missing for family abductions is influenced by three factors: (1) the definition of family abduction used, (2) the population from which the study sample is obtained, and (3) the method by which the sample is obtained. Previous studies have found varying lengths of time missing depending upon these three factors. For example, Hatcher, Barton, and Brooks (1990) found a more lengthy period for non-family abductions. In that study, the investigators: (1) defined the case as one qualified for registry in the National Center for Missing and Exploited Children's' (NCMEC) data base in calendar year 1987, (2) used the NCMEC data base as a sample of the total population of all family abducted children in the U.S., and (3) analyzed all cases in the data base, compared to the current study, the longer lengths of time missing in that study are probably due to the number of shorter term family abductions which were resolved prior to NCMEC data base entry at that time. Alternatively, Finkelhor, Hotaling, and Sedlak (1991) found a less lengthy period for non-family abductions. In that study, the investigators: (1) defined the event as an unauthorized child removal by a non-custodial parent, (2) used random digit telephone dialing as a survey method to

identify a sample of family abduction cases then interviewed the left-behind parents, and (3) analyzed those cases interviewed. In the current study, the investigators: (1) defined the event as appearing prospectively in the records of designated police departments and achieved a common definition across departments, (2) used the records and in-person interviews as a sample of all family abduction cases in the U.S., and (3) analyzed all cases over an 18 month prospective data collection period. The principal lesson from these various studies appears to be that the closer one gets to the police department case entry level, the more short term family abduction cases are identified.

Location of Child Recovery in Family Abductions. The site of child recovery in family abduction cases varied, with one-third of the children being found less than 100 miles from their home in the same state, and slightly less than one-third being found more than 1,000 miles from their home in a different state. This finding illustrates the wide range of flight behavior exhibited by family abductors, which considerably complicates the recovery efforts.

Reunification Meeting. The amount of time between notification of recovery and the actual reunification meeting was less than twelve hours in half of the cases. Within 48 hours of recovery, four-fifths of the recovered children had been reunified, but 6.6% had still not been reunified at one week post recovery. In four-fifths of the family abduction cases, the reunification meeting with child and left-behind parent is less than thirty minutes, followed by child and parent return home, with no guidance for post recovery assistance.

Assistance Provided to Parents for Reunification with Recovered Child. Most parents in family abduction were not notified first by a police officer, but by an individual tangential to the family and other than relatives, attorneys, friends, social workers, etc. While every parent would want the earliest possible notification of child recovery from whatever source, recovery notification by a police officer involved with the case is preferable from a law enforcement perspective and may be preferable from a parent perspective as the officer represents the most knowledgeable and reliable source of information about the recovery. At present, however, such notification is not being made by law enforcement in most cases, or by other individuals well known to the family.

Almost nine-tenths of left-behind parents received no instructions or guidance about reunification with their child. These families must then approach the reunification without any guidance as to what to say or do, what to expect in terms of child behavior, what would happen during the reunification meeting, or who to call for help after the reunification meeting.

In 7% of child recoveries from family abduction, reunification of the child with the left-behind parent can be delayed for weeks. Such delays typically involve charges from the abducting parent of pre-abduction sexual/physical abuse of the child by the custodial parent. While these cases are a relatively modest percentage of the total, they are highly problematic for all agencies and parties concerned. Study should be focused upon identifying the characteristics of such cases where the charges appear to be a reunification delaying tactic versus cases where the charges are substantiated.

Primary Source of Support for Left Behind Parent After Child Recovery. After child recovery from family abduction, the law enforcement officer was the most frequently utilized resource outside the family for left-behind parent support and coping. After child recovery from family abduction, 95% of left-behind parents did not cite any mental health professional, social worker, member of the clergy, or social support agency staff member as the primary contact for support and coping.

Recovered Child and Sibling Difficulty in Return to School. Nine-tenths of the children recovered from family abduction returned to school within ten days of recovery. Ninety-four percent of the recovered children and all of their siblings were reported to have no difficulties with the return to school.

Left Behind Parent Expectation of Harm to Child During Abduction. More than two-thirds of the left-behind parents felt that the child was recovered with about the same harm as expected, and more than one-half of the left-behind parents were about as relieved as they expected to feel. However, one-fifth of the left-behind parents reported more harm than expected. Individuals assisting left-behind parents need to be aware that child recovery from family abduction does not automatically equal parental relief from high stress.

Family Return to Normal Daily Pattern After Child Recovery. After child recovery from family abduction, almost two-thirds of the families returned to a normal daily pattern within one week after child recovery.

Emotional Distress for Siblings and Children Recovered from Family Abduction. While 80% of the remaining children in the family cases are clinically distressed at approximately one month post disappearance, 27.3% of the remaining children in the family cases are clinically distressed at eight months post disappearance.

Sixty-six point seven percent of family abduction recovered missing children were above clinical distress levels at point of reunification (under 45 days post-

disappearance) and 35.3% were above clinical distress levels at eight months post disappearance.

Over half of the recovered family abducted children experienced symptoms of emotional distress including anxiety (57.6%), and changes in eating habits (51.5%), with almost half of the children also experiencing nightmares (42.7%), as well. While most families affected by family abduction return to a normal daily pattern within one week after child recovery, this general picture of a return to a normal family daily life pattern may obscure other very important problems. Specifically, across families, the majority of parents report high rates of problems for children recovered from family abduction, including nightmares, anxiety symptoms, and headaches. While the return to school for these children was prompt and with no reported difficulties, it is apparent that the number of children experiencing emotional symptoms at home after recovery from family abduction is quite substantial.

Mental Health/Social Services After Child Recovery. Following child recovery from family abduction, over half of the families did not participate in any type of therapy or counseling service. The most frequently utilized social service support was a missing child agency, which provided assistance in 13% of the cases.

Perceived Law Enforcement Competence During Recovery and Reunification. Most of the left-behind parents rated the law enforcement as highly competent during the recovery and reunification with their family abducted child. However, more than one-third of the left-behind parents rated law enforcement as incompetent during the family abduction investigation. This substantial minority of dissatisfied left-behind parents warrants attention and concern from policy makers in both government and law enforcement.

First, reunification meetings are extremely short, with most being concluded in 15 minutes or less. It is highly probable these very short meetings are due to a lack of structure or knowledge by the participants as to what to say or do in these meetings, and that the resulting anxiety is most easily reduced by returning to more "normal" activities such as leaving the meeting, returning home, etc. Neither the goals for the actual reunification meeting nor for any subsequent period of reunification family adjustment appear to be specified, adding to the ambiguity and anxiety of the process. While there is no inherently justified reason for longer reunification meetings, it is certainly clear that the reunification process could well benefit from a statement of goals and methods, extending from the actual reunification meeting on to the subsequent family adjustment period.

Second, almost 90% of families of missing children across all three categories received no pre-reunification guidance and assistance. For the remaining

10% of families who did receive guidance, the most useful information came from books and friends, rather than from law enforcement, psychological, or social service sources. These results indicate that almost all families of missing children face one of the most distressing events in the entire disappearance episode without any support and guidance.

Third, mental health professionals were present at only 1.7% of the reunification meetings. This participation is accounted for by a single mental health professional who was present at a single parental abduction reunification. It is especially worthy to note that no mental health professionals were present at the stranger abduction reunification meeting to assist the families and recovered child. Further, social service workers were present at only 14% of the reunification meetings across all categories. This absence of mental health or social service professionals means that a very high degree of responsibility for managing reunification meetings is place upon the individual police officer. This requires the police officer to attempt to accomplish a difficult task without technical support training, or technical support personnel.

For parental abduction reunification meetings, the following conclusions are noted:

- 66% of the parental abduction reunification meetings occurred at a transportation depot such as a bus station, or at site such as a school or abducting spouse home from which the child was physically taken by the custodial parent.
- 10% of the parental abduction reunification meetings occurred at a parent's home.
- 10% of the parental abduction reunification meetings occurred at a social service agency.
- 50% of the parental abduction reunification meetings were less than 15 minutes in length.
- 80% of the parental abduction reunification meetings were less than 30 minutes in length.
- Extended family were present at 30% of the parental abduction reunification meetings.
- A (presumably new) spouse was present at 25% of the parental abduction reunification meetings.
- Police officers were present at 25% of the parental abduction reunification meetings.

APPENDIX C- CHILD TRAUMA REVIEW

The Repercussions of Trauma for Children

Events of the last 30 years, such as the Vietnam war, increased numbers of airline crashes, improved understanding of the damaging impact of rape, and natural disasters, have shown both researchers and the public that adults can be deeply effected by violent and traumatic experiences. As more has become known about the experience of adults, interest and concern about the traumatic impact of violence on children has increased. However, it has only been in the last decade that child trauma has received serious attention. Public interest in the impact of trauma on children have been strengthened by incidents like the abduction in Chowchilla, California of a school bus of children, the Stockton, California school yard shootings, the abduction murder of Polly Klass and by a growing social awareness about the extent of child physical and sexual abuse.

Historical Observations of Childhood Trauma

The contemporary increase in attention to child trauma is striking considering Freud's emphasis on child development as it effects personality and his early recognition that trauma was an overwhelming experience which disrupted an individual's ability to cope and assimilate information. He observed that trauma resulted in feelings of "utter helplessness" (1926) and the need to engage in repetitive behavior.

In a review of post-traumatic stress disorder in children and adolescents, Lyons (1987) documented the development of theoretical conceptions of trauma. She describes that early psychodynamic explanations considered trauma the result of "energy overload" in which the "stimulus barrier" of an individual was penetrated More recently psychodynamic theorists have postulated that trauma is based on "information overload" which results because traumatic events occur outside the range of normal human experience and people cannot cognitively process the incoming information. The inability to process this information leads to further anxiety and disruption of cognitive judgment. Horowitz (1976) proposed that the reaction to trauma has a phasic nature beginning with (1) "denial of the incomprehensible situation", and leading to (2) "intrusive re-experiencing of the vividly encapsulated traumatic imagery". Both early and late psychodynamic formulations regard an individual's developmental stage as being central to the impact and accompanying symptoms following trauma.

The behavioral model of PTSD is based on two-factor learning theory. The model makes use of both classical (Pavlovian) and instrumental/operant

conditioning. Within the framework of classical conditioning, the traumatic event is viewed as inherently distressing for individuals and acts like an unconditioned stimulus. The traumatic event is paired or associated with initially neutral stimuli, which act as conditioned stimuli, and come to elicit anxiety as did the traumatic event. For example, if someone were mugged in a park, they might come to fear and avoid parks due to an association with the mugging. Behavioral theory maintains that individuals respond to trauma based on instrumental/operant conditioning in which they learn to control their behavior in order to produce a desired consequence. In the case of PTSD, the desired consequence is relief from anxiety and individuals will avoid stimuli associated with the trauma (both unconditioned and conditioned).

Outside of psychoanalytic theory development, the majority of the work related to trauma in childhood has consisted of descriptions of symptoms following specific traumatic incidents, such as floods, fires, sexual molestation, or warfare. Some of the earliest accounts of childhood trauma were made by Anna Freud and Dorothy Burlingham (1943) during their work at the Hampstead War Nursery in England during World War II. This nursery offered relief to children in London who were homeless following numerous air raids. Their Annual Report of January, 1942 summarizes their work with 103 children, many of whom had lost their parents, permanently or temporarily, due to death, physical illness, or mental disorder. The homes of other children had been destroyed during bombings and many of them had lived in air raid shelter for extended periods of time. The case of Bertie, a four-and-a-half year old boy, exemplifies some of the reactions to trauma which Anna Freud observed and reported.

Freud described Bertie as a slim boy with clear skin and delicate features. He was friendly and always greeted people with a smile. Prior to coming to the nursery, Bertie had lived with his mother and father, who were known to be attentive and affectionate toward him. On one occasion, following a bombing, Bertie's father did not return from work for lunch. Becoming increasingly anxious, his mother began to search for his father, and eventually discovered at the morgue that her husband had been killed. Shortly after this, Bertie developed tonsillitis and was sent to a hospital where he contracted scarlet fever. His mother, confronted by another loss, and fearing that Bertie would also die, became psychotic and was taken to a hospital. After staying in the hospital for five months, Bertie was taken to the Hampstead Nursery. When asked about his father, Bertie said he was "a workman who tidies away the bricks from the houses which Hitler threw down." He also said that he wanted to be a "big boy" so that he could visit his mother in the hospital. Although he had been with his mother when she discovered the death of his father and he had been taken to the grave site, he had the fantasy that his father would return from work when the war ended. He enjoyed playing war games, which included bombing and killing, as did several other children at the

nursery. Bertie also displayed behavior which was at first confusing to nursery staff. He would jump-up and run to the corners of the room, searching for something, and then contort his face. He also insisted on wearing heavy clothing even when it was warm. Later, Freud concluded that he appeared to be acting as his mother had while searching for his father. His insistence about wearing warm clothing appeared to be a repetition of his mother's desire to keep him healthy and cure his tonsillitis. This case displays the anxiety, fantasies, and repetitive play which Freud observed in many of the children at the nursery.

Based on their general observations of children at the Hampstead War Nursery, Anna Freud and Burlingham (1943) further concluded that, if bombing incidents occurred when children were in the care of their own mothers, or familial mother substitutes, they did not appear to be particularly traumatic. The authors comment, "Their (the children's) experience remains an accident in line with other accidents of childhood --it is a widely different manner when children during an experience of this kind are separated from and even lose their parents."

The work of Freud and Burlingham was an insightful and detailed account of the reactions of children who endured lengthy war time trauma. While this initial description is a milestone work, the symptoms experienced by these children were associated with a series of traumatic events extending throughout the wartime period. This points out that our understanding of the effect of child trauma is complicated by the range of traumatic events which children may experience. Events may be single and isolated (witnessing of a homicide or suicide, experiencing a natural disaster, or a plane crash), or involve extended exposure (war or sexual abuse). Trauma may be personally experienced or witnessed, and it may involve physical injury or solely psychological damage. It may include family members or strangers. Further, children may experience combinations of trauma types, for example, a child may experience long-term deprivation and then witness the homicide of a parent. The age and the resilience of the individual child must also be considered.

Contemporary Research on Child Trauma

Contemporary research on childhood trauma is still in the descriptive phase. There has been no systematic exploration of the differential effects of various types of trauma, or of the psychological resilience that particular children may possess. The absence of a theoretical framework with which to study childhood trauma has made it difficult to obtain an integrated understanding of trauma to children. Even without such a framework, clinicians have begun to consider modes of treatment which may to be helpful to children following trauma. Clinical studies in response to a variety of stressors has shown that children's reactions to stress are developmentally related, children's methods of coping may have unique

characteristics, and few milestones in long term therapy with traumatized children can be identified. With these limitations of knowledge in mind, the following sections will review what is known about: (1) how children experience trauma, (2) the consequences of trauma, and (3) existing treatments.

Terr (1985) has pointed out that most reports of childhood trauma prior to 1970 were retrospective accounts made by adults about their early life. While these reports only discussed the impact of traumatic events on long-term personality development, they indicated that psychotherapy could help in the recall of traumatic experiences, established recurring nightmares as a major symptom of trauma, and demonstrated that traumatic experiences could be withheld from conscious experience over a period of time, and then be remembered.

Some of the events which are more commonly experienced by children as traumatic are divorce, illness, hospitalization, and surgery. In a review of adjustment disorder and post-traumatic stress syndrome in children, Turkel and Eth (1990) discussed the impact of these life events.

Post Traumatic Stress Disorder (PTSD) was introduced as a psychiatric and psychological term applied to adults in the third edition of the Diagnostic Statistical Manual in 1980 (DSM-III) (American Psychiatric Association, 1980). In this edition however, there was no description of PTSD in children. References to PTSD in children appeared in the revised DSM-III-R (American Psychiatric Association, 1987) and then in the DSM-IV (American Psychiatric Association, 1994).

PTSD refers to a set of symptoms which follow an extremely disturbing event which is outside the range of usual human experience and which would be seriously distressing for most people. The traumatic event usually involves a life-threatening disaster of which the individual may be a victim or witness. The response involves intense fears and helplessness, and is followed by the critical symptoms of re-experiencing, psychic numbing, and increased arousal, as described by DSM-IV. With regard to PTSD and children, Pynoos, et al. have noted that there appears to be a relationship between degree of exposure to a traumatic experience and the child's risk of developing PTSD, in that higher direct exposure increases PTSD risk. (Pynoos, Frederick, Nader, Arroyo, Steinberg, Eth, Nunez, & Fairbanks, 1987).

Differential Trauma Response by Age

Eth and Pynoos (1985) have summarized how children respond to trauma differently depending upon age the age categories of (1) infants, (2) preschoolers, (3) school aged children, and (4) adolescents.

Infants. Infants do not appear to develop a pattern of symptoms until between the ages of 30 and 36 months, at which time memory encoding and retrieval capacities are developed (Terr, 1988).

Preschoolers. This group of children appears to be particularly vulnerable to trauma because they have the least well developed coping strategies. They are also the most highly influenced by the reactions of adults. Following trauma, they are withdrawn, sometimes mute, anxiously attached, and display regressive behaviors (Elizur & Kaffman, 1982). They tend to reenact the traumatic experience through play, focusing on the point which was critical to them.

School-aged children. School-age children may be inconsistent in their behavior following trauma. They may intermittently become irritable, provocative, or infantile (Arroyo & Eth, 1985). They are particularly prone to the development of psychosomatic symptoms, such as stomach aches, and headaches (Krystal, 1978).

Adolescents. In adolescents, disenchantment and rebelliousness may be accompanied by premature entrance into adulthood. Adolescents are likely to be sensitive to the stigmatization of trauma, and frequently develop poor impulse control and judgment, suicidal behavior, sexual promiscuity, and drug abuse. In a study of Viet Nam veterans, adolescent soldiers were more likely to develop PTSD than older soldiers. This effect was heightened when veterans lost group support at the time of injury (van der Kolk, 1985).

Reports about the well-being of children following trauma have occurred as a result of: 1) common ongoing childhood traumas, such as divorce, illness, hospitalization, and surgery, 2) natural disasters and war, 3) witnessing violence, 4) physical abuse, 5) sexual abuse.

With regard to children's method of coping, Figley (1989) has listed a series of methods employed by the child for coping with either traumatic or non-traumatic stress. These are listed as: 1) crying, 2) withdrawal, 3) fantasy, 4) sleep, 5) feigning illness, 6) regression, 7) acting out, 8) altruism, 9) identification with the aggressor, 10) anticipation, 11) denial, and 12) sublimation.

Crying is described as a method frequently selected by children of bringing attention to their anxiety and eliciting comfort from adults. Withdrawal is described as a simple process of cognitively focusing on other things. This may result in a child who is not physically withdrawn from family activities but who appears psychologically preoccupied. Sublimation is another form of withdrawal allowing the child to become substantially engrossed in an activity such as video

games or self-structured play activity. Fantasy allows a child to cope by pretending they are somewhere else, are with someone else, or are someone else. Sleep is often employed by children, as a coping mechanism, as the child stays in bed, takes long naps or goes to bed early, in the absence of trauma related nightmares this coping mechanism has particular value. In feigning illness, the child may become psychosomatically ill or may consciously pretend to be sick, frequently producing extra parental attention, or release from parental performance expectations. With regression the child may revert to a behavior pattern more characteristic of an earlier age category, generally characterized by increased demands, dependency, and childish behavior. Acting out involves the impulsive violation of family or community rules of behavior, thereby shifting attention to the violation and away from the trauma. In altruism, the child may become quite helpful and useful to other family members enabling them to focus on thoughts separate from the trauma while receiving positive reinforcement from adults for their helpful behavior. In identification with the aggressor, a limited number of children identify with the power and control demonstrated by the aggressor, despite the trauma to self and family that the aggressor my be causing. In anticipation, the experience of a traumatic event may cause the child to seek, to plan and prepare for other possible traumas. This serves to provide a sense of structure and control, whether this security is realistically warranted or not. Humor can be employed by a child as a means of distraction, when the options of crisis or trauma resolution appear limited or non-existent. Finally, denial is referenced as one of the most frequent methods of coping with trauma by both children and adults. The successful use of denial is based upon a) moderation and b) timing. Moderate use of coping provides a needed temporary release from on-going stress and tension. Further, when denial is employed at times that do not significantly effect public behavior or performance.

Trauma effects by Type of Event

Divorce. Wallerstein and Kelly's (1976) recent study of 131 children from divorced families describes the effects of divorce for children of different ages. Children two to three years of age typically become anxious, display regressive behavior, and throw tantrums. Children three to four years old express a fear of losing their parents, while those children between five and six years old are both anxious and aggressive. Between the ages of seven and ten years old, sadness, fear, and feelings of deprivation were present. Those children in the ages of nine and ten years old appeared to be angry and isolated. Wallerstein and Kelly (1974) reported that the adolescents who managed the divorce most successfully were able to separate themselves from the conflicts of their parents and use denial to their benefit.

Illness. Bedell, Giodani, Amour, Tavormina, and Boll (1977) reported that chronic illness alone was not enough to produce psychological illness, but that it

did make children more vulnerable to other forms of stress. When physical illness caused rejection by family members, severe emotional distress resulted (Weinberg, 1970). Kellerman, Zeltzer, Ellenberg, Dash, and Rigler (1980) compared the attitudes of ill and healthy children about life and found them to both be positive. They concluded that for some chronically ill children denial may function adaptively by allowing them to avoid the most difficult features of their illness.

Hospitalization. Generally, a child's age and family support received will determine their ability to cope successfully with hospitalization. Pre-school children appear to be more disturbed by hospitalization than school age children. Infants older than seven months express distress upon initial separation from parents but eventually accept the care of others and are docile while in the hospital (Schaffer & Callender, 1959). While older children are aware of the implications of illness, increased awareness facilitates adaptation.

Surgery. Information about the reaction of children to surgery is conflictual. Jessner, Blom, and Waldfogel (1952) found that tonsillectomies were traumatic for all children, but Jackson, reported that most children were only minorly affected by this procedure. Adjustment to cardiac and renal transplants differed depending upon previous levels of adjustment (Tisza, Dorsett, & Morse, 1976), and adapting to the implantation of a cardiac pacemaker was mediated by denial and identification with medical staff (Galdston & Gamble, 1969).

Natural Disasters. Research on children's reactions to naturally occurring disasters is more limited than research on adult reactions. Prior to 1953, for example, not a single investigation of childhood responses to this type of traumatic experience appears in the literature. Since that time, however, several select studies have been undertaken (Young, 1953; Bloch, Silber & Perry, 1956; Perry & Perry, 1959; Perry, Silber, & Bloch, 1956; Drabek & Boggs, 1975; Krim, 1976; Milne, 1977; Blaufarb & Levine, 1977; Burke, Borus, Burns Millstein & Beasley, 1982), some of which deal exclusively with children's reactions, others dealing more primarily with family and community reactions which directly or indirectly influence the individual child.

In one of the first investigations of children's reaction to natural disaster, Bloch et al. (1956) studied 185 children (ages 2-15 years; mean age = 10 years) who survived a major tornado that swept through the small town of Vicksburg, Mississippi, killing several children. The researchers administered a questionnaire to the children and conducted an unstructured interview with their parents shortly after the event. Two psychiatrists evaluated the reactions of the children and family members who had varying levels of involvement with the disaster. Immediate psychological impact was the focus of study. Thirteen of the children suffered:

1. Severe symptoms, including increased dependency and clinging to parents, regressive behavior such as bedwetting

2. Night terrors involving the reliving of the trauma

3. Phobic avoidance of the outdoors

4. General irritability and sensitivity

5. Abandonment of previously learning skills

6. Re-enactment of the trauma in their play

Seventeen percent of the children demonstrated mild forms of disturbance, while the majority (61%) showed no signs of immediate emotional disturbance. There was insufficient data on the remaining 9% to establish judgment on the presence or lack of symptoms.

Clinically, the authors made several interesting observations about levels of child disturbance as follows:

1. Many of the effected children had an immediate tendency to deal with the trauma by using strong defense mechanisms, i.e., denial and suppression. These feelings ultimately gave way, in the more psychologically intact children to feelings of acceptance and learning to live with loss.

2. Awareness of the tornado at the time of its occurrence, physical presence in the impact zone, and actual personal injury were all factors that were positively associated with increased emotional disturbance in children. On the other hand, there appeared to be no significant relationship between emotional disturbance and vicarious involvement when injury or death occurred to friends. There was a significant relationship when injury or death occurred to family members.

3. As a group, 6-12 year olds showed more signs of disturbance than their younger counterparts.

In a companion study which focused primarily on family response to the same tornado disaster (Perry, Silber & Bloch, 1956), it was reported that consistency in parental behavior toward children was the most important factor in child positive adjustment following the disaster. Pre-existing emotional problems

in the parent were also related to child's problems after the traumatic event. Unfortunately, no long-term follow-up of these children or their families was conducted in either of these studies, and therefore, it is uncertain as to what problems persisted or why.

Perry and Perry (1959) investigated children's emotional responses to another series of tornadoes which hit two schools in rural Mississippi two years after the studies previously referenced. In this disaster, children again were the primary victims, as the tornado struck while classes were in session. In all, 29 persons were killed and 109 injured. Interviews with 62 children (Range = infancy - 17 years; mean age = 7.1 years), and their families were conducted between one and two weeks following the event. In addition to documenting the children's problems as a result of the tornado, this study also looked at parent-child total family behavior, and outside influences (e.g., the manner in which the disaster experience is handled by the community, by peer groups, by the school). Results indicated that the children involved in this tornado experienced similar, but overall fewer and less severe symptoms when compared to the 185 children in the prior Vicksburg study. For example, bedwetting occurred in only one case. While the children reported fear of wind and bad weather, these symptoms did not prevent them from returning to school. Dependency and regressive clinging to parents, a commonly reported symptom in the earlier study, was not present among these children. Initially the differences in findings appear contradictory. However, the authors indicate three important factors which they believe led to fewer child problems.

1. In the school tornado, many more children and families were affected, and consequently more support was gained from others, in this close-knit rural community, who suffered a similar experience. In the Vicksburg tornado, affected children and families were more isolated.

2. The families in the school disaster were more flexible in their post-incident organization and helping behavior. For example, if a parent was absent due to death or injury, a larger pool of extended family members were present to meet the increased emotional demands of the child. In the Vicksburg disaster, family systems were smaller and helped less.

3. Children in the school disaster had opportunity to gain self-esteem in their families by resuming important household or farm duties. In the Vicksburg community, children were not assigned such chores or tasks.

The conclusion was that child disaster problems are not only determined by the parents own disaster reaction, but also by extended family willingness to help, and direct re-involvement of the child in family recovery tasks.

Milne (1977) reported on the effects of a major cyclone (Cyclone Tracy) on 649 children who ranged in age from preschoolers to older adolescents. There were 3 subgroups: 1) stayers, or children of families who remained in their homes both during and after the disaster; 2) returned evacuees, or children whose families initially left their homes for safety reasons but later returned, and; 3) non-returned evacuees, or children whose families permanently relocated after the disaster. Between 7 and 10 months after the cyclone, parents were asked to report on their child's behavior. Results revealed the following:

1. No significant sex differences between boys and girls in terms of emotional problems.

2. The most common symptom reported was a persistent fear of wind, and rain (26.2%), fear of the dark (12%) and fear of jet aircraft noise (11.4%). These symptoms were reminders of the frightening noise and darkness associated with the cyclone.

3. The youngest children (under 5 years of age) were most severely affected. 15.2% of the children in this age group demonstrated clinging toward their mothers, and 9.7% demonstrated repeated bedwetting. Frequency for all problems (fear, regression, aggression) showed a steady decline as the age of the children increased.

4. With regard to the different subgroups (Stayers, Returnees, Non-returnees) it appears that problems were most pronounced for the non-returned evacuees, especially for those children with poor pre-disaster school or social performance. Forty-seven percent (47%) of these children demonstrated either some or many academic and/or social problems.

5. Overall, the researcher notes that the lack of consistency in child problems and the failure of many children to develop any symptoms at all combined with a recovery rate of 45% in the 7-10 months following the disaster indicates that the impact of this type of trauma is not as severe as expected.

In terms of children's response to disasters other than tornadoes, Blaufarb and Levine (1972) reported on families seen at a child guidance clinic following an earthquake. While still sleeping, they were awakened with their homes severely

shaken, many were thrown out of bed, and unable to stand during the initial 30 seconds of violent shock. This made it impossible for children to reach their parents. When they were able to reach each other, families reported clinging together either in a doorway or in bed.

In a multiple-week period following the earthquake, eight hundred families telephoned the clinic for assistance. Of this group, 300 came in for appointments. The families were seen in small groups over a five week period, with most families (85%) attending only one session. A central reaction in the 3-12 year old group was fear of going to sleep in their own rooms, accompanied by persistent demands that they sleep with their parents. For those that could sleep in their own rooms, insomnia was very common. A younger group of children (3-6 years old) expressed fear of being alone in their house, even though their mothers were in the next room. These children were afraid of playing with children, preferring to be with their mothers to whom they clung. Additionally, there were infrequent problems in toilet training and eating. Overall, the children's reactions were viewed as an attempt to hold on to parent attention for security and safety.

Newman (1976) investigated a flood disaster on eleven children, who survived the Buffalo Creek Dam break. All of the children were under 12 years of age at the time of the event. The researcher conducted individual interviews, and asked children to tell stories and draw, two years after the traumatic event. Consequently, this study, unlike many others, focused on the long term psychological impact on the child victim. Results revealed the following three differences in emotional and behavioral response depending on the age of the child:.

1. The preschoolers in this small sample demonstrated confusion, rather than overwhelming anxiety or fright. They also showed an increase in, and sometimes excessive need for security, often clinging to their parents. Hyperactivity was reported in some of these children, as was excessive fear, bedwetting, and night terrors. The researchers also noted the difficulty preschoolers had in differentiating their dreams from reality.

2. Five to 11 year old children experienced depression, hopelessness, and chronic anxiety.

3. The oldest children demonstrated their distress by delinquent behavior, or withdrawing. Major factors thought to be associated with trauma response were: 1) the developmental level of the child at the time of the trauma; 2) the child's perception of the reaction of his/her family; 3) direct versus non-direct exposure to the disaster.

Once again, these results showed younger children to be more vulnerable, and parental reaction and level of direct disaster exposure as most important.

Burke et al. (1982) surveyed 81 preschool children following a 1978 blizzard in Revere, Massachusetts. The study looked at child problem behavior after the disaster, and parent denial of children's problems. A questionnaire was completed by parents and teachers regarding the children's behavior six months prior to and five months following the disaster. Results indicated four conclusions:

1. The aggressive conduct score among these children (i.e., "bullying," significantly after the blizzard).

2. School Problem Behavior scores (i.e., "does not like to go to school," and "will not obey school rules") decreased significantly. For the 43 younger children, Anti-Social scores (i.e., "stealing from parents" and "stealing at school") increased significantly.

3. In a separate analysis ("special needs" children behavior showed a significant worsening overall. Anxiety scores (i.e., "afraid of people;" "shy;" "afraid of being alone") decreased for girls and increased for boys.

4. Parents denied that their children's behavior had worsened since the disaster.

Overall, the main finding was that problem behaviors among children do show a significant increase following a natural disaster, and that parents have a tendency to deny such problems.

Several researchers investigating child responses to natural disasters have focused on reactions of the immediate and extended family. Young (1954) studied the role of the extended family following the 1953 flooding of two English towns. In describing the reluctance of victims to evacuate and take refuge in official aid centers, the author found that, not surprisingly, evacuees were much more likely to seek out safety in the homes of relatives. Of a total of 10,000 evacuees, 6,000 had found refuge independently with relatives. These results were consistent with those of Drabek and Boggs (1975) who interviewed 178 of 3,700 families evacuated from their homes during a massive flood in Denver, Colorado. Results indicated families most often evacuated as units, and showed a strong tendency to take refuge in homes of relatives, rather than in official centers. In a related study, Drabek, Key, Erikson, and Crowe (1975) found that not only do disaster families count on each other for physical protection and safety, but also their extended

family relationship patterns are strengthened over the long term. Victim families, when compared to non-victim families, reported more frequent contact with immediate kin, more often sought help from these sources, and visited more frequently with extended family members. These results underscore the central role the extended family plays for both child and adult victims of natural disaster.

Child War Trauma. In addition of Freud and Burlingham (1943), several other investigators have studied post trauma effects on World War II children. Carey-Trefzer (1949) examined case records of 212 children who were in contact with a London Child Guidance Clinic both during, and up to four years after the war. The following symptoms were observed in children:

1. In 71% of the cases increased aggression, increased inhibition, and general nervousness occurred.

2. In 55% of the cases, fears and general anxiety was present.

3. In 31% of the cases school difficulties were present.

4. Sixty-one percent of the boys demonstrated one or more problems compared to 39% of the girls.

5. Children of neurotic mothers were at much higher risk for post-war problems.

6. Direct exposure to bombing was the most significant factor on child post-war problems.

7. Evacuation and displacement from home were responsible for more serious long-term effects.

Finally, Carey-Trefzer concluded that in the majority of cases pre-war problems were the cause of current problems, not war trauma.

Burt's (1943) study of British children in wartime found similar results. For those children that did have problems, the 2-5 year old category was at greatest risk. Like Freud and Burlingham, and Carey-Trefzer, Burt concluded that the traumatic experience itself was far less serious for children than being in the presence of a panicked parent.

Brander (1943) reported on the psychological effects among Finnish children during and after the Russo-Finnish War of 1939-1940. While failing to cite the actual number of children observed, the author described six immediate

and long term responses that were most directly related to evacuation experiences and air raid alarms, both with and without subsequent bombing.

1. During forced evacuation, frequently reported problems in children included confusion, depression, anorexia, bedwetting, and night terrors.

2. These symptoms were reportedly more frequent and more severe when evacuation was hurried and unplanned.

3. In the air raid situation, specifically during the pre-bombing drill period, no specific child problems were observed. In fact, for many children, the wailing of sirens proved to be quite exciting, with no fear attached. Once the bombing commenced, however, children responded with hysterical screaming upset behavior.

4. As the bombings continued, the trauma became so intense for the children that they stopped reacting, and withdrew.

5. Long-term problems (more than a year later) included tics, bedwetting, and depression.

6. There was a tendency, particularly among the boys, to engage in war simulation play as a means of coping.

Finally, Brander noted, "Only much later does one become conscious of the experience in its total reality. The reaction time, therefore, can be considerably prolonged. A rather unimportant fact, such as the appearance of a friendly airplane, became the cause of new violent reaction. That such disturbing experiences leaves an after effect for quite some time seemed to be proved by the frequency of rather severe cases of pavor nocturnes (night terrors) after air raids."

Coromina (1943) studied children during the Spanish Civil War. Her report was based on of 50 children under 2-1/2 years old, 100 preschoolers, 50 children ages 5-12, and 8 girls ages 13-16. Coromina's six conclusions were:

1. Children separated from their parents and evacuated under good conditions, placed in child residences protected from bombing, hunger, and unrest showed no signs of psychological disturbance.

2. Children evacuated with their families and living in refugee camps distant from bombing showed frequent, mild, psychic disturbances, including anxiety, depression and delinquency.

3. Children not evacuated and living with family in bombed areas showed an increase in similar problems.

4. Children who were less than 2-1/2 years of age, not separated from their mothers, including those in bombed zones, showed no problems.

5. The preschool age children had the most frequent problems. The symptoms noted were a decrease in aptitude for play, a general sadness, isolation and frequent bedwetting.

6. War game simulation and play was observed, particularly in older boys.

Mercier and Despert (1943) examined 350 French youngsters during World War II, ranging in age from eighteen months to eleven years. The authors concluded:

1. Overall, the children demonstrated remarkable adaptability.

2. Pre-existing child problems were made worse by war stress (Mercier, et.al., 1943).

3. Family attitude and response had considerable influence on the immediate reactions of the child.

In another study on children's reactions to war, Ziv, Kruglanski and Shulman (1974) compared 521 children, ages 5-11, from frequently bombed settlements (stress group) to 297 same aged children from settlements that were not bombed (non-stress group). The groups were matched with respect to age, socio-economic status, cultural background, as well as the length of their parents residence in the respective settlements. The findings were that:

1. The stress group of children exhibited more aggression as well as a greater degree of appreciation for courage behavior by others.

2. No differences were found between the two groups on their attitudes toward war.

The major conclusion drawn from all studies of the traumatic effects of war was that children do engage in active coping even under such extremely stressful situations.

Arroyo and Eth (1985) studied thirty children traumatized by Central American warfare. Evaluations were conducted between 3 weeks and 34 months after their arrival in the U.S. The following results were found:

1. A large group of problems were found including suicidal behavior, somatic complaints, antisocial behavior, sleep difficulty, separation anxiety, defiance, and multiple school-related problems.

2. Age differences in problems were observed.

3. Diagnoses of post traumatic stress disorder (33%) and adjustment disorder (29%) were most common.

4. Difficulty in sequencing of traumatic events and long-term memory problems were reported frequently.

5. Six of the thirty children had problems severe enough to require in-patient hospitalization.

The authors concluded that beyond the easily observable problems of war stress, these children over time demonstrated other difficulties, including restriction in social activity, remaining house-bound, and anti-social behavior.

Witnessing Persecution, Torture, and Death. Allodi (1980) reported on interview and projective drawing data of 203 children of parents who were detained and disappeared in Santiago, Chile from 1973-1977. The children were subsequently in contact with a Santiago mental health agency. All were under 12 years of age with the majority under 6 years of age. The author found:

1. Frequent problems of withdrawal (78%), depression (70%) and intense fears triggered by sirens, nighttime engines, etc. (78%), loss of appetite, weight and sleep disturbance, regression in behavior, school performance problems, excessive dependency and clinging.

2. Factors associated with problem severity included younger age, longer exposure to trauma, social isolation, and inadequate or untrue explanations for parental absence.

3. Long-term problems in psychological development were noted, but not precisely described.

Allodi (1980) also evaluated another group of 23 Argentinian and 5 Mexican children whose parents underwent political persecution and imprisonment. Half of this group were temporarily separated from their parents, then reunited. Results indicated that:

1. Common problems were insomnia, eating disorders, regressed behavior, aggressiveness, and somatic complaints.

2. Excessive dependence on parents, particularly when the child was directly exposed to violence, was very common.

3. The most persistent problems over time were dependency and aggressiveness.

4. Irritability and aggression were only reported for older children or as a later problem for the younger age group.

5. All these symptoms were related to the loss of parent attention or protective home environment due to parental preoccupation, distress, or absence.

Coh, Kirstein, Holzer, Lone, Koch & Severin (1980) studied a group of 75 children whose parents were subjected to physical and/or mental torture. The ages ranged from one to 21 years. The children were examined two to six years after their parents were released from prison and reunited with the family. Results from physical exam and interview with the child and his/her family indicated that:

1. Thirty-six percent were anxious and especially sensitive to noise. Frequent crying was also reported.

2. Thirty-five percent of the children had difficulty falling asleep and nightmares.

3. Thirty-three percent developed bedwetting and 16% became introverted, depressed, and had difficulty establishing relationships with children their own age.

4. Seventeen percent exhibited aggressiveness, eating disorders, and memory impairment.

5. A variety of somatic problems were observed in a small percentage of children.

The authors concluded that, after a certain lapse of time, children exposed to this type of trauma frequently develop serious and long-lasting problems.

Kinzie, Sack, Angell, Manson, and Rath (1986) studied the effects of trauma experienced by children during the regime of Pol Pot in Cambodia during 1975-1979. At the time of the interviews, the children were living in the United States and their average age was 17. Most of them had lived in concentration type situations between the ages of 8 and 12. During this time, they had been separated from family, witnessed murders of both family members and others, endured forced labor, and starvation. Of the group, 50% developed post traumatic stress disorder, and displayed depressive symptoms.

Pynoos & Eth (1985) investigated the responses of 50 children who had witnessed personal acts of violence within weeks of the actual trauma (murder/rape/suicide of a parent). The children were also followed up through the subsequent criminal proceedings (time unspecified). The predominant problems reported by virtually the entire sample of children, included:

1. Repeated thoughts of the central violent action when physical harm was directed at the parent.

2. Frightening fantasies or dreams of revenge.

3. In the rape situation, disruption of the child's sense of security and vulnerability. Girls became terrified by identification with the mother as victim. Boys, too, felt more vulnerable, but several of them noticeably identified with the rapist rather than their helpless mother. Children of both sexes often feel extreme guilt. Subsequent discussion of the sexual component of the act often became taboo within the family, confusing the child.

4. In the suicide situation, disillusionment, distress, continued reenactment of the violent act in play, repeated thoughts, denial, and vulnerability. Long-term follow-up on this group was not available.

Overstimulating and/or Frightening Experiences. In addition to the trauma resulting from witnessing violence, other scenes have proven to be overwhelming for children. The witnessing of intercourse between adults has stimulated sadistic and/or castration fantasies (Kliman, 1968), night terrors and fearfulness (Fraiberg, 1952) in children. It has been noted that witnessing child birth can be traumatic for some children (Anderson & Shafer, 1979).

Sexual Abuse. Child sexual abuse is most frequently perpetrated by immediate family members (incest) or by acquaintances and neighbors. Girls are more frequently reported as victims of abuse. While sexual abuse is reported to occur most frequently between the ages 11 and 14 (DeFrancis, 1971), of those cases occurring under the age of 12, 50% involve children less than six years old.

Sexual abuse has two variants, one in which the child stimulates the adult, and the second, termed "sexual misuse" by Brant & Tisza (1977), in which the child is stimulated in an age inappropriate fashion. Sexual abuse results in both physical and emotional sequela. Infants have traumatized genitalia, and problems eating and sleeping. Toddlers and preschool children may incur genital irritation and injury, as well as anxiety, insomnia, somatic complaints, and difficulty with attention. Brant and Tisza (1977) have also indicated that children may develop compulsive behavior, precocious "sexual play" and phobias.

As is true with most research on the psychological problems from childhood trauma, the majority of studies on the effects of childhood sexual victimization have been descriptive and anecdotal. These studies often utilize subjective judgments of mental health professionals formed during evaluations and treatment of sexually abused children, and retrospectively with adults, predictably resulting in contradictory findings. Some investigators concluded that sexual abuse has little or no adverse psychological impact on the child (Bender & Blau, 1937; Weiner, 1962; Henderson, 1983). Yorukoghu & Kemph (1966) for example, described two children involved in long term incestuous relationships, who failed to demonstrate any serious of significant psychological problems. The authors hypothesized that the lack of problems was probably the result of adequate psychological development prior to the incest experience. It was suggested that these children were able to see the parent offender as seriously disturbed, and were able to effectively defend themselves psychologically against frequent and prolonged sexual intrusion. Consistent with this position, Rasmussen (1934) reported on 54 children who had sexual experiences with adults. 80% were evaluated as having normal adult adjustment.

As difficult as it may be to believe, other studies have concluded that the effects of sexual victimization can be positive. Rossenfeld, Nadelson, Krieger & Backman (1977) for example suggest that sexually abusive relationships may provide the child with at least some caring and concern in an otherwise depriving environment.

On the whole, however, most of the more recent, well designed research conducted on larger samples has demonstrated that there are identifiable short term and long term problems from sexual victimization of the child (Browne & Finkelhor, 1986).

DeFrancis (1971), for example, in a study of 263 victims of sexual abuse, judged 66% of them as being emotionally damaged. Frederick (1985) reported on a sample of 150 children under the age of 18, who presented to various agencies following a traumatic event. Evidence showed post traumatic stress disorder at a high frequency in three groups of children who experienced various types of traumatic events. Of the 50 children who had experienced physical assault, all 50 were diagnosed as having PTSD, more than any other group. The author also found that of a total of 300 cases of child molestation, he had never seen a case where symptoms of Post Traumatic Stress Disorder were not present if the child was over six years of age.

Several studies have found a link between sexual abuse and various forms of psychiatric illness. For example, Carmen, Rieker, & Mills (1984) investigated the histories of 188 psychiatric in-patients and found that 43% of the sample had histories of physical and/or sexual abuse. Rosenfeld (1979) found a history of incest in 6 of 18 female psychiatric patients.

In one of the only large scale studies conducted on a non-clinical population, Finkelhor (1979) surveyed 796 college students to elicit their reactions and responses to childhood sexual experiences. A central question was posed to students as to whether they felt their experiences as children (mean age for boys = 11.2 years; mean age for girls = 10.2 years) were positive, mostly positive, neutral, mostly negative, or negative. The results of this survey yielded very useful data regarding psychological impact of sexual victimization, including:

1. The greater the age difference between the child and the individual with whom the child is engaged in sexual activity, the greater the trauma. This was especially true for girls.

2. The older the child, the more traumatic the experience.

3. The trauma associated with sexual involvement is greatly increased when there is force and/or coercion involved in the act.

4. The closeness of the relationship between child and partner increases the impact of the trauma. Child sexual involvement with fathers and stepfathers was more traumatic than sexual contact with uncles or grandfathers. Additionally, it was found that sexual involvement with grandfathers or uncles was equally as negative as with strangers.

5. Children's sexual experiences with male partners were consistently experienced as more negative than with female partners.

6. The extent of sexual activity does not appear to be related to greater levels of trauma in children. Simple fondling was the most negative of any actual physical contact.

7. The duration or repetition of sexual experience was unrelated to the extent of trauma.

8. The revealing or keeping secret their sexual activity does not increase the extent of trauma for children.

Lusk and Waterman (1986) reported that 20% to 50% of child victims evidence clinically significant problems. The Tuft's study (1984) found that 17% of sexually abused 4-6 year olds and 40% of abused 7-13 year olds demonstrated serious problems when measured six months after victimization. In another study, Adams-Tucker (1982) investigated 28 sexually abused children referred for treatment and found that, as a group, their problems were in the moderate to severe range.

On the one hand, many of these studies do not share a common definition of symptoms or emotional distress. Still other studies have relied on retrospective reports by adults sexually abused as children, which is known to be biased and influenced by such things as memory distortion Additionally, there is a notable lack of follow-up data in many of these studies. Despite these study design limitations, existing evidence supports the conclusion that sexual abuse is associated with problems in significant numbers of children. Even in non-clinical samples, there are traumatic effects, most often when there is force involved, and when there is a large discrepancy between the age of the child and their involved sexual partner.

Considerable research attention has been given to the relationship between childhood sexual abuse and the development of specific problems. Browne and Finkelhor (1986) found consistent evidence of the following:

1. Fear, anxiety, depression, anger and hostility.

2. Inappropriate sexual behavior in a significant portion of the female victim population.

3. Long-term effects included depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward re-victimization and substance abuse.

In their work on coping with sexual trauma, Roth and Newman (1991) emphasize that the affects which follow sexual trauma include: helplessness, rage, fear, loss, shame, guilt, and diffuse emotional distress. They also note that victims maintain differing levels of emotional awareness following trauma. They describe six levels of emotional awareness:

1. No conscious awareness of emotion, but evidence that it is present. At this level, a victim may have the awareness that an emotion should be present, but does not experience the emotion.

2 Tentative movement toward awareness of emotion. At this level, a victim's behaviors may be driven by emotions which are not verbally expressed. For example, a person might avoid reminders of the traumatic event, such as television programs focusing on similar subject matter, or individuals resembling those involved with the event.

3. Awareness of emotion not directly associated with the trauma. For example, a victim of abduction might acknowledge fear of being alone, but not connect it to the abduction.

4. Awareness of emotion directly associated with the trauma. At this level, a victim might admit that he/she had feelings about the traumatic incident.

5. Attempt to deal with negative feelings. For example, a victim might decide to talk to a family member or counselor in order to deal with feelings about the incident.

6. Resolution. At this level, a rape victim might realize the rapist no longer has power over her or that her new knowledge of self-defense methods make her less helpless.

Other studies investigating both short and long term effects of child sexual abuse report a rather large number of psychological reactions that generally fall into two broad victim response categories: 1) inward directed, self-blaming, avoidant, and 2) outward directed, aggressive, attacking response. While many children show a mixture of both types of responses, and one child can shift in his/her typical response pattern over time, it is still useful to examine these categories in more detail.

The first category is: Type I (Inward directed, self-blaming, avoidant responses). Guilt and shame are commonly reported problems in sexually abused

children (DeFrancis, 1970; Herman, 1982; Tsai & Wagner, 1978). Clinical reports frequently include evidence of child victims blaming themselves for the abuse (Summit & Kryso, 1978), and in situations of intrafamilial abuse, that they caused the dissolution of their family (Lusk & Waterman, 1986). In describing the rape trauma syndrome, Burgess and Holmsetrom (1975) include expressions of guilt and shame as commonly reported. Reporting on adolescent victims of sexual assault, Ageton (1983) describes these same problems present in a significant portion of her victim sample not only initially but also in a 3 year follow-up. Rosenfeld (1979) remarks that guilt feelings often intensify over time for the victim, particularly if the abuse is on-going. He states that whereas young children are not typically aware of the social taboo against such behavior, older children generally are, and it is these children who tend to experience a significant amount of guilt and shame over their involvement.

Anxiety and fear are also characteristic of this response type. Adams-Tucker (1981), who reported on a clinic sample of 28 sexually abused children, found that anxiety was the third most commonly presenting complaint. This anxiety can reach fairly severe and extreme levels. In the Tufts University study (1984), 13% of the sexually abused 4-6 year old children and 45% of the 7-13 year olds were found to have substantial fears. Several studies have also reported that victims stay inside and refuse to leave home (Burgess & Holmstrom, 1975). Psychophysiological symptoms typically associated with extreme anxiety and fear are also reported, including changes in appetite, sleep disturbance, recurring dreams and nightmares, stomachaches and headaches (Burgess & Holmstrom, 1975; Adams-Tucker, 1981, 1982).

Depression and suicidal behavior are two other specific symptoms associated with this response type. Adams-Tucker (1981) found that 21% of her clinic sample of sexually abused children listed suicide attempt as a presenting complaint on initial evaluation, and 15% were depressed. In reviewing the cases of 10 adolescent females ranging in age from 14 to 17 who were all victims of father-daughter incest, Molnar and Cameron (1975) reported a common clinical picture of an acute depression and suicidal thoughts. Summit (1983) found that sexually abused children tend to develop a "helpless victim" mentality that affects their ability to respond in other situations.

The second category is: Type II (Outward directed, aggressive, attacking response). Anger and hostility have been frequently reported symptoms of sexually abused children. The Tufts University study (1984) reported that almost half of the 7-13 year old group demonstrated increased hostility. Hostility and outward directed anger were less for the 4-6 year olds and adolescent groups, but still higher than normal scores for those age groups.

Physical Abuse, Sexual Abuse, and Neglect. Written in 1962, C. Henry Kempe's description of the battered child stimulated new concern about child abuse and the implications for professionals (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). As a pediatrician Kempe saw the injuries incurred by children first hand.

Child maltreatment is currently the leading cause of injury and death for preschool children, and for those children who survive, a serious form of trauma and stress. Although legal definitions of child abuse vary across jurisdictions, "it is generally agreed that abuse implies an act of commission, in contrast to neglect, which signifies an act of omission" (Wallick, 1990). Emotional abuse is also generally considered to be reportable (Wallick, 1990).

In her summarization of the impact of abuse on children between the ages of one to five, Wallick (1990) contends that abused and neglected children are at risk for emotional disturbance. In his extensive work with abused children, Green (1982) noted that these children frequently developed "paralysis of ego functioning and acute anxiety states." They anticipate that rejection and violence are part of normal relationships.

Child Trauma and Developmental Theory

Most of the work on child responses to trauma have been examinations of children following specific events. Terr's work with the kidnapped children of Chowchilla is one of the best examples of this type of study. Terr used the psychodynamic framework as a context for her observation of children. Her work is one of the few which has a theoretical perspective.

Child Trauma in the Context of Development. Mowbray's (1988) overview of reports about children who experience violence stands out as one of the few considerations of child trauma in the context of child development. She points out that reactions to trauma vary with age due to cognitive development, moral development, and accompanying defense mechanisms. She also contends that developmental differences are likely to be what distinguishes the post-trauma experiences of children from adults.

Mowbray has observed that a child's cognitive development will determine how traumas are perceived. Very young children view the world from an egocentric perspective. In the early stage of development, they are not able to empathize with others and attribute events to their own actions. For example, they may feel they did something to cause a flood or an accident. Children also understand death differently depending upon their age. For very young children, the sadness and anxiety of death is associated more with separation because, for

example, children between the ages of three and five do not understand that death is permanent.

Mowbray indicates that children of different ages then predominantly make use of certain defense mechanisms. Young children may cry, tremble, and express their feelings openly while older children tend more frequently to defend against anxiety using introjection, identification, denial, repression, projection, displacement, and fixation. Adolescents additionally use intellectualization. Mowbray's formulation does not provide specific age ranges for the use of these defense mechanisms.

Pooling the limited number of observations related to the reactions of children following traumatic experiences, Mowbray summarized the reactions of preschool, school aged, and adolescents children, finding that:

1. Preschool children were more apt to fear elements related to the traumatic experience and these fears were frequently generalized to other situations.

2. Somatic problems, restitutive play, regression, and separation anxiety were more common in preschool and school aged children, as compared to adolescents.

3. Nightmares were experienced by children across age groups. The nightmares of older children contained more distortions and disguise than those of younger children which contained more uncamouflaged death scenes.

4. The development of fantasies, anger, interpersonal problems, problems with school, guilt, depression, and self-deprecation were more prevalent in school age children than adolescents.

Mowbray suggested that guilt may be more significant in older children due to the development of conscience. Fantasy may act as a substitute to the healing play of younger children. Older children may more frequently display apathy, personality change, intellectualization, anxiety, and acting out behavior. Due to disagreement about the existence of regression and denial, these were not included in Mowbray's analysis. Terr (1979, 1981, 1983) has reported that these defenses of regression and denial were not present in the children she studied. Alternatively, Pruett (1977) indicated that children can engage in a form of denial, specifically, "when there is significant object loss, the object's internalization may be repressed into "non-existence".

Mowbray concluded that childhood reactions to trauma were largely distinct from the responses of adults. The development of treatment for children has also taken a path which is different from that of treatment for adult victims of trauma. The early descriptive information about child trauma has not led to the development of treatment for children, as it has for adults. In order to better understand this disparity, the treatment methods for adults and children will be reviewed.

Treatment of Childhood Trauma

Although models of treatment for adult trauma victims have been considered not applicable to children (Mowbray, 1988), they have provided a context which has been used in initial approaches with children. Ochberg's (1988) post-traumatic stress therapy (PTST) is representative of general approached used with adults.

Conclusions From Adult Trauma Treatment

Ochberg (1988) introduced a post-traumatic stress therapy which calls for the therapist to "respect the dignity and potential strength of the client" and omits any focus on prior weakness or failure in coping. The treatment consists of five "paradigms" or functions which reflect a victim's distress and suggest a path towards health. The five paradigms are: bereavement, victimization, autonomic arousal, death imagery, and negative intimacy.

Bereavement. Bereavement, of course, involves mourning the loss of a loved one and frequently, as Ochberg points out, mourning the loss of a part of oneself, hopes for the future, and a sense of stability. While bereavement over loss is a normal process, it may be complicated by previous losses. The process of grieving is assisted by the expression of emotion, understanding the significance or meaning of the loss, clarifying any mixed feelings which existed in the relationship, and ultimately the ability to trust and attach to significant others.

Victimization. Ochberg explains that while bereavement involves sadness, victimization involves feeling humiliated, invaded, like a loser, and put down in terms of the dominance hierarchy. He believes that we have few words to explain this sensation and that it is useful to help the victimized individual to understand how this state differs from bereavement.

Autonomic Arousal. Autonomic arousal as a physiological response to danger which has been described by Seyle (1976) as part of the general adaptation syndrome. This response is often experienced as fear or anxiety and may become generalized to other situations. Ochberg points out that physiological reaction is a

logical part of traumatic experience and that is beneficial for victims to understand this.

Death Imagery. As explained by Ochberg, death imagery is not only the vision after trauma but the image of one's own mortality. Trauma weakens the defenses which normally protect people from thinking about death. Post-traumatic therapy can assist in fortifying defenses and the ability to avoid uncontrollable fears and memories.

Negative Intimacy. Ochberg uses the term negative intimacy to refer to episodes of rape, kidnap, and assault. These incidents involve personal invasion and are accompanied by feelings of disgust, self-loathing, or loathing of others.

PTST is aimed at helping the trauma victim obtain mastery over events and feelings. While Ochberg does not believe that these paradigms comprise a complete list of problems and treatment dimensions, he does introduce these as critical components in successful treatment.

Ochberg's model is for adult post trauma treatment. It is not clear how it could be adapted for the treatment of children, or if the paradigms he has introduced would be useful in this regard. This is not surprising since there are only a handful of treatment recommendations which have been made for children attempting to cope with trauma, which will now be reviewed.

Child and Family Trauma Treatment

The Treatment of Child Trauma from a Child Centered Perspective. Child centered trauma treatment is referenced in several literature reviews as exemplified by Terr (1989). These reviews provide most useful descriptions of symptomatology and psychodynamics, with play therapy being consistently cited as the primary vehicle to bring out the child's problems, allowing mastery of the trauma through repetition and symbolic reenactment. Mowbray (1988) has referenced six issues to be addressed in long term child centered trauma treatment: 1) helping the child to face the truth of what has happened, 2) dealing with the damaged goods syndrome of poor self-image and avoidance of interpersonal relations, 3) identifying guilt and self-blame, 4) dealing with emotions such as anger, grief, and fear, and how these may be expressed, 5) helping the child identify and access support resources for future trust and protection and 6) for child victims of sexual assault, how to deal with pleasurable feelings they may have experienced, their need to feel clean, or their need to assert power and dominance. Unfortunately, one does not find the degree of specificity of treatment for child trauma that is available for working with other childhood disorders.

Based on her work with the children abducted in Chowchilla, Terr (1979) made several treatment recommendations for children who had experienced such group violence. As described by Manglesdorff (1990), these included:

1. Families should be contacted immediately by mental health workers, prior to knowing the outcome of traumatic events. This should be done in an effort to establish a supportive relationship as early as possible.

2. Mental health evaluations should be conducted immediately upon availability of victims.

3. Ongoing contact with children and parents is recommended. Individual interviews, as opposed to group meetings, allow families to express anxiety and hostility to mental health professionals, as opposed to the media and members of the community.

4. It should be noted that the effects of trauma on children may not be observed by parents for six to twelve months following the trauma.

Recognizing the paucity of information about treatment of children following trauma, Terr (1988) reviewed the most commonly used treatment modalities. While she does not outline a model of treatment, her review presents a range of interventions used with children. She begins by noting that how children experience trauma is effected not only by the mental health treatment they receive but also by the behavior and responses of parents, teachers, and news broadcasters. Each have a critical role in how children experience trauma.

In terms of professional assistance available, Terr listed the traditional modes of group therapy, family therapy, behavior therapy, psychodynamic therapy, play therapy, and pharmacological treatment.

Terr cited Zimmerman's (1983) use of debriefing groups with hostages, following release by terrorists, as an example of the successful use of group psychotherapy. Although groups may be useful for individuals who have experienced the same trauma, an experienced clinician may be needed when there are victims of different ages involved. When using groups with children who have been sexually abused it is important to be mindful that children can inadvertently "catch" anxiety and symptoms from the experiences of others.

Although there is little information on the effectiveness of behavior modification with children, Terr reported that systematic desensitization is often used immediately after a trauma to help children to move through their daily life.

Similarly, there is no systematically reported information on the use of psychodynamic techniques with children. Terr (1985) suggests that children may be helped by expressing thoughts and feelings related to the trauma and subsequent fantasies generated by the experience. She describes that it is important for the therapist to listen openly to the child, and to clarify, and interpret when appropriate. The therapist can additionally teach parents to help children at home to further support the gains established in treatment.

Terr reported that play therapy was useful in helping children work through their feelings related to trauma. She suggested that specific guided forms of play, as well as play with typical toys, was useful. She suggested that, more than the recall of the traumatic event, it was important for children to rediscover the painful emotions, shifts in "life philosophies" and "cognitive distortions" which they can acquire following trauma. Play can be used to recover and alter the course of these perceptions before they become buried and ingrained in a child's personality.

Terr reported no awareness of published studies which addressed the use of tricyclic antidepressants, monoamine oxidase inhibitors, or adrenergic agonist in the treatment of traumatized children, although she did report that antidepressants are being prescribed.

After reviewing the limited information which describes the process and results of these interventions, she made several conclusions. She suggested that family therapy was useful if all members of the family had experienced the same trauma, as is frequently the case with natural disasters. Intra familial sexual abuse was an exception to this general observation. She reported that family treatment was helpful in preventing long term personality change and fears, but least useful in approaching internal trauma related fantasy.

While Terr has summarized the small amount of information which addresses interventions with children following trauma, she has not presented a model or course of treatment. James' (1989) work describes a treatment model for traumatized children which integrates interventions previously used in general child psychotherapy. James maintains that treatment of the victimized child should broadly include:

1. The child's exploration of painful feelings.

2. A treatment sequence which occurs over a period of time which is responsive to the developmental needs of a child.

3. The active participation of caregivers in the child's life.

4. The accessing of information from the child which would not be elicited spontaneously and communicating to the child that these feelings are not shameful and can be dealt with directly.

5. The communication of positive clinical messages to the child which are transferred in a playful manner in order to balance difficult personal and clinical work.

6. Attention to "physical, cognitive, emotional, and spiritual" parts of the child.

7. Uncovering of any secret, dysfunctional, and deviant behavior.

8. Awareness on the part of the therapist that treatment may involve dealing with repulsive and painful situations which may have an impact on the clinician.

James points out that if the traumas of children are not addressed they can lead to a continuation of confused emotions and incorrect information. This may result in the acquisition of incorrect information, a fear of playing, dreaming, and an inner sense of worthlessness. In terms of incorrect information, she gives an example of one young boy who believed that his mother's body was still inside the crushed car in which she had died six months earlier.

James recommends that the treatment of victims of childhood trauma include a thorough assessment, caregiver participation, and an evaluation of, what she refers to as, traumagenic states. She suggests that this child victim assessment include:

1. The child's past and present functioning.

2. The specific traumatic events leading to the child's current condition.

3. The experience and meaning of the event for the child.

4. The child's strengths and areas of difficulty.

5. The resources available to the child.

One aspect of treatment which differs from a more classic model of psychotherapy, is James' approach to the sequence of treatment. She conceptualizes treatment more like that administered by a family physician. This prescribes an on-going relationship between the therapist, family, and child in

which the therapist is available, when needed, as the child passes through different stages of development. She contends that it is unrealistic to believe that remnants of the trauma will not emerge during later stages of development.

The involvement of caregivers is central to James' model and is used to promote the child's self-acceptance. At different points during treatment, the therapist deals openly and directly about the events of the trauma with both the child and the parents. This models mastery of the event. The treatment does make allowances for differences in the amount and ability of caregiver participation. James outlines alternative modes of intervention for minimally, medium, and maximally involved caregivers. For example, maximally involved parents would meet with the therapist bimonthly to discuss the child's progress and make plans for what can be done to help at home. Maximally involved parents would additionally play an active role in the child's treatment, sometimes leading parts of clinical sessions with the assistance of the therapist. Conversely, minimally involved parents might meet with the therapist for an hour a month and participate in approximately ten minutes of each clinical session.

James suggests that treatment should explore the "traumagenic", or "emotional conditions" which have their origins in traumatic experiences. She has expanded upon those suggested by Browne and Finkelhor (1986) related to child sexual abuse. Browne and Finkelhor identified four emotional conditions with accompanying psychological dynamics, impact, and behavioral characteristics. James' traumagenic states include: self-blame, powerlessness, loss and betrayal, fragmentation of bodily experience, stigmatization, eroticization, destructiveness, dissociative/multiple personality disorder, and attachment disorder. She suggests that these along with the child assessment can be used to develop a treatment plan.

Using James' model of treatment, traumagenic states can be explored and altered through specific "techniques and exercises" useful in helping children deal with their thoughts and feelings. Although James lists numerous exercises, three of these are: 1) the basket of feelings, 2) affirmations, and 3) movement and music. The basket of feelings exercise is useful for children with contradictory, or hard to express feelings. In this exercise, a child is given a basket of colored ink pens asked to write down different feelings people have. The exercise is aimed at helping the child understand that it is all right to have conflictual and painful feelings. In the affirmations exercise, children are helped to internalize a positive message about themselves by saying or writing certain phrases, such as, "I am loving and kind", or "I have a rainbow of feelings." During the movement and music exercise, a child can be helped to gain a greater sense of body integrity. The child and the therapist can engage in different types of movement to the pace of a range of music including environmental sounds, new age, or Sesame Street.

Movements may include pretending to ski, explore underwater, act like a snowflake, etc.

Although James' model is not based on a specific psychological orientation or theoretical position, it stands out as coherent treatment plan containing creative and useful intervention techniques. It was formulated for the treatment of general trauma in children and could have applications with the subcategory of sexually abused children.

As opposed to focusing on a complete model of treatment, Pynoos and Eth (1986) developed an interview technique aimed at engaging a child in treatment and working through critical features of the traumatic event. This is based on interviews of over 200 children who witnessed traumatic, violent events, such as the homicide of a parent. The interview was designed for children between the ages of 3 and 16 years of age and begins by letting or assisting the child to play or fantasize. This helps the clinician to understand the defenses utilized by the child during the trauma. In the second phase of the interview, the interviewer follows the child's leads and focuses on the actual traumatic incident. This portion of the interview is used to allow the child to vividly relive the event and release emotions related to the experience. The details of the violence and traumatic event are discussed and, according to the authors, it is frequently useful to ask the child when the worst moment for him/her occurred. At this phase, it is useful to talk with children about their inner plans of action, or what they wanted to do, their desire to retaliate, and their fears of counter-retaliation. During the closing phase of the interview, the clinician works with the child to summarize what was discussed, the clinician shares expectable traumatic reactions with the child, and the child's courage in facing the trauma is acknowledged. Upon termination, the clinician always gives the child a professional card to let him/her know how the clinician can be contacted. In cases where further treatment is necessary, this procedure has appeared beneficial in facilitating treatment.

Expanding upon the interview technique introduced by Pynoos and Eth (1986), Pynoos and Nader, (1985) developed treatment for child victims of community violence. Based on their observations of children exposed to community violence, the authors described the following symptomatology in children:

1. Children reliably identify traumatic events.

2. Children do not experience flashbacks, as described by adults, but do re-experience the trauma. Children are most likely to re-experience images or sounds related to violent events. This is most frequent for children who observed people being killed or heard cries for help.

3. Children have traumatic dreams which frequently make it difficult for them to sleep soundly.

4. Children experience a diminished interest in activities and play. They are more apt to be detached, distant from friends, and anxiously attached.

5. Children display an increased startle response, nervousness, and avoid reminders of the trauma.

6. While children grieve following community violence, they may not tell anyone about their grief reactions.

Pynoos and Nader concluded that the severity of symptomatology is related to the extent of exposure to life-threatening events. Their observations regarding how children respond to community trauma have led them to recommend the following interventions:

I. Plan for services immediately after the violent incident.

A. Triage and screen by degree of exposure. Identify the degree of exposure to violence (i.e. proximity, first-hand observation).

B. By other risk factors: Individual response may seem out of proportion to the incident -indicates presence of other factors.

II. Provide on-site psychological first aid.

A. Liaison with leaders in the community and be prepared to deal with hesitation, lack of knowledge, politics, and trauma-related anxieties.

B. Find a location on or near the site of the incident. Churches and schools provide better sites than do mental health centers due to those sites providing fewer psychological barriers.

C. Whether or not the violence has occurred on a school campus, the school setting can be an ideal place for screening, classroom consultation and individual treatment. Major points to consider include:

1. Restore the school community by encouraging group sharing of experiences; maintain normal school functions.

2. Provide specific help to individuals and groups. Administrators should meet with mental health professionals to review what happened, reactions, future actions.

3. Students should be provided access to the counseling and nursing offices. These visits will provide temporary relief and serve as the foundation for more thorough work. After the first week the classroom is ideal for group consultation. The classroom is the best place to address children's fears of recurrence and related cognitive distortions and help children develop coping skills.

4. Teachers need to be provided psychological support. Children often take cues from their teachers and will be especially aware of their teachers' reactions after a violent incident. Teachers will be especially helpful in screening and referring students who need help. They must be informed of common child reactions to violence. Typically, teachers most often notice unexpected aggressive behavior, but withdrawn and inhibited behavior also may result. They also must be encouraged to allow students to express their feelings and concerns.

5. School support staff need to work closely together to ensure that children and their parents receive help if they need it.

   a. The school nurse plays an important role because children often report somatic complaints after a traumatic event. Additional nursing services may be necessary as referrals to the nursing office can be expected to increase.

   b. The mental health staff may be seeing a large number of traumatized children in a short period of time. They should maintain a list of individuals referred to them, their symptoms, and risk factors. The staff should also assist other school personnel in expressing their feelings and reactions to the traumatic event and its aftermath.

III. Parents and families should be allowed to express their concerns and to learn about common post-traumatic reactions. Initial meetings might be school-wide; subsequent meetings are probably more helpful if organized by grade, classroom, or degree of exposure to the traumatic event. Parents should be encouraged to allow their children to verbalize their concerns and feelings

and to understand their children's responses to the trauma. Regressive behavior, for example, should be tolerated for a limited time rather than punished. Some parents will need individual consultation.

IV. Provide age-appropriate psychological first aid for children. Design treatment for four major symptom groupings:

A. Post-traumatic stress disorder. Treatment goals include addressing fears of recurrence, normalizing the recovery process, helping the child understand his reactions, and restoring a sense of security.

B. Grief. Treatment goals include dealing specifically and concretely with issues related to death and loss, providing a supportive environment for the grieving process.

C. Worry about another. Treatment goals include legitimizing the child's concern, weaning them from any continued worry.

D. Exacerbation or renewal of symptoms related to previous life experiences.

The intervention model for children exposed to community violence proposed by Pynoos and Nader, is one of the few models that presents an integrated strategy for child, family, school, and community members. Additional treatment models which include family members will be reviewed.

The Treatment of Child and Family Trauma from a Family Perspective

The literature on programs for the treatment of child and family trauma from a family perspective is even more severely limited than literature on child centered trauma treatment. Our examination will focus upon three programs: 1) The Family Bereavement Project (Kelmer and Koocher, 1988), 2) The Family Trauma Treatment Program (Figley, 1989), and 3) The Rape Trauma Treatment Program (Erickson, 1989).

Family Bereavement Project. One example of a treatment program for child and family trauma from a family perspective is the Family Bereavement Project under the direction of Kemler and Koocher (1988), developed with funding support by the National Institute of Mental Health. This program was developed to assist families in which a child has died. The goal of this program is to reduce the long term adverse emotional impact of this child loss by enhancing communication and mutual support among family members, thereby minimizing interpersonal isolation and emotional discomfort among surviving family members. The program

addresses 11 topic areas: 1) normal grieving, 2) anger and guilt, 3) children's ways of grieving, 4) children's questions about death, 5) children's fears about death, 6) helping children to cope with grief, 7) coping with grief as a married couple, 8) communicating, 9) length of grief over loss, 10) re-involvement, and 11) need to seek professional help.

In the first topic, normal grieving, the therapist with the program indicates to the family that they have suffered a very significant loss. Grief is seen as a normal process of recovery from that loss and that each person should have the right to his or her own way of dealing with painful events. This may include sadness, unspecified anger, specific anger at the child who has died, physical illness, self-doubt, increased temperamental sensitivity, or an almost real perception that the dead child is still alive. Reassurance is offered that these reactions are a normal part of the grieving process and will not go on indefinitely.

In the second topic, anger and guilt, the therapist indicates to the family that these can be intense and often disturbing feelings. The anger may be directed toward individuals who are felt to have had an instrumental role in the child's death, toward the child for having died and left the family, unspecified anger at the world, or anger directed at individuals not involved in the child's death. Family members are encouraged to vent their anger either through talking or physical exercise. Cognitive processes of survivor guilt, as well as second guessing actions which might have prevented the child's death are also reviewed.

In the third topic, children's ways of grieving, the therapist indicates that sibling grief following the death of a brother or a sister may be less overtly visible than the grief of adults, even though the experienced feelings are quite similar. As they have difficulty managing such strong feelings, their tolerance for long periods of sadness is limited, therefore they use play and other activities as an emotional diversion. This may lead to a bereaved sibling moving from an overt expression of grief to a play activity in a relatively short period of time. Fearful, demanding, or angry misbehavior may be present more than overt expressions of sadness. The child's grief is stated to be intense and to reoccur intermittently over a substantial period of time.

In the fourth topic, children's questions, the therapist supports answering the siblings questions about death in a simple and clear fashion.

In the fifth topic, children's fears, the therapist indicates that children of different ages view death in different ways and that it is not until age six or seven that most children understand that death is a permanent state. The family is cautioned that many children have concerns that an angry or jealous thought about the deceased child may have in some way been responsible for the death.

In the sixth topic, helping children to cope with grief, the therapist indicates that parents may find it difficult to cope with their own emotional distress and still be available to attend to the emotional distress of the surviving siblings. Parents are encouraged to let children know that they will still be there to provide care and that it is helpful to minimize family routine and rule changes.

In the seventh topic, coping with grief as a couple, the therapist again indicates that individuals cope with loss in their own way but focuses upon couple issues.

In the eighth topic, communicating, the therapist recognizes that bereaved family members may isolate themselves and withdraw not only from their own families but also from people in general. Increased availability and support for reestablishing communication is reinforced.

In the ninth topic, length of grief over loss, the therapist indicates that grief continues in a cyclical fashion over a prolonged period of time with holidays, birthdays, and the anniversary date of the child's death being especially difficult. Family members are reminded that such reactions may be unanticipated and intense, but are relatively short-lived.

In the tenth topic, re-involvement, the therapist supports the family members to become reinvolved in outside relationships and activities. Family members are advised that the loss of the child for some individuals contributes to a broader or deeper understanding of the way in which they live their life.

In the eleventh topic, need to seek professional help, the therapist lists the following signs (if frequent and persistent) as indicators for seeking professional help: a) staying withdrawn from family and friends, b) patterns of aggressive behavior, c) persistent anxiety, especially when separating from parents and surviving children, d) persistent blame or guilt, e) wanting to die, f) accident proneness, g) acting as if nothing happened or being happier than normal, h) unusual or poor performance at school/work, i) physical complaints, and j) extended use of prescription or non-prescription drugs, and alcohol.

The program has a manual for therapists that provides guideline and content sections for each of the three sessions. In Session One, the guideline section reviews the grief process, identifies the program as being limited to three sessions and labels the therapist's role as a facilitator of communication. The first session begins with the telling of the story of the child's death, providing each member of the family with the opportunity to express their reactions and feelings and to hear each person's perspective. The therapist is provided with a list of specific questions

to provide structure and prompt the family to deal with the death and funeral in some detail. As children are involved in each session, the meeting room contains a variety of play materials which provide younger children with an alternative means of communicating their feelings. If the family finds difficulty in communicating, the therapist is encouraged to recognize this openly and inquire about the family's typical style of interaction. The issue of blame and the search for someone to blame, the potential consequences of holding on to the blame, and increased protection of surviving children is to be openly addressed. The last part of this session involves working with the parents separately to address parent-child and marital partner issues. The content section for Session One operationalizes the above material with specific suggested statements or reactions.

In Session Two, the parents are met with alone to determine whether the recommendations of Session One were followed and were helpful or not. The entire family is then met with. The focus is upon two major components: a) remembering the deceased child, and b) writing a letter to the deceased child. Meaningful pictures or belongings of the deceased child are utilized as a way to encourage this content, with the letter assisting an understanding the finality of the death. A decompression period is encouraged before terminating the session as the writing of the letters may produce intense reactions. The content section for Session Two operationalizes the above material with specific suggested statements or reactions.

In Session Three, the family is moved toward anticipating the future, by considering what days or family occasions might remind them of the deceased child. In this session, a shift is made from recognizing the normality of grief reactions and parents are provided a list of the previously referenced specific warning signs that may warrant further professional evaluation and therapy. Reintegration of the family into the community is explored by determining what disruptions have taken place with outside activities, and then supporting family members in the renewal of those activities. Finally, the family is encouraged to communicate some of their thoughts with regard to their hopes for the future. The content section for Session Three operationalizes the above material with specific suggested statements or reactions.

Traumatized Family Treatment Program. Charles Figley, a recognized leader in trauma research and treatment, has recently consolidated his experience in working with traumatized families into a treatment program. Figley's approach begins with the specification of characteristics of families who respond functionally or dysfunctionally in response to trauma. It then proceeds to examine a series of treatment pre-conditions, followed by a five phase treatment program.

McCubbin and Figley (1983a) and Figley (1983) cite eleven characteristics that assist in differentiating families who cope well with stress from those who do not: a) clear acceptance of the stressor, b) family centered focus of the problem, c) solution oriented problem solving, d) high tolerance, e) clear and direct expressions of commitment and affections, f) open and effective communication utilization, g) high family cohesion, h) flexible family roles, i) efficient resource utilization, j) absence of violence, and k) infrequency of substance use.

Clear acceptance of the stressor indicates that, although the traumatic event may be temporarily overwhelming, the functional family is able to accept that the event has occurred and are able to begin to mobilize resources. Family centered focus of problem refers to a family's recognition that trauma to a single family member is, in fact, a problem for the entire family system. Solution oriented problem solving is demonstrated by functional families in moving beyond recognition of the trauma to implementing action oriented solutions. High tolerance is especially important, as a individual family member's eccentric behaviors may become more pronounced during post trauma adjustment. Clear and direct expressions of commitment and affection verbally reassures family members that the family intends to survive the trauma. Open and effective communication utilization refers to the family which has a reduced number of taboo or nondiscussable topics. High family cohesion reassures family members through frequent daily contact that the family will survive the trauma. Flexible family roles provides useful adaptation, as the trauma may require individual family members to assume new roles. Efficient resource utilization refers to a family's willingness to seek out interpersonal and material resources from extended family and friends. Absence of violence means that effective sanctions are in place in the family that exclude violence as an acceptable way to vent frustration. Infrequency of substance abuse indicates that the family does not employ alcohol, prescribed drugs, or illegal drugs as an acceptable response to trauma or extreme stress.

Figley's program screens families to see if they are considered candidates for treatment with the following questions: a) What set of circumstances brought this family to treatment? b) How committed are they as a family? c) Is psychological or systemic trauma a critical issue in this family? d) How much are family members suffering? e) Can some method of family relations skills training be developed?

In examining the above questions, Figley offers the following desired responses. The circumstances that have brought this family to treatment should include a partial awareness that their current difficulties are linked to the traumatic event. The family needs to be committed to treatment as a family, rather that just being committed to assist a overtly dysfunctional family member. In looking at psychological or systemic trauma, evidence must be available that at least one

traumatic event has been experienced directly by one family member, and indirectly by at least one other family member. As families differ in their definitions of suffering, each family needs to clarify what constitutes tolerable and intolerable suffering within their system. Finally, almost all of the family members need to indicate some willingness to try family relations skills training. If several family members are strongly opposed to family therapy, the potential for program success is highly limited.

The Figley treatment program has five phases: (1) building commitment to therapeutic objectives, (2) framing the problem, (3) reframing the problem, (4) developing a healing history, and (5) closure and preparedness.

In Phase One, building commitment to therapeutic objectives, the program emphasizes working with the therapist to agree upon common objectives for the treatment process. Post- traumatic symptoms are addressed directly, as significant information is provided about normality of such symptoms for almost everyone who is placed under severe stress. The therapist conveys the message that families can successfully master the challenges posed by traumatic events.

In Phase Two, framing the problem, the family members "tell their story" in the most complete and unedited way possible, especially the items in the family that are in need of change. The therapist consciously shifts the family's attention away from blaming any individual member of the family, thereby framing the problem as requiring the family to respond as a unit.

In Phase Three, reframing the problem, traumatic symptoms are interpreted as opportunities for change or new understanding. Family members are encouraged to attend to even the smallest positive signs within their post trauma adjustment struggle. This is intended to focus energy upon working primarily with the positive elements of the family situation, as contrasted with dwelling upon the frequency and severity of trauma symptoms.

In Phase Four, developing a healing theory, the therapist and the family members construct a coping pattern for the family based upon positive behaviors demonstrated during the first three phases. This provides a more overt and formal family coping system which becomes known by all family members.

In Phase Five, closure and preparedness, the goal is to have the family recognize that successful mobilization has occurred in the face of severe stress, that the family is responsible for this successful mobilization, and that the family is significantly better prepared to cope with any new stress episode.

Figley's traumatized family treatment program offers significantly more examples that show the therapist how his phases are implemented, illustrating the depth of his clinical experience with traumatized families. However, as is the case with other post trauma family oriented treatment programs, quantitative assessment of positive or negative effects upon families is not yet available.

Rape Trauma Treatment Program. The Rape Trauma Treatment Program as described by Erickson (1989) deals with intervention for both adult female rape victims and their families. Although the Rape Trauma Treatment Program begins with a designated adult female victim and is therefore not wholly applicable to child victims, the Program does incorporate a subsequent assessment and treatment process for the family. For this reason, it is worthy of description.

Erickson's assessment of the adult female rape victim's experience is stage based which is consistent with assessment approaches for other types of victimization. Three phases are described: 1) initial reactions, 2) subsequent reactions, 3) long term reactions. The initial reaction occurs immediately following the rape. It is often a period of shock and disbelief with substantial use of denial. Alternatively, other victims will express the opposite of this behavior, becoming agitated and highly emotionally reactive. Subsequent reactions occur during the first few days to several weeks following the rape trauma, as victims begin to feel the physical effects of the assault, as well as physical symptoms such as headaches and gastrointestinal disturbances. These behaviors are frequently accompanied by fatigue and startle reactions. Long term reactions include recurring waking images, nightmares, mood swings, and the development of increased fears. Cognitively, victims may search for a reason or explanation for the crime repeatedly reviewing the event as a means of attempting to gain some sense of control over a functionally uncontrollable situation. The Erickson Treatment Program is cited as being especially useful for victims who, at this stage, remain withdrawn and interpersonally isolated.

The program references family adjustment by discussing differential recovery process and the nature of family member reactions. With regard to differential recovery process, family members may attach emotional significance to different aspects of the rape and may find themselves at different stages in the recovery process at any given point in time. With regard to the nature of family member reactions, devaluation, frustration, helplessness, anger, blame, and over protectiveness are commonly noted. It can be easily seen that family member reactions may in some ways parallel the reactions of the rape victim, producing frequent competition for the limited post-trauma nurturance and social support available in the family.

Family coping with trauma is divided into three topics: 1) factors influencing family coping, 2) functional family coping, 3) transitional family coping, and 4) dysfunctional family coping.

Factors influencing family coping include: a) prevailing cultural views, b) nature of the crisis, and c) prior functioning. Prevailing cultural views may influence the way in which the family perceives the rape event, e.g. whether the female victims behavior contributed to the crime or whether the crime is viewed as a violent act or as a sexual act. The nature of the crisis precipitated by the rape event is generally sudden and unpredictable, placing an additional burden upon families with a limited record of success in coping with sudden crisis. This is closely related to the factor of prior functioning. Organization and flexibility in sex role attitudes, sexual relations, and beliefs about sexual access are cited as items of prior family functioning which would assist in a generally positive family adaptation response.

Functional family coping in the Program includes a) role flexibility, b) externalized blaming, c) mobilizing resources, d) open communication, e) appropriate social supportiveness. Reaction to the rape trauma may require role shifts within the family, as different family members may require attention or support at different times. The ability of family members to accommodate to such attention demands significantly enhances family coping. External blaming allows the family to focus upon the rapist behavior rather than a critical assessment of the female victim's behavior during the rape. Mobilizing resources in an action oriented response assists in providing a sense of well being and control, even though the action behaviors are taking place after the event. A family ethic of open communication reduces the potential for individual isolation and anxiety about thoughts or emotions associated with the rape. Appropriate social supportiveness refers to a family system which is able to assess the post-trauma needs of the victim and provide support that meets those needs, rather than just the support that is easiest for family members to provide.

Transitional family coping means that not all coping responses are clearly functional or dysfunctional, but they may need to be differentially employed during the post-trauma adjustment period. Responses of this nature include: a) denial, b) withdrawal, c) behavioral self-blame. Denial may well be useful initially as it allows family members to perform routine tasks, thereby restoring the prior day to day sense of family structure. However, denial exercised at times of public performance demand quickly becomes identified and labeled as pathological. Withdrawal may provide family members with the opportunity to individually review their thoughts and feelings, as such a complete lack of boundaries in a family system may well contribute to additional anxiety and fear. Withdrawal over a significant period of time produces isolation and slows the healing process. In

behavioral self-blame, family members review the traumatic event, attempting to locate behaviors which would have changed the outcome. Initially, this process provides an action oriented defense. However, characteristic self-blame shifts from "I did a stupid thing" to "I did a stupid thing because I am a stupid person."

Dysfunctional family coping in the program includes: a) misguided attitudes, b) internalized blame, c) guilt, d) anger, e) revenge, f) helplessness, g) distraction/avoidance, h) patronizing/overprotecting, and i) inappropriate social supportiveness. These topic headings largely reflect the opposite of topic headings listed under function family coping in the program.

The actual treatment program is labeled as a Three-Day Consultation in which the emphasis is on integrating the rape experience into the family system (Figley, 1986). The first interview is to contain both a clinical assessment, as well as, quantitative assessment. Six quantitative assessment measures are listed: a) the Impact of Events Scale (IES), b) DSM-III-R Post Traumatic Stress Disorder (PTSD) diagnostic criteria, c) Rape Attitude Scale (RAS), d) Rape Myth Acceptance Scale (RMA), e) Family Adaptability and Cohesion Evaluation Scales (FACES III), and f) Purdue Social Support Scale (PSSS). However, the program presents no information with regard to how family member's scores on these assessment instruments would differentially effect treatment, nor does it present a procedure for differentially utilizing the profile of assessment scores of a given family member. In the absence of such documentation, it must be assumed that Program therapists are, in fact, relying upon clinical interview data for assessment and diagnosis.

A period of parallel treatment for the adult female rape victim and for the family proceeds the Three-Day Consultation. In this parallel treatment, the adult female survivor and family members are separately provided with the opportunity to a) informally relate the story of the rape and its aftermath, b) participate in small support groups, c) write an autobiography and d) discuss contemporary patterns of interaction in the family. The adult female victim then composes, with the assistance of the therapist, a letter or speech inviting the family to participate in the Three-Day Consultation. If the therapist determines that the family is ready for this consultation process a meeting is scheduled with the adult female victim and her family to prepare an agenda of items to be reviewed. These items are then divided into three categories a) issues related to the adult female victim, b) issues related only to other family members, and c) issues related to the family as a whole. The structure of the Three-Day Consultation consists of two two-hour therapy sessions followed by one three-hour session, occurring within a maximum five-day period with at least one night between each session. The first day is focused upon the adult female victim discussing with the family her cognitive and emotional experience of the rape and its aftermath. The second day clarifies the victims

experience and attends to the family members cognitive and emotional experiences. Third day focuses on the effects of the rape trauma on the family system and upon coping mechanisms. A brief follow-up interview by phone or in person is suggested at approximately six months after the conclusion of the program.

The Rape Trauma Program has value in its effort to place value upon pre-treatment assessment, and to specify in detail the clinical interactions occurring throughout the treatment process. Significant caution must be exercised, however, in the implementation or generalization of this Program as pre-treatment assessment is not quantified, and there is no data on the Program's effectiveness.

It is noted, however, that above described family trauma treatment programs do share nine common features: (1) emphasis upon the unique experiences of the victim, (2) emphasis upon understanding the family nature of any trauma directed toward an individual family member, (3) emphasis upon, and tolerance for, individual differences of coping, (4) reduction of blame for victim behavior, (5) increased communication of thoughts and feelings among family members, (6) restoration of day to day family structure, (7) seeking family commitment to identify resources and mobilize those resources for change, (8) development of a sense of achievement for surviving the trauma, and (9) identifying the family coping skills that can work in the future.

Treatment of Child Sexual Abuse. Of all types of child trauma, sexual abuse has received the greatest amount of attention to date. As a result of the Kinsey report, conducted in the early 1950s, people learned that female children were frequently confronted by sexual approaches by adult males. Based on a survey, which included 4000 women, 25% reported a sexual encounter with an adult male prior to the age of 12. A 1984 survey by Russell indicated that of women who reported a history of sexual abuse by a family member, only 2% of those cases were reported to the police. Reports also indicate the majority (94%) of intrafamilial sexual abuse occurs between fathers and daughters (Justice & Justice, 1979; Lukanowicz, 1972; Maisch, 1972; and Weinberg, 1955).

There are currently laws and guidelines aimed at preventing sexual abuse which are utilized by the public, law enforcement, legal, and social service providers. Clinicians are becoming increasingly aware that the treatment of sexual abuse requires cooperation between therapists and state agencies (Summit, 1981).

Herman (1988) has reviewed treatment strategies for victims of father-daughter sexual abuse. She has reported that treatment of perpetrators is not successful unless it is required by law. In general, most therapists agree that the initial focus of treatment for a family in which sexual abuse occurred, should be on

stopping the abuse. Removing the father from the home prevents the child from being displaced and feeling punished. During the initial crisis period, the child should be reassured that there are adults outside of her home who believe her story and will not allow her to be further abused.

Once sexual abuse within a family has been disclosed, the emotional intensity contra-indicates family therapy as a treatment of choice, although it can be used in later stages of therapy (Giarretto, et al., 1978). At the initial point of crisis, group therapy for individual family members has been useful. Herman reports that one of the critical features which prevents further abuse and promotes recovery in the child occurs when the mother in the family is able to protect her children.

Summary

Although the prevalence of childhood trauma has been increasingly recognized as a serious problem, there are currently only a small number of treatment models, and these have not been founded in theory. The works of Terr (1985, 1987, 1989), Friedrich (1990), James (1989), Pynoos and Eth (1986), Pynoos and Nader (1985), and those by Herman (1988) are among the few intervention strategies which have focused on the post traumatic reactions of children. While Terr's work has largely been based on the psychodynamic perspective, she has not offered a complete model of treatment. While definitely useful, the strategies introduced by James, and Pynoos and Eth, and Pynoos and Nader are without a conceptual structure, making them difficult to interpret and replicate. The preventive strategies proposed by the Federal Emergency Management Agency (FEMA) and the American Psychological Association (APA) are part of a growing recognition about the serious and lasting effects trauma can have on children, and also point to the role of the community at large.

Protective Factors for Children

A Partial Shield from Trauma Effects. Kimchi and Schaffner (1990) have said that "what is a stressor for one person is an episode of zestful living for another" and that this can also be true for children. The recognition that not all children react the same way to trauma or psychological stress led to a great interest in the study of invulnerability, resilience, and protective factors in children. As part of their review of protective factors, Kimchi and Schaffner (1990) differentiated the various features which contribute to a child's health in the face of adversity.

Kimchi and Schaffner define protective factors as "persons, environments, situations, and events that appear to temper predictions of psychopathology based upon an individual's at-risk status." This is contrasted with resilience, which

specifically includes an individual's characteristics or attributes. The possession of resilience indicates that an individual is consistent in successfully adapting to biological and psychological risk factors and stressful events due to his/her innate qualities. Invulnerability is conceptualized as competence displayed in difficult circumstances.

Garmezy, Masten and Tellegen (1984) described three models of the functioning of protective factors. In the compensatory model, "stress factors and individual attributes are seen as combining additively in the prediction of outcome." Within this model personal attributes of resilience can counter balance the impact of stress. In the challenge model, moderate stress may enhance coping abilities in a preventative fashion. In the immunity-versus-vulnerability model, protective factors act to modulate or dampen the impact of stress, thereby functioning as a type of limited immunity against stress. At this date, none of these models of protective factors against trauma effects has been accepted more that the other.

Garmezy (1985) asserted that protective factors fall into three general categories: (a) positive personality of the child, (b) supportiveness of family, and (c) an external support system which fosters coping strategies.

Kimchi and Schaffner (1990) have summarized the nine primary protective factors as evidenced by the literature:

1. Temperament and constitution: Temperament in infancy appears to be related to resilience. Resilient infants were characterized as easy to deal with by their caregivers and consequently, generally received substantial amounts of affection from caregivers.

2. Genetics: Numerous studies of the etiology of psychopathology have shown that there is hereditary factor involved in the development of many psychological disorders. It appears that heredity, environmental factors, and innate aspects of the individual interact in the development of disorder and stress response. The diathesis stress model has been used to describe the interactive process in which the larger the innate predisposition, the lower the amount of external stress needed in the development of symptoms.

3. Birth order: First-born boys appear to be more resilient than later-born boys. It is believed that having the attention of both parents during the early stages of development augments resilience.

4. Gender: At birth, boys appear to be at greater risk for perinatal stress, congenital defects, and death than girls. While boys reported a greater

number of stressful life events in childhood, girls reported more stress in adolescence. Resilience in girls was fostered by households with an absence of overprotection, emphasis on independence, and consistent support from a primary care giver. Resilient boys, on the other hand, came from families which provided structure, emotional expression, and a positive male role model.

5. Intelligence: Intelligence appears to have a positive impact on stress resistance. Rutter (1979) has reported that academic achievement and social competence are reliable predictors of stress resistance. In a comparative study of 168 middle-class school children, those with high levels of achievement improved under high levels of family stress, while similar levels of stress caused children with less academic success to decompensate.

6. Caretakers and Family: The establishment of a secure attachment to at least one caregiver is a consistent observation in resilient children studied. Good relationships between siblings have also been associated with fewer psychiatric symptoms.

7. Friends: Resilient children establish and maintain friendships over time. Friendships with children from stable homes appear to be particularly useful in helping resilient children gain a deeper understanding of their own family life (Wallerstein & Kelly, 1980).

8. Societal Protective Factors: Factors, such as positive experiences with school, teachers, and religious affiliation have been shown to increase the resilience of children (Rutter, 1979). Exercise has also been shown to assist in the ability to manage stress.

9. Hardiness: Based on existential personality theory, Kobasa, Maddi & Kahn (1982) introduced the concept of hardiness. Hardiness is comprised of commitment and involvement in one's life, the belief that one can control and influence events, and that life will present challenges which will lead to further development. Hardy individuals appear to have less illness than non-hardy individuals when under stress.

APPENDIX D: DATA FORMS

FACT SHEET FOR PARENTS:

FEDERAL DEMONSTRATION PROJECT TITLE: Model Treatment and Services Approaches for Mental Health Professionals Project

PROJECT GOAL: Few issues in recent years have generated as much legislative activity, media activity, and public interest group activity as the problem of missing children. The U.S. Congress and almost every state legislature has passed legislation to increase the responsiveness of law enforcement to child abduction cases. Yet, mental health services to children recovered from abduction and to their families are very limited in many parts of the country. Funded by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice, the "Model Treatment and Services Approaches for Mental Health Professionals Project" is designed to increase the extent and quality of counseling services for children recovered from abduction and their families.

PROJECT OBJECTIVE: To provide technical assistance and guidance through printed training materials and telephone consultation directly to local community therapists and counselors working with children recovered from stranger or non-family abduction and their families.

PROJECT FUNDING: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

PROJECT SITE: National Center for Missing and Exploited Children, 2101 Wilson Blvd. Suite 550, Arlington, VA 22201.

PROJECT STAFF: Dr. Carolyn Murphy is a senior clinical psychologist who provides the training materials and telephone consultation to therapists and counselors. Dr. Carolyn Murphy is supported by Dr. JoAnn Behrman-Lippert of the Western Center for Child Protection in Reno, NV and Dr. Chris Hatcher of the Center for the Study of Trauma, University of California in San Francisco. Dr. Lippert and Dr. Hatcher have worked to develop a therapy program for recovered children and their families over the past ten years.

WHAT WILL THE PROJECT PROVIDE TO THE THERAPIST OR COUNSELOR WORKING WITH YOUR RECOVERED CHILD AND YOUR FAMILY?

The project is based upon a model of understanding and therapy for recovered children and families developed over many years by Dr. JoAnn Lippert and Dr. Chris Hatcher. At each step of your therapy, the project staff will work directly with your therapist, providing printed education materials and telephone consultation.

WILL THE PROJECT PROVIDE THERAPY OR COUNSELING TO MY RECOVERED CHILD AND MY FAMILY OR SUPERVISION TO MY THERAPIST OR COUNSELOR?

No, this is a program of education and consultation only. Your therapist will determine the services to be provided in your individual case, while drawing upon the experience and publications of our project staff who have specialized in assisting recovered children and their families.

WILL THE PROJECT PROVIDE FUNDS FOR THE COST OF THERAPY OR COUNSELING TO MY RECOVERED CHILD AND MY FAMILY?

No, this is a program of education and consulation only. County victim/witness programs in the prosecutor's office in your county may provide you with assistance in determining what state funds are available and how you can apply. Your own health insurance program and/or sliding fee agencies such as community mental health centers and family service agencies may be helpful as well.

IF YOU WISH YOUR RECOVERED CHILD AND THE FAMILY TO BE CONSIDERED FOR PARTICIPATION IN THIS PROGRAM:

1. Your child needs to have been registered with the National Center for Missing and Exploited Children (NCMEC) and to have been assigned a Case Manager at the Center.
2. Your recovered child and your family need to have a therapist or counselor in your local community.
3. If you do not have a therapist or counselor in your local community, you should contact the local psychological association, community mental health agency, family service agency, or the victim/witness program in the prosecutor's office for referrals to state licensed therapists or counselors (This project does not provide referrals to therapists or counselors).
4. Meet with the therapist or counselor at least once. If you wish, you may provide them with the "Fact Sheet for Therapists and Counselors" which explains this project.
5. Your therapist or counselor may wish you to sign a release of information form so that he/she can talk with NCMEC about your possible participation in the project.
6. As soon as your recovered child and/or your family have met at least once with the therapist or counselor, call your NCMEC Case Manager at 703-235-3900. Request that you and your recovered child be considered for participation in the

program and provide the name, address, and phone number of your therapist or counselor.
7. Space for participation in this program is limited. However, every effort will be made to accommodate children and families with therapists/counselors motivated to be involved in this program. Your NCMEC Case Manager will provide notification of acceptance into this project.
8. When notification of acceptance has taken place, you and your therapist will receive an agreement to participate form for your review and approval.

FOR FURTHER INFORMATION, CONTACT YOUR NCEMC CASE MANAGER AT 703-235-3900

FACT SHEET FOR THERAPISTS AND COUNSELORS:

FEDERAL DEMONSTRATION PROJECT TITLE: Model Treatment and Services Approaches for Mental Health Professionals Project

PROJECT GOAL: Few issues in recent years have generated as much legislative activity, media activity, and public interest group activity as the problem of missing children. The U.S. Congress and almost every state legislature has passed legislation to increase the responsiveness of law enforcement to child abduction cases. Yet, mental health services to children recovered from abduction and to their families are very limited in many parts of the country. Funded by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice, the "Model Treatment and Services Approaches for Mental Health Professionals Project" is designed to increase the extent and quality of counseling services for children recovered from abduction and their families.

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WHAT WILL THE PROJECT PROVIDE TO THE THERAPIST OR COUNSELOR WORKING WITH THE RECOVERED CHILD AND THE FAMILY?

The project is based upon a model of understanding and therapy for recovered children and families developed over many years by Dr. JoAnn Lippert and Dr. Chris Hatcher. At each step of therapy, the project staff will work directly with the therapist, providing printed education materials and telephone consultation. The

project begins with a recognition of the education and experience base of the therapist, and actively seeks to build upon that base with specialized knowledge in the assessment and treatment of recovered children and their families in particular.

WILL THE PROJECT PROVIDE THERAPY OR COUNSELING TO A RECOVERED CHILD AND A FAMILY OR PROVIDE CLINICAL SUPERVISION TO A THERAPIST OR COUNSELOR?

No, this is a program of education and consultation only. Each therapist will determine the services to be provided in the individual case, while drawing upon the experience and publications of our project staff who have specialized in assisting recovered children and their families.

WILL THE PROJECT PROVIDE FUNDS FOR THE COST OF THERAPY OR COUNSELING TO A RECOVERED CHILD AND A FAMILY?

No, this is a program of education and consulation only. County victim/witness programs in the prosecutor's office in your county may provide the family with assistance in determining what state funds are available and how the family can apply. The family's health insurance program and/or sliding fee agencies such as community mental health centers and family service agencies may be helpful as well.

WHAT STEPS DO FAMILIES OF RECOVERED CHLDREN NEED TO TAKE TO BE CONSIDERED FOR PARTICIPATION IN THIS PROGRAM:

1. The child needs to have been registered with the National Center for Missing and Exploited Children (NCMEC) and to have been assigned a Case Manager at the Center.
2. The recovered child and the family need to have a therapist or counselor in their local community.
3. Parents of recovered children who do not have a therapist or counselor in the local community are referred to the local psychological association, community mental health agency, family service agency, or the victim/witness program in the prosecutor's office for referrals to state licensed therapists or counselors (This project does not provide referrals to therapists or counselors). This family may have contacted you as a result of referrals from one of these agencies.
4. The parent(s) need to have met with the therapist or counselor at least once. The parent(s) are encouraged to provide the therapist or counselor with this "Fact Sheet for Therapists and Counselors" which explains this project.
5. This project recognizes the importance of patient/client confidentiality. You may wish to have the parent(s) sign a release of information form so that you can talk with NCMEC about the possible participation of family and therapist in the project.
6. As soon as the recovered child and/or the parent(s) have met at least once with the therapist or counselor, the parent(s) will call their NCMEC Case Manager at

703-235-3900. The parent(s) will request that the recovered child and family be considered for participation in the program and provide the name, address, and phone number of the therapist or counselor. The project psychologist will then contact you by telephone to further explain the project and answer any questions.
7. Space for participation in this program is limited. However, every effort will be made to accommodate children and families with therapists/counselors motivated to be involved in this program. The family's NCMEC Case Manager will provide notification of acceptance into this project.
8. When notification of acceptance has taken place, you and the parent(s) will receive an agreement to participate form for your review and approval.

FOR FURTHER INFORMATION, CONTACT PROJECT PSYCHOLOGIST DR. CAROLYN MURPHY AT 703-235-3900.

Missing Children Model Treatment Program
Staff Initial Case Contact Form

(Completed Case Activity Form for each new case contact to be Faxed each week prior to regular scheduled telephone consultation)

Model Program Staff Member Name:_____

Name of Child Recovered:_____

Date of Disappearance:_____

Date and Location of Recovery:_____

Date of Referal to Program:_____

Type of Abduction:_____

Name of Recovering Parents (or family member):_____

Sibling Names, sex, and ages:_____

_____

Address of Recovering Parents:_____

_____

Phone of Recovering Parents:_____

NCMEC Referral Source:_____

Date of Referral:_____

Initial Point of Contact:_____

Date of Initial Contact:_____

Missing Children Model Treatment Program
Staff Initial Case Contact Form

Family Undecided (IF YES)
Staff Consulted:_____

Models Project Staff Consulted:_____

Consensus Follow up Plan:_____

Individual Responsible for Follow up Contact:_____

Date of Follow up Contact:_____

Result of Follow up Contact:_____

Family Willing, Therapist Identified (IF YES)
Therapist Name:_____

Therapist Address:_____

Therapist Phone:_____

Therapist Fax:_____

Date of Initial Contact with Therapist:
Program Explained Orally: (Yes/No)

Therapist Consents to Participate: (Yes/No)

Program Materials #1 Sent (Date and by Fax/Mail):
_____

Therapist Undecided (IF YES)
Staff Consulted:_____

Models Project Staff Consulted:_____

Consensus Follow up Plan:_____

Missing Children Model Treatment Program
Staff Initial Case Contact Form

Individual Responsible for Follow up Contact:_____

Date of Follow up Contact:_____

Result of Follow up Contact:_____

Initial Therapist Assessment/Treatment Plan:

1._____

2._____

3._____

4._____

Initial Models Staff Recommendations/Consultation to Therapist

1._____

2._____

3._____

4._____

Program Materials #2 sent (Date):_____

Program Manual sent (Date): _____

Therapist/Models Program Staff Regular Telephone Consultation Appointment (Interval, Day of Week,Time):

_____

MODEL TREATMENT PROJECT
INSTRUCTIONS FOR THERAPISTS
PROJECT MEASURES

1. General orientation. Every federally funded model project is required to use quantitative measures to document various activities of the project. Appendix A of this memo provides a short description of each measure used and the areas that the measure provides information on. Each measure is a well established psychological instrument Each measure: (1) has been used with a variety of trauma populations and (2) has been employed in other large scale studies of families of missing children. Due to funding limitations, the scope of the measures in this project is limited to recovered child behavior. Other projects have looked comprehensively at the effects of abduction upon adult behavior and sibling behavior in the family.

2. Project measures. The project measures are:

A. Family Information and History Form-This brief measure records basic identifying family information. This measure is completed by the therapist with the assistance of the parent(s). This measure is completed only once, at the beginning of therapy.

B. Abduction Event Form-This measure records basic information about the circumstances of the abduction and the recovery. This measure is completed by the therapist with assistance of the parent(s). This measure is completed only once, at the beginning of therapy.

C. Achenbach Child Behavioral Checklist-This measure records parent opinion about child behavior. This measure is completed by the primary caretaking parent in the family. This measure is completed twice, first at the beginning of therapy and second at the end of therapy or at the end of the project (whichever occurs first).

D. Symptom Checklist (SCL-90)-This measure records parent opinion about their own behavior. This measure is completed by the primary caretaking parent in the family. This measure is completed twice, first at the beginning of therapy and second at the end of therapy or at the end of the project (whichever occurs first).

The primary caretaking parent in the family will usually be the mother. Exceptions to this will be: the father does most of the caretaking for the child in a two-parent family, the father recovered the child from a parental abduction by the mother, neither father nor mother are involved in caretaking for the child. In cases where these exceptions may seem to apply, please consult with project consultants to determine who will be designated as the primary caretaking parent for the purpose of completing this measure.

D. Frederick Trauma Reaction Index Form C (Child)-This measure records parent opinion about selected child trauma symptoms. This measure will be completed by the primary caretaking parent in the family. The primary caretaking parent is defined above. This measure is completed twice, first at the beginning of therapy and second at the end of therapy or at the end of the project (whichever occurs first).

3. Introduction of Project Measures by Therapist to Parent-The following is a suggested introduction of project measures by the therapist to the parent of the child. You may wish to modify this sample introduction to fit our personal style. However, please be sure to cover each of the points in the sample introduction.

"As you remember, you are participating the Model Treatment for Families of Missing Children Project with the National Center for Missing and Exploited Children. Participation in the project involves the completion by a parent of forms covering family history and child abduction/recovery information, as well as a few psychological measures. I have a consent form for you to read and sign. As you read it, you will notice that it is very similar to the consent form that you signed when you first agreed to participate in the project. Please read the form and let me know if you have any questions."

Allow the parent to read the form and sign it, or if the parent has any questions, call project consultant for the answers.

"First, there is a form with questions covering family history. The first question is. . ."

Obtain and write in the answers to the questions in the family history form. Please print or type your answers so our project staff will be able to read the forms without needing to call you for clarification.

"Second, there is a form with questions covering the events in your child's abduction and recovery. The first question is. . ."

Obtain and write in the answers to the questions in the family history form. Please print or type your answers so our project staff will be able to read the forms without needing to call you for clarification.

"Third, now we have a few psychological measures for you to complete with paper and pencil. Each of these measures have been completed by thousands of adults who have been affected by traumatic events in their lives. This makes the results of the measures important to the project, because it helps to see how your experience compares with the experience of other parents who have had a child abducted.

Like other paper and pencil measures you may have taken in school or on the job, your task is to answer the questions as best you can. There are no right or wrong answers to the questions on these measures. Just answer each question to the best of your ability. Your "first impression" answer is likely to be the best answer. Feel free to ask me question if necessary.

Let's get started with this measure which is called the Child Behavior Checklist. This measure asks questions about your child's behavior."

Allow the parent to complete the Child Behavior Checklist. Please review the completed measure to insure that all items have been answered and the marks are clear and legible.

"Now, let's complete the next measure which is called the Frederick Trauma Index. This measure also asks questions about your child's behavior."

Allow the parent to complete the Frederick Trauma Index. Please review the completed measure to insure that all items have been answered and the marks are clear and legible.

"Now, let's complete the last measure which is called the Symptom Checklist. This measure asks questions about you, not about your child."

Allow the parent to complete the Symptom Checklist. Please review the completed measure to insure that all items have been answered and the marks are clear and legible.

"We're all through for today. Thanks for helping with the completion of the measures.

When we finish therapy, we will return to the measures and complete them once again."

Make a copy of the completed measures and retain them in your confidential case file. Mail the original completed measures back to the project in the stamped, self-addressed envelope provided to you. When we have verified receipt of the original completed measures, destroy your file copy. The reason for destroying your file copy is that these measure are not intended for clinical interpretation and therefore might be subject to misuse or misinterpretation at some later point in time.

DESCRIPTION OF PROJECT MEASURES

1. Achenbach Child Behavior Checklist-This measure consists of two pages (the front and back of a single sheet of paper), followed by 113 items to be rated by the parent. Please note that the Checklist only presents the response option code at the top of page 3 and at the top of page 4 as follows:

0=Not True
1=Somewhat or Sometimes True
2=Very True or Often True

Most parents will pick up and remember this coding very easily, while a few will require your assistance and monitoring.

Items 23 and 30 refer to school problems. If the recovered child is not in school, tell the parent not to complete these items.

APPENDIX E: PARENTAL ABDUCTION CASE SUMMARY

Child:

1. Name:
   Age:
   Case Number:
   Law Enforcement Contact:
   Law Enforcment Contact Phone Number:
   Custodial Parent Name:
   Custodial Parent Address:
   Custodial Parent Phone (H)_____(W)_____:

2. Date of Child Disappearance:
   Date of Child Recovery:
   Location of Child Recovery:
   Recovering Law Enforcment Agency:
   Contact at Recovery Agency:

3. Medical Clearance Obtained:
   Medical Facility Name:
   Physical Symptoms Noted:
   Agency/ Professional Responsible for Care:

4. Psychological Symptoms Noted:
   Agency/Professional Responsible:

5. Child Returned to Custodial Parent:
   Law Enforcment/Other Staff Present at Reunification:

6. Child Not Returned to Custodial Parent:
   Child Placed With Other (Name):
   Placement Address:
   Placement Phone Number:
   Other Jurisdiction Retains Child:
   Other Jurisdiction CPS Contact:
   Other Jurisdiction DA Contact:
   Local Jurisdiction Retains Child:
   Local Jurisidiction CPS Contact:
   Local Jurisdiction DA Contact:

PRE-ABDUCTION ALLEGATIONS OF ABUSE
LAW ENFORCEMENT/PROTECTIVE SERVICES CONTACTS
(ABDUCTING AND/OR RECOVERING PARENT)

Child Protective Services/Welfare Contacts: ____Yes ____No
Dates of Contacts:
Locations:
Reasons for Contacts:
Case Worker(s):
Disposition:

Emotional Abuse:
____Substantiated ____Not Substantiated ____Not Reported
Dates of Allegations:
Location(s):
Investigated By:
Agency:
Disposition:

Physical Abuse:
____Substantiated ____Not Substantiated ____Not Reported
Dates of Allegations:
Location(s):
Investigated By:
Agency:
Physical Evaluation Done: ____Yes ____No
Location:
Date:
Findings:
Disposition:

Sexual Abuse:
____Substantiated ____Not Substantiated ____Not Reported
Dates of Allegations:
Location(s):
Investigated By:
Agency:
Physical Evaluation Done: ____Yes ____No
Location:
Date:
Findings:
Disposition:

Neglect:

____Substantiated ____Not Substantiated ____Not Reported

Dates of Allegations:
Location(s):
Investigated By:
Agency:
Physical Evaluation Done: ____Yes ____No
Location:
Date:
Findings:
Disposition:

Prior Psychological Evaluations: ____Yes ____No

Dates of Evaluation:
Location(s):
Evaluated By:
Agency:
Findings:

Outside the Home Placement: ____Yes ____No

Dates:
Placement:
Location(s):
Reason for Placment:
Caseworker:
Disposition:

Allegations of Parental Abuse to Another Child: ____Yes ____No

____Substantiated ____Not Substantiated ____Not Reported

Dates of Allegations:
Location(s):
Investigated By:
Agency:
Dispostion:

Allegations of Spousal Abuse: ____Yes ____No

____Substantiated ____Not Substantiated ____Not Reported

Dates of Allegations:
Location(s):
Investigated By:
Agency:
Dispostion:

VISITATION / CUSTODY COURT ORDERS PRE-ABDUCTION

Was Custody or Visitation disputed by either parent? ____Yes ____No
Were there Allegations of Child Endangerment/Abuse/Neglect/Deprivation?
____Yes ____No
Were the allegations ____Substantiated ____Not Substantiated
Psychological Evaluations Connected With Disputes? ____Yes ____No
Physical Evaluation Connected With Dispute: ____Yes ____No
Jurisdiction of Visitation / Custody Orders:
Dates of Orders:
Court Findings:

APPENDIX F: REUNIFICATION PROTOCOL

Length of Time Child missing : _____

___age at time of abduction ___yrs. ___mo. (date abducted_____)
___age at time of recovery ___yrs. ___mo. (date recovered_____)

Siblings:

___no siblings
___also abducted
___left with non-abducting parents
___rationale for abduction

Circumstances of Abduction:

___child taken by custodial parent
___child taken by non-custodial parent
___child taken during normal visitation contact
___child taken from another location, e.g., school, babysitter
___child taken by force

Initial Explanation to Child for Abduction:

___extended vacation
___go away and live with me always
___other parent is hurting you
___other parent doesn't care about you/love you
___other parent is dead
___no explanation given to child

Prior Planning for Abduction:

___abducting parent made no plans pre-abduction
___abducting parent acted without assistance
___abducting parent made no financial preparations
___abducting parent made plans pre-abduction, (birth certificates, false ID)
___abducting parent enlisted assistance from family members/friends
___abducting parent contacted outside groups
___abducting parent sought financial assistance from family/friends
___abducting parent sought finanical assistance from outside groups
___abducting parent pre-planned for financial needs

Communications to Child About Left Behind Parent During Abduction:

___non-abducting parent abandoned you
___non-abducting parent didn't want you/didn't love you any more
___non-abducting parent hurt you/abused you
___physical

___sexual
___neglect
___emotional
___deprivation
___non-abducting parent is alcoholic/drug addicted
___non-abducting parent wanted to take you away so I can never see you
___non-abducting parent will hurt you if they find you
___non-abducting parent will hurt/kill me (abducting parent) if they find us
___non-abducting parent has died
___non-abducting parent is a bad person who hurt the abducting parent, e.g., infidelity, domestic violence

Communications to Child About the Abducting Parent:

___I'm the better parent
___I can take better care of you than other parent can
___I love you more
___I can't live without you
___You belong to me
___I'll harm you if you disclose our identity to anyone
___I'll get put in jail if we're found

Circumstances During the Abducted Period:

___name change
___sex change of the child, e.g., child made to dress/behave like other sex
___changes in physical identity, e.g., haircut, hair color change, clothing
___language other than English spoke in home
___taken out of country (international)

Living Conditions During Abducted Period:

___lived with abducting parent
___lived with someone other than abducting parent
___taken to another country (list locations)
___frequent moves (list locations)
___lack of residence, e.g., travel trailer, hotel
___inadequate residence
___school denial
___social isolation/lack of peer relationships due to isolation
___lack of financial resources
___abuse during abduction
___medical neglect
___preventitive care, such as immunizations
___diagnostic care, such as medical examinations
___failure to hospitalize when needed
___remedial care, such as surgery or regular medication

___prosthetic care, such as eyeglasses

CHILD'S PERCEPTIONS/BELIEFS

Perceptions of Abduction:

___child aware that abducted
___child not aware that abducted

Perceptions/Beliefs About Abducting Parent:

___identify with abducting parent
___fear of abducting parent
___anger with abducting parent
___confusion about abducting parent
___allegations of abuse of abducting parent
___uninvolved

Perception/Beliefs About Recovering Parent:

___fear of recovering parent
___anger with recovering parent
___confusion about recovering parent
___interest in recovering parent
___sense of abandonment by recovering
___fantasy of recovering parent rescuing them

Child's Memory of Recovering Parent:

___no memories
___memories
    ___positive (list)
    ___negative (list)
    ___neutral (list)

Child's Pre-Abduction Memories:

___no memories
___memories
    ___parental relationship (list)
    ___conflicts in family (list)
    ___siblings (list)
    ___divorce, if applicable (list)
    ___visitations, if applicable (list)
    ___domestic violence (list)
    ___abuse (list)
    ___school/communtiy (list)

Child's Perceptions/Beliefs Regarding Recovery:

___relief
___fear of outcomes
___anger over recovery
___confusion over recovery

RECOVERING PARENTS

Child's Response to Seeing Recovering Parent:

___fear of recovering parent, e.g., they will hurt/abuse me
___they will take me away, I'll never see my abducting parent again
___numbness or apathy
___they're dead, "I don't have another parent."
___anger, e.g., they abandoned me, they hurt the abducting parent

Strength of Child's Concept About Recovering Parent:

___extreme, e.g., child retreats when discusssing recovering parent
___very strong
___moderate
___ambivalent
___positive

Recovering Parent's Actions During Abducted Period:

___no effort towards recovery
___limited efforts to recovery
___active efforts to recovery
___types of effort:
    ___law enforcement contacts, e.g., police, FBI, state law enforcement
    ___state clearing houses for missing children
    ___National Center for Missing and Exploited Children (NCMEC)
    ___private investigator
    ___media exposure
    ___legal advice sought
    ___missing children non-profit organization (list)
    ___other (list)

Recovering Parent's Beliefs Pre-Recovery About Recovery:

___lost hope
___belief the child would be located

Changes in Recovering Parent's Life Since Abduction Initiated:

___residence change

___relocation to another city/region
___marriage/significant other relationship
___divorce
___new children: ___natural, ___step
___losses/death, e.g., extended family
___education
___financial change
    ___decrement
    ___increment
___job changes
___family/friend changes
___medical problems
___substance abuse
___emotional problems

Recovering Parent's Expectations of the Child at Reunification:

___child will be happy about recovery
___child will be glad to see me
___child will remember me
___no residual effects, "Everything will be normal"
___instant family
___child may be frightened
___uncertain what to expect

Circumstances of Recovery:

___voluntary by abducting parent
___police involvement
    ___abducting parent cooperative
    ___abducting parent resistive
___court ordered
___media
___non-profit organization
___other
___where child was recovered (list)

Immediate Consequences of Recovery:

___abducting parent detained
___child placed in foster care
___child placed with relative
___child taken to hospital
___child taken to police station to wait
___child returned to recovering parent

Abducting Parent's Statements/Response to Child at Time of Recovery:

___anger (list)
___tearful (list)
___warns the child (list)
___other (list)