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Child Sexual Abuse

EUGENIA HSU, GEORGANNA SEDLAR, MARY F. FLOOD, and DAVID J. HANSEN

DESCRIPTION OF THE PROBLEM

CHILD SEXUAL ABUSE is a disturbingly prevalent problem that has received increased attention from researchers, clinicians, and the general public during recent decades. Incidence studies from the 1990s provide the best estimate of the numbers of children and families affected by this problem, but even the advancement in comprehensive and methodologically sophisticated efforts are believed to underestimate the problem. The Third National Incidence study of Child Abuse and Neglect estimated that in 1993, approximately 217,700 children nationwide had experienced harm from sexual abuse, and that sexually abused children accounted for 29% of the total number of children who suffered any form of child maltreatment (i.e., physical, sexual, and emotional abuse and neglect; National Center on Child Abuse and Neglect, 1996). Child protective service agencies in the United States reported that in 1998, 1.6 children per 1,000 children experienced sexual abuse, with approximately 75% involving girls as victims (U.S. Department of Health and Human Services, 2000). Underreporting and failure to substantiate actual cases of abuse are likely to influence these figures, leading to widespread speculation that they are substantial underestimates of actual occurrence.

A considerable body of research has examined the effects of sexual abuse on children and documented its generally deleterious consequences (Kendall-Tackett, Williams, & Finkelhor, 1993; Paolucci, Genuis, & Violato, 2001; Wolfe & Birt, 1995). Most studies have focused on relatively short-term correlates of childhood sexual abuse and found a notable range and variability in behavioral and emotional responses associated with sexual abuse. The research indicates that symptoms vary in intensity, number, and character. Some children exhibit no to minimal symptoms, whereas other children display a combination of symptoms (Finkelhor & Berliner, 1995; Hecht & Hansen, 1999; Kendall-Tackett et al., 1993). Kendall-Tackett et al. reviewed 45 studies examining the impact of sexual abuse on children and found a

diverse array of symptoms in different age groups. Their review indicates that inappropriate sexual behavior, anxiety, and nightmares were the most common symptoms of sexually abused preschool-age children and that both preschool-age and school-age victims frequently experienced symptoms of Posttraumatic Stress Disorder (PTSD), such as nightmares and reexperiencing the event (Kendall-Tackett et al, 1993). School-age children also reported experiencing fear, academic problems, aggression, and hyperactivity (Kendall-Tackett et al, 1993). Adolescent victims tend to have poor self-esteem and display maladaptive behaviors, such as running away, engaging in promiscuous behaviors, committing illegal acts, abusing substances, engaging in self-injurious behaviors, and attempting suicide (Gil, 1996; Hecht & Hansen, 1999; Kendall-Tackett et al, 1993). Depressed mood is a symptom common to all age groups (Kendall-Tackett et al, 1993; Paolucci et al, 2001). Despite such breadth of prominent psychological consequences across age groups, sexually abused children do not appear more symptomatic than clinically referred nonabused children, with the exception that sexually abused children exhibit more PTSD symptoms and sexualized behavior than do other referred children (Friedrich et al, 2001; Kendall-Tackett et al, 1993; Wolfe & Birt, 1995). In addition, no typical "profile" or diagnostic syndrome uniformly applies to the majority of sexual abuse victims (Finkelhor & Berliner, 1995; Wolfe & Birt, 1995).

Researchers have examined incident characteristics of the abuse and contextual factors in the child's life and environment to explain the variability in symptomatology and the lack of a single diagnostic profile for child victims of sexual abuse. Characteristics of the abuse experience, such as severity (e.g., fondling, penetration), identity of the perpetrator, duration and frequency of sexual contact, and use of force are thought to influence the type and severity of children's symptoms (Kendall-Tackett et al, 1993; Wolfe & Birt, 1995). Contextual factors that contribute to variation in symptom presentations include age at the time of the assessment, other child variables (e.g., gender, children's attributions about the abuse), familial relationships (e.g., quality of parent-child relationship, maternal support), the presence of multiple forms of maltreatment (e.g., physical abuse, neglect), and offenders' responses to abuse allegations (Friedrich, 1998; Kendall-Tackett et al, 1993; Saunders & Meinig, 2000). Despite variability in specific symptoms, sexual abuse appears to impact three broad areas of adjustment and functioning: the individual or self (e.g., self-esteem, internalizing feelings); relationships (e.g., social interactions, externalizing problems with peers and family); and sex (i.e., sexual knowledge and abuse-related issues; Futa, Hecht, & Hansen, 1996; Hansen, Hecht, & Futa, 1998).

CASE DESCRIPTION

This chapter describes the case of two adolescent girls who were living in foster care with their maternal aunt and her family, the Kraller family.¹ The girls and their aunt and uncle participated in Project SAFE, a university-based program for sexually

¹ Identifying information on the case was altered to protect the Kraller and Smith families' confidentiality.

abused children and their nonoffending caregivers, which is described in detail in the Course of Treatment section. The Kraller family was referred to Project SAFE by the local Child Advocacy Center. Miriam Kraller contacted the Child Advocacy Center when she learned that her two nieces (her younger sister's daughters), Gina (age 14) and Suzy (age 13), had been sexually abused and were moving in with her and her family due to their mother's inability to care for them. Both Gina and Suzy reportedly had experienced sexual abuse while living with their mother (Abigail Smith) in Alabama. Mrs. Kraller sought help because she was concerned about the impact of the sexual abuse on her nieces.

Miriam and Matthew Kraller had been married for 13 years at the time of the referral to Project SAFE. Mrs. Kraller worked as a human resources manager in a local business corporation and Mr. Kraller worked as a production worker in a local factory. Mr. and Mrs. Kraller had one son (Travis, age 9) and one daughter (Stephanie, age 15).

Gina and Suzy were living with a family friend in Alabama when they came to the attention of child protective authorities because they and the friend's children were engaging in illegal, unsupervised activities (e.g., driving a car). Gina and Suzy were removed from their home and placed in foster care. The girls disclosed experiences of sexual abuse during the time they were receiving child protective services in Alabama.

Mrs. Kraller's first contact with Project SAFE was a request for information made before her nieces arrived in her home. She indicated that she would contact Project SAFE again after her nieces had time to adjust to their new living arrangements. A few months after the initial telephone call, Mrs. Kraller contacted Project SAFE to set up an intake appointment. Mr. Kraller was unable to attend the intake assessment, yet both Mr. and Mrs. Kraller were highly motivated to participate in treatment.

CHIEF COMPLAINTS

During the intake assessment, Mrs. Kraller said that she had had little time to get to know Gina and Suzy and expressed concerns that her caregiving style would be different from that of her sister. She also feared that the girls would engage in future risky behaviors because of their prior history. Both Gina and Suzy displayed sexualized behaviors (e.g., being overly friendly with men they did not know well, talking in a flirtatious manner, asking to look at sexually explicit TV shows) on a regular basis, according to their aunt. Mrs. Kraller also identified distinct concerns and strengths for each of the girls. She described Gina as having some difficulties getting along with others (including her sister, cousins, and other children). According to Mrs. Kraller, Gina did not have any close friends and was socially isolated from her peers outside of school. Mrs. Kraller was most concerned about Gina's lack of interest in her academic achievement and shared that Gina was previously diagnosed with a learning disability in reading. When asked about Gina's best qualities, Mrs. Kraller responded that Gina was sensitive, patient, and had a good sense of humor. For Mrs. Kraller, the most concerning aspects of Suzy's behavior were her low self-esteem and inability to calm down. Mrs. Kraller described Suzy's positive attributes as her happy demeanor and her devotion to her sister.

HISTORY

Mrs. Kraller provided information about Gina's and Suzy's abuse histories at the initial assessment session. Although the case was being handled out of state, Mrs. Kraller was considered to be a good historian regarding characteristics surrounding the abuse incidents.

According to Mrs. Kraller, Abigail (Ms. Smith) arranged for Gina to be "married" to a male acquaintance (age 36) when Gina was 12 years old. According to Mrs. Kraller, Gina believed that she was this man's legitimate wife for a period of time. Reportedly, no force was used during the abuse. Mrs. Kraller reported that the abuse included vaginal intercourse, but she was uncertain if other types of abuse occurred. Mrs. Kraller also believed that multiple offenders were involved. The abuse occurred over the course of approximately one year. Law enforcement was involved after Gina reported the abuse when she was in foster care, but there was no court or trial involvement because the alleged perpetrator could not be located and was believed to have left the country.

Suzy's abuse was disclosed at the same time as Gina's, although details about Suzy's abuse were less clear. According to reports, Suzy was abused by her mother's boyfriend when she was approximately 7 or 8 years old. Mrs. Kraller believed fondling and exposure were involved and vaginal penetration was suspected. Suzy was treated for a bladder infection 10 months prior to the assessment. Mrs. Kraller believed that Suzy had experienced more abuse incidents than were initially disclosed. In treatment, however, Suzy reported experiencing abuse on only one or two occasions.

BEHAVIORAL ASSESSMENT

A comprehensive assessment relying primarily on self- and parent-report measures was conducted to assess the effects of sexual abuse on the children and to identify co-occurring family issues. Assessment information was gathered from multiple informants (i.e., child and parent) and conducted at key time periods: pretreatment, post-treatment, and three months following treatment. A brief description of the child and parent measures is provided below. These measures were previously reviewed and have adequate psychometric properties (see Hansen et al., 1998, for more detailed descriptions of the measures). Weekly rating forms were also completed to monitor progress in treatment and are described in the Course of Treatment section.

At the intake session, both girls were relatively quiet. They were attentive during the description of the treatment program and cooperative in completing the intake measures.

CHILD SELF-REPORT

Child self-report measures assessed multiple domains of child functioning, particularly internalizing problems and self-esteem. The Children's Depression Inventory (CDI; Kovacs, 1992) is a 27-item measure used to assess recent cognitive and somatic symptoms of depression. Each item on the CDI has three choices reflecting severity of the symptoms: 0 = absence of symptom, 1 = mild symptom, and 2 = definite symptom. The Hopelessness Scale for Children (HSC; Kazdin, Rogers, &

Colbus, 1986) is a 17-item scale (true-false format) that measures feelings of hopelessness and negative expectations about the future. The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1985) is a 37-item measure (yes-no format) that assesses general anxiety, with a Total Anxiety score comprising physiological, subjective, and motor symptoms of anxiety. The Self-Esteem Inventory (SEI; Coopersmith, 1981) contains 58 items (like me-unlike me format) that measure children's attitudes about themselves in social, academic, family, and personal areas of experience. The Children's Loneliness Questionnaire (CLQ; Asher & Wheeler, 1985) is a 24-item questionnaire (5-point Likert-type scale) that assesses children's feelings of loneliness, social adequacy, and subjective estimations of peer status. The CDI and RCMAS utilize T-scores with a mean of 50 and standard deviation of 10. Range of scores on the other measures are as follows: HSC (0 to 17), SEI (0 to 100 without the Lie Scale), and CLQ (16 to 80 without eight items that are not included in the score).

At the beginning of treatment, Gina and Suzy displayed different clinical presentations. In general, Gina reported substantial problems in many areas of adjustment, whereas Suzy reported problems in only a few areas. Gina reported moderate levels of depressive symptoms (CDI T-score = 62). She indicated that she felt like crying many days, had trouble sleeping many nights, felt alone many times, and was not sure that things would work out for her. Gina's self-report measure responses were consistent with feelings of hopelessness and negative expectations about the future (HSC score = 8). For example, she endorsed feeling that she should give up because she could not make things better for herself. She exhibited clinically significant anxiety-related symptoms (RCMAS T-score = 69). Although all three domains on the RCMAS were elevated, she was reporting very high levels of physiological manifestations of anxiety (e.g., often feeling sick in her stomach, hands feeling sweaty, waking up scared some of the time). Her responses suggested that she was experiencing feelings of loneliness and social inadequacy (CLQ score = 47), as she did not have anyone to talk to in her class, felt alone at school, and found it hard to make friends at school. Her self-esteem score on the SEI (Total score = 58) suggested that she had a poor self-concept in social, academic, family, and personal areas of experience. In particular, Gina described especially low self-esteem in the school and academic settings (e.g., finding it very hard to talk in front of the class, often getting discouraged at school, not doing as well in school as she would like to, and her teachers making her feel that she was not good enough). Her self-report was consistent with Mrs. Kraller's concerns that she displayed a lack of interest in school, had some difficulties academically due to the previously diagnosed learning disability, and was socially isolated from her peers.

In contrast to Gina's scores, Suzy's self-report scores at intake did not reflect maladjustment in most areas of functioning. However, her Lie scores on two instruments were elevated, suggesting that she may have tried to present herself favorably or downplay her distress. Evaluation results for Suzy must be considered in light of her response style. For example, Suzy's SEI score reflected a high self-concept, but her Lie score was 6 (with a maximum score of 8). Similarly, her RCMAS score fell within the normal range, but her Lie score was in the 84th percentile. Her self-report suggested much below average level of depressive symptoms (CDI T-score = 34) and she did not endorse feelings of hopelessness about her future (HSC score = 1). Fur-

thermore, she appeared to view herself as being socially adequate and experiencing few feelings of loneliness in peer interactions (CLQ score = 24).

Gina and Suzy completed two measures of abuse-specific reactions in addition to the measures of internalizing problems and self-esteem issues. The Children's Fears Related to Victimization (CFRV) is a 27-item subscale of the Fear Survey Schedule for Children-Revised (FSSC-R; Ollendick, 1983). The CFRV lists situations that sexually abused children seem to find particularly distressing (e.g., people not believing me, being lied to by someone I trust, people knowing bad things about me), and children rate how afraid they are of the situation using the options none, some, or a lot. Scores on the CFRV range from 27 to 81. The Children's Impact of Traumatic Events-Revised (CITES-R; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991) is a 78-item semistructured interview developed to measure the impact of sexual abuse from the child's perspective across areas of posttraumatic stress, abuse attributions, social reactions, and eroticism. Children rate each statement on the CITES-R as very true, somewhat true, or not true. The 26-item Posttraumatic Stress subscale assesses intrusive thoughts, avoidance, hyperarousal, and sexual anxiety (with a range of scores from 0 to 52); this subscale provided the most salient information about Gina's and Suzy's needs.

Gina reported posttraumatic stress symptoms (e.g., trying to stay away from things that remind her of what happened to her, thinking about what happened to her even when she did not want to, hoping she never had to think about sex again, and sometimes feeling very scared when she is reminded of what happened; CITES-R, PTSD scale score = 30) and some fear about situations that sexually abused children typically find distressing (CFRV score = 58). Despite her reluctance to report internalizing and self-esteem problems, Suzy's responses to the measures of abuse-specific symptoms were similar to those of her sister. Suzy reported experiencing posttraumatic stress symptoms (PTSD scale score on the CITES-R = 29), such as trying to forget what had happened to her, being upset when she thought about sex, sometimes wanting to cry when she thought about what happened, and wishing that there was no such thing as sex. She also experienced fears in situations that sexually abused children seem to find distressing (CFRV Score = 55).

PARENT SELF-REPORT

Mrs. Kraller completed the pretreatment assessment measures that provided information about Gina's and Suzy's functioning. The Child Behavior Checklist-Parent Report Form (CBCL; Achenbach, 1991) is a 113-item checklist used for the assessment of parents' perceptions of social competence and behavioral problems of their children ages 4 to 18 years. The widely used CBCL uses T-scores for interpretation. The Child Sexual Behavior Inventory (CSBI; Friedrich et al., 1992) is a 35-item inventory of the frequency of various sexual behaviors such as sexual aggression, self-stimulation, gender-role behavior, and personal boundary violation observed in children ages 2 to 12. Each item is rated along a 4-point scale and the scores range from 0 to 105.

Mrs. Kraller's responses to the assessment instruments indicated that both Gina and Suzy were exhibiting significant behavioral symptoms. Gina was experiencing pervasive emotional and behavioral problems (CBCL Total T-score = 85), with clin-

ically significant problems in internalizing (CBCL T-score = 88) and externalizing (CBCL T-score = 76) domains, according to her aunt's report. Similarly, Mrs. Kraller reported pervasive behavioral problems for Suzy, as most of the CBCL subscales were in the clinically significant range and the CBCL Total T-score was clinically significant (T-score = 71). Particularly, Mrs. Kraller noticed severe attention problems (T score = 81) in Suzy. She reported significant sexual behavior problems for both Gina and Suzy, as shown by her responses on the CSBI (scores of 35 and 26, respectively). Gina reportedly imitated the act of sexual intercourse, made sexual sounds, talked about sexual acts, hugged adults she did not know well, and was overly aggressive, whereas Suzy was overly friendly with men she did not know well, talked in a flirtatious manner, and seemed very interested in the opposite sex.

Family functioning across multiple domains was assessed through parental self-report instruments as well. The Family Adaptability and Cohesion Evaluation Scales (Olson, 1986) is a 20-item self-report measure that assesses adaptability, cohesion, and family satisfaction. The Family Crisis Oriented Personal Evaluation Scales (F-COPES; McCubbin, Olson, & Larsen, 1987) is a 30-item measure used to assess effective problem-solving coping attitudes and behavior (e.g., seeking spiritual support, passive appraisal) used by families in response to problems or difficulties. Two dimensions of family interactions are assessed by the FCOPES: internal family strategies and external family strategies. The Dyadic Adjustment Scale (Spanier, 1976) is a 32-item instrument that assesses the quality of a dyadic relationship (in this case, Mr. and Mrs. Kraller's marital relationship) and four specific aspects of the relationship: dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression. The Symptom Checklist-90-Revised (Derogatis, 1983) is a 90-item multidimensional symptom inventory that provides a global measure of psychological distress based on respondents' ratings of the degree of distress experienced for various symptoms. These measures did not indicate that the Krallers were experiencing significant problems at intake in these areas, nor did these measures show significant changes over the course of treatment for the Kraller family. Therefore, they are not discussed further.

MEDICAL CONSULTATION

Project SAFE treatment does not include a medical consultation or examination. Families are typically referred to Project SAFE by community and state agencies such as a local child advocacy center and the Department of Health and Human Services. Necessary medical examinations are provided prior to families' contact with Project SAFE. For example, the local child advocacy center provides a child-friendly environment where medical examinations and forensic interviews are conducted.

In Gina's and Suzy's cases, sexual abuse was discovered when they were living in foster care in another state and medical examinations were not conducted at the time of disclosure. Nevertheless, medical practitioners have an important role in diagnosing and treating sexually abused children. DeJong (1998) summarized four main reasons for conducting medical examinations: (1) to reassure child victims and their parents that they are normal and healthy; (2) to detect, prevent, and treat abuse-related medical conditions (including sexually transmitted diseases and pregnancy); (3) to collect and provide verbal and physical evidence for protection of the abused child; and (4) to collect and provide verbal and physical evidence to help prosecute

the abuser. General guidelines have been published by the American Academy of Pediatrics (1999) for physicians evaluating childhood sexual abuse. Practice guidelines recommend obtaining a history (including behavioral changes and a clear statement about the abuse), performing a physical examination, and using laboratory data. Physical examinations typically include a medical history, a complete physical exam, and a thorough examination of the genitalia using a colposcope. Colposcopes are used with either still or video cameras to photographically preserve any signs of trauma, and resulting photographs or videotapes are given to law enforcement as part of a criminal investigation (Levitt, 1998). Medical examinations also may involve laboratory tests, forensic collection, and treatment of medical conditions. Despite advances in medical technology, medical evidence of sexual abuse is hard to obtain and "a high percentage of children with well-documented abuse will have normal physical examinations" (Jenny, 1996, p. 200). Specific signs and symptoms of sexual abuse include rectal or genital bleeding, sexually transmitted diseases, and developmentally unusual sexual behavior. Two high-probability physical indicators of child sexual abuse are pregnancy in a child and venereal disease in a child younger than age 12 to 14 (Faller, 1993).

CASE CONCEPTUALIZATION

The variability of symptom presentation following sexual abuse makes generalizations about the effects of child sexual abuse difficult; however, several models have attempted to identify mediating and moderating variables in the adjustment process. Two widely recognized models are the traumagenic dynamics model (Finkelhor & Browne, 1985) and the transactional model (Spaccarelli, 1994). Because detailed review and critique of these models are beyond the scope of this chapter, readers are referred to other sources for additional conceptualizations and perspectives (e.g., Cicchetti & Toth, 2000; Conte, 1990; Hansen et al., 1998; Wolfe & Birt, 1997).

The traumagenic dynamics model (Finkelhor & Browne, 1985) views the extent of a child's symptoms following child sexual abuse as dependent on the child's experiences of four trauma-causing factors, known as "traumagenic dynamics": traumatic sexualization, betrayal, stigmatization, and powerlessness. An application of the traumagenic dynamics model helps account for Suzy's and Gina's adjustment at intake. *Traumatic sexualization* describes a variety of processes by which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate manner (Finkelhor & Browne, 1985). According to Suzy, her offenders told her they were doing nothing wrong and were teaching her to have sex. This message may have contributed to Suzy's belief that abuse happens to all girls. These experiences may have changed her view about herself sexually and therefore may account for her increase in sexualized behavior and potentially risky behavior reported by Mrs. Kraller over the course of treatment. Although Gina displayed problematic sexual behavior at intake, this behavior substantially subsided over the course of treatment and follow-up, consistent with the model's position that traumagenic processes are open to change over time.

Betrayal occurs when the child realizes that a trusted person has manipulated him or her and caused him or her harm. Therefore, the closeness of the relationship between the offender and the child is likely to affect the degree of betrayal experienced

by the child (Finkelhor & Browne, 1985). Betrayal processes may account for some of Suzy's and Gina's difficulties after the abuse. Suzy reported that prior to the abuse, she felt safe, happy, and comfortable with the offenders. Suzy's offenders did not admit that they did anything wrong and, in fact, blamed someone else for the abuse. Gina's perpetrators did not admit to any wrongdoing, either, and it appears that Gina may have believed she was married to one of the perpetrators for a time. Therefore, Suzy and Gina are likely to have felt betrayed by the perpetrators' actions and unwillingness to acknowledge the abuse incidents.

Stigmatization refers to the negative messages about the self, such as feelings of shame or guilt, that are communicated to the child during and after the sexual abuse (Finkelhor & Browne, 1985). Stigmatization processes seemed to contribute to Gina's adjustment difficulties, particularly her poor self-image, as evidenced by her low scores on the SEI. Besides not admitting to any abuse, Gina's offenders told her never to tell anyone about the abusive incidents. Such messages, particularly the instruction to keep the abuse a secret, may have increased Gina's sense of stigma and, subsequently, been incorporated into her self-image. Gina indicated that if the abuse had not happened, then maybe she would not feel "weird." She also expressed a desire to stop putting herself down in the future. Overall, her presentation was consistent with the traumagenic model's proposition that victims may view themselves as "spoiled goods."

Powerlessness occurs when the child's will and sense of efficacy are repeatedly contravened, and the child experiences violence, coercion, and threat to life and body (Finkelhor & Browne, 1985). Both Gina and Suzy reported posttraumatic stress symptoms, suggesting that they may have experienced a certain sense of powerlessness and fear during the abuse. For example, Suzy described her abuse as "scary," "gross," and "painful." Similarly, Gina indicated that after the abuse, she thought that she could have stopped it, but she was not sure how.

The transactional model (Spaccarelli, 1994) contributes additional understanding about Gina's and Suzy's adjustment following sexual abuse. According to the transactional model (Spaccarelli, 1994), children's development progresses through a series of person-environment transactions that influence healthy or psychopathological outcomes. Children's environments are considered to be continually changing, which affects their development and available resources. In addition to external resources, children also possess internal resources that can influence their organization of the environment. In this model, the impact of sexual abuse on the child's family and community environment is as important as the characteristics directly associated with the abusive events (e.g., seriousness, frequency, duration, and coerciveness).

The model's emphasis on environmental factors is particularly relevant for understanding Gina and Suzy. The transactional model starts with the belief that victims of sexual abuse encounter a series of stressors (Spaccarelli, 1994). Based on the background information provided by Mrs. Kraller, the girls were experiencing environmental stressors prior to and concurrent with the abuse. These stressors may have contributed directly to the occurrence of sexual abuse, or they may have created an underlying family system that allowed sexual abuse to occur. Once the abuse began, it may have exacerbated the other environmental stressors as well.

The transactional model predicts that a victim's risk for poor mental health outcomes increases as a function of the total abuse stress across three categories of

stressful events: abuse, abuse-related, and public disclosure events (Spaccarelli, 1994). Among the salient abuse-related events, the girls' family environment was key. Prior to moving in with the Krallers, the girls were faced with a lack of family stability. Numerous friends and partners of their mother came in and out of the household. Gina's "marriage" was allegedly arranged to help her mother financially. Additionally, when the girls were found by law enforcement, they were riding around town unsupervised, with an unlicensed, underage driver. Gina and Suzy encountered multiple changes in living environments over a relatively short period of time: living with their mother, followed by living with their friend's family, then temporary foster care, and finally settling in with the Kraller family. Although the children may have lacked maternal support subsequent to law enforcement involvement, Mr. and Mrs. Kraller's unwavering support and timely responding helped to buffer against prior negative experiences. In addition to family dysfunction, the girls also endured many public disclosure events. These events included police involvement and interviews in Alabama, removal from their home, and contact with the local child advocacy center. Although the girls did not have to appear in court for any criminal or civil cases directly associated with the sexual abuse (e.g., perpetrator court case), they did participate in the hearing that terminated their mother's parental rights.

Mr. and Mrs. Kraller provided substantial environmental resources for Gina and Suzy. After a considerable period of chaos and instability, they provided a secure and stable environment. The type and amount of support the girls received was an important environmental factor in their adjustment. A prime example of the Krallers' support was their timely involvement in treatment. Their participation in group treatment was an admirable way to convey their support. Although information on the girls' individual functioning prior to the abuse was limited, the transactional model supports the notion that differences in their abuse experiences, developmental stages, and prior functioning most likely played a role in their adjustment.

The transactional model suggests that children's cognitive appraisals and coping strategies mediate the effects of sexual molestation and related life events and function as the immediate causes of symptoms. Spaccarelli (1994) emphasized that sexually abusive events are likely to lead to negative cognitive appraisals and problematic coping strategies, although not all children develop such appraisals or use maladaptive coping strategies. The model posits a bidirectional influence for appraisals and symptoms, in which children's psychological symptoms influence cognitive appraisals and coping strategies as well as being influenced by them.

Both Gina and Suzy expressed negative cognitive appraisals of themselves and their role in the abuse. For instance, Gina believed that if the abuse had never happened, she would not feel "weird" and would be able to make friends easier. Gina assumed responsibility for the abuse, believing she could have stopped it. Suzy's belief that abuse happens to all girls is a cognitive appraisal that may have contributed to her relatively higher self-esteem. Alternatively, her belief may have led her to feel vulnerable and frightened. The coping strategies employed by Gina and Suzy appear to have included some risk-taking behaviors and avoidance. For example, Gina used humor and cartoon-like voices when she was nervous or anxious during sessions, suggesting an attempt to avoid dealing with her feelings. Despite this initial avoidant coping strategy, Gina began to use support from her aunt and uncle as an alternative coping mechanism strategy during the course of treatment.

RATIONALE FOR TREATMENT CHOICE

Finkelhor and Berliner (1995) concluded from their review of treatment literature that, "taken as a whole, the studies of sexually abused children in treatment show improvements that are consistent with the belief that therapeutic intervention facilitates children's recovery" (p. 1414). Children who are not treated may exhibit difficulties in areas of daily functioning (e.g., school, peer, and familial relationships) and have a significant chance of being revictimized (Browne & Finkelhor, 1986; Kendall-Tackett et al, 1993). Therefore, it is important to assess sexually abused children's needs carefully and offer treatment to children with behavioral and emotional problems associated with the abuse.

Several treatment modalities (e.g., individual, group, family) have been implemented with child sexual abuse victims; however, empirical evidence supporting the different approaches is limited (King et al, 1999). The current trend in clinical psychology is to depart from nondirective supportive therapy and shift toward the use of empirically validated treatment protocols (Ollendick, 1999; Weisz, Weiss, & Donenberg, 1992). Despite this movement, standardized treatment programs are underutilized with child sexual abuse victims and their families. Studies have shown preliminary support for using abuse-specific therapy to decrease related symptomatology (e.g., Berliner & Saunders, 1996; Deblinger, Lippmann, & Steer, 1996; Deblinger, Steer, & Lippmann, 1999). Cohen and Mannarino (1998) found that sexual abuse-specific cognitive-behavioral therapy was more effective in decreasing depressive symptomatology and improving clinical presentation than nondirective supportive therapy. The inclusion of nonoffending parents has also been identified as an integral part of positive treatment outcome for sexually abused children (Celano, Hazzard, Webb, & McCall, 1996; Damon & Waterman, 1986).

Research findings suggest that group therapy is a potentially beneficial treatment modality for sexual abuse victims. Reeker, Ensing, and Elliott (1997) analyzed literature on group therapy and found that "effective group treatments for sexually abused children do exist" (p. 695). They reported that the greatest advantage of group treatment is that participants have the opportunity to share with others who have had similar experiences. Another benefit of group therapy is its high cost-effectiveness and low labor involvement (Reeker et al, 1997). However, additional research is needed to identify the characteristics of effective group treatments. In the Reeker et al review, multiple treatment modalities were included, providing little clear direction on group structure or content.

Most nonoffending parents do not have their own support system, and a supportive environment may be beneficial for parents to process what has happened to their child and family. Group treatment has been suggested for treating nonoffending parents because it provides parents a supportive atmosphere where they can give and receive support with other parents who share similar experiences and resolve stressful issues (Landis & Wyre, 1984). Group therapy offers additional benefits to parents not available in individual therapy. Group therapy gives the parents a greater opportunity to develop social skills and to participate in role modeling and role playing (Sgroi & Dana, 1982). Groups also help parents regain a sense of belonging to something, develop supportive friendships, and decrease the isolation that usually occurs after disclosure of abuse (Schonberg, 1992; Sgroi & Dana, 1982). To date, only one known cognitive-behavioral group treatment outcome study for nonoffending mothers and

their sexually abused children has been completed (Stauffer & Deblinger, 1996). Parallel groups were conducted with 19 nonoffending mothers and their young sexually abused children, ages 2 to 6. Results indicate that following treatment, mothers experienced lower levels of general distress, exhibited less avoidance of abuse-related thoughts and feelings, and responded more appropriately to their children's behaviors and abuse-related issues (Stauffer & Deblinger, 1996). Project SAFE is unique as a parallel, standardized group treatment for sexually abused children *and* adolescents and their nonoffending caregivers (Futa et al., 1996; Hansen et al., 1998; Hecht, Futa, & Hansen, 1996).

COURSE OF TREATMENT

Project SAFE is a standardized group treatment program for sexually abused children (ages 7 to 16) and their nonoffending parents or caregivers. Project SAFE is operated through the Psychological Consultation Center at the University of Nebraska-Lincoln (UNL), a clinic for research training and service.

Separate groups are conducted simultaneously for children and parents. Groups meet for 90-minute sessions for 12 consecutive weeks, covering 10 modules. Each group is cofacilitated by two therapists who are doctoral students in the clinical psychology program at UNL. The same topics are covered in the sessions for children and parents, incorporating education and strategies to prevent future sexual abuse.

Project SAFE groups are generally small, usually with 3 to 4 children and 4 to 6 parents. The group in which Gina and Suzy participated had one other 13-year-old girl. Similarly, the parent group included Mr. and Mrs. Kraller and the parents of the other child.

The treatment protocol was developed from a systematic review of the literature on treatment programs for sexually abused children and their nonoffending parents. The intervention was designed to address three critical target areas impacted by sexual abuse: the individual or self (self-esteem, internalizing feelings); relationships (social interactions and externalizing problems with peers and family); and sex (sexual knowledge and abuse related issues; Futa et al., 1996; Hansen et al., 1998). Procedures used in sessions are psycho educational, skill building, problem solving, and supportive. Different protocols are used for younger children and adolescents to address the children's developmental levels appropriately. The treatment overview of Project SAFE and descriptions of the modules below are focused on the adolescent's group, given Gina's and Suzy's ages. Specific details about techniques used in Project SAFE can be obtained by referring to a chapter by Hansen et al. (1998) or by contacting the authors for a copy of the treatment manual.

Each child group began with Circle Time, when each child shared with the group how her previous week went, and ended with a Free Time, when the children and therapist named one good thing that each group member did during the session. This latter structured activity, led by one of the therapists, promoted the girls' positive self-esteem, helped the session end on a positive note, and allowed the lead child therapist an opportunity to check in and talk to the parents. Each parent group began with a brief discussion of the child's behaviors at home during the previous week and ended with the lead child therapist joining the group to discuss how the children reacted to that week's session and to answer any questions the parents may have. This check-in

period was useful in providing parents reassurance about how their children were doing in treatment; it also provided the parents an opportunity to discuss any concerns they had about their children directly with the child therapist. Additionally, the check-in period allowed the parents to be informed on the upcoming session and address any related concerns.

TREATMENT MODULES

Module 1: Welcome and Orientation The goals of Module 1 were to introduce the purpose and intent of group, to discuss issues of confidentiality, to establish group rules, and to promote rapport building and group cohesion (e.g., describe unique qualities about themselves and the meaning of being a part of a group). Parents were given basic information about sexual abuse (e.g., prevalence, definition) and the importance of parental support in their children's treatment.

Module 2: Understanding and Recognizing Feelings Module 2 focused on helping the children to identify feelings in themselves and others; to encourage the expression of feelings; to examine possible causes and consequences of feelings; and to understand the range and multidimensionality of feelings. Parents were encouraged to identify how they respond to feelings, learn more appropriate and effective ways to express emotions, and learn ways to help their children express their feelings. Furthermore, parents discussed how their children express their feelings through their behavior, and how at times, the behavior might not seem to match the feeling. Parents were also encouraged to generate and discuss adaptive coping skills (e.g., engage in relaxing activities, seek social support).

Module 3: Learning about Our Bodies Module 3 included learning correct information about developing bodies, sexual development, and gender differences; discussing issues related to dating and decisions about sex; increasing comfort with dialogue in the family about sex-related issues; and improving the children's selfimage and correcting misperceptions about themselves as "damaged goods." The parents' group focused on increasing the parents' ability and comfort in discussing sexuality and other sex-related issues with their children. In addition, a discussion was held about their children's body image at their stage of development and how sexual abuse may affect body image. Specific ways to enhance their children's body image and self-esteem were identified.

Module 4: Standing Up for Your Rights The purpose of Module 4 was to empower the children, to prevent future abuse by appropriately asserting themselves, to identify a plan (e.g., whom to call, what to do) if abuse does happen again, and to enhance support networks. In the parent group, a brief discussion of assertiveness was conducted to help parents distinguish among assertion, aggression, and defiance in their children. Additionally, prevention issues were discussed and parents generated ways to prevent future abuse of their children.

Module 5: My Family Module 5 was intended to identify the strengths within the family, to discuss the effects of disclosure on the family, to address special concerns

when the offender is a family member or close family friend, and to discuss supportive family members and other sources of support. A main goal of this module was to reduce feelings of isolation through identification of family strengths and sources of social support. Additional topics in the parent group included identifying the effects of disclosure on the parents' behavior toward the child and siblings (e.g., overprotectiveness) and how the family (e.g., relationships) may have changed.

Module 6: Sharing What Happened, Part I This module was conducted in two sessions focused on reducing feelings of isolation and stigmatization about the abuse through disclosure to the group. Other topics included dealing with others' reactions to disclosure, identifying feelings related to the abuse and disclosure, and encouraging expression of these feelings. When disclosing their abuse, adolescents were given the option to complete a summary sheet (modified from de Young & Corbin, 1994) with various responses about different aspects of the abuse (e.g., where the abuse took place, how they felt about the abuser before the abuse) that served as a nonthreatening, structured way to disclose their abuse to others. Each group member decided whether she wanted to read her responses off the sheet or share her story in her own way. Therapists focused on normalizing these feelings and addressing any faulty assumptions or cognitive distortions that the children expressed. The parents were informed that the children were discussing difficult material and that they might be upset after the session and even during the upcoming week. A discussion was conducted on possible "regression" (e.g., return of problematic behaviors) that may result from talking about the abuse, and parents discussed ways to problem-solve should this occur. Parents were reminded to be sensitive listeners and to encourage their children's expression of feelings regarding the abuse. They were also reminded about the importance of being supportive of their children and being available to talk with them about these difficult topics.

Module 7: Sharing What Happened, Part II Module 7 was an extension of Module 6, focusing on the offender. The goals included educating the adolescents on why offenders offend, placing the responsibility and blame on the offender, and dealing with issues involved in the offender's relationship to the family. Children were asked to talk about their feelings about their own offender and how their feelings might have changed from before the abuse. Similarly, parents were asked to describe their own feelings about the offender and how their feelings might have changed from preabuse to postabuse. Parents were given support and ideas about how to be sensitive to their children's feelings surrounding the abuse, and how to deal with their own strong reactions of anger or guilt.

Module 8: Understanding My Feelings about What Happened to Me Module 8 was designed to assist the children in understanding their feelings surrounding the abuse and enhance their positive self-image. Feelings that were targeted include stigmatization, guilt, and shame surrounding the abuse. Effects of these feelings on behaviors were discussed. Children were encouraged to channel negative feelings into an appropriate outlet (e.g., be angry at the offender and not at themselves) and to identify positive peer relationships. Parents explored the extent to which they shared the same feelings as their chil-

dren (e.g., guilt, shame, anger) and were encouraged to remain sensitive to their children's feelings. The stages of grief within the context of child sexual abuse (i.e., shock/denial, anger, guilt/depression, bargaining, acceptance) were also discussed.

Module 9: Learning to Cope with My Feelings Module 9 was conducted in two sessions and focused on reducing present feelings of anxiety and depression, exploring the relationship between mood and behavior, and identifying coping skills, such as problem solving and relaxation training. Parents generated a list of coping techniques they found useful when they experience distress. Coping techniques included problem-focused coping (e.g., problem solving, finding more information), tension reduction and relaxation techniques (e.g., engaging in pleasurable activities, exercise), and using social support systems (e.g., friends, family, church, mental health professionals).

Module 10: Summary and Goodbye The goal of Module 10 was to provide a summary of the group experience and to discuss ways of maintaining gains and dealing with separation. Children reviewed content and information from group in a game format. Parents also reviewed the major themes of the group and were asked to focus on the changes they have seen in their children and themselves. If necessary, referrals for additional services were discussed with families. At the end of session, parents and children joined together for a party to celebrate how hard the members worked and to help provide closure for the session.

BEHAVIORAL OBSERVATIONS

Both Gina and Suzy attended all twelve group sessions. Overall, both girls actively and appropriately participated in treatment. At the outset of treatment, both appeared nervous and uncomfortable about participating in treatment activities. Suzy appeared particularly uncomfortable when group discussion focused on self-perceptions since the abuse (Module 3). When she was uncomfortable or nervous, she frequently fidgeted and became restless (e.g., played with her sister's foot, played with clock on a table). She also pulled her hair in front of her face to cover her eyes. She was silent for much of the discussion about bodies and sex, although she was attentive and interested in the discussion and other group members' comments. At the beginning of treatment, Gina was nervous and seemed more comfortable interacting with her sister than with group leaders. As treatment progressed, she appeared more comfortable with the group. At times, she indicated that she felt she was talking too much, although her comments were appropriate in length. She dealt with her discomfort through the use of jokes and laughter; in fact, she frequently spoke in an immature, cartoon-like voice.

Both girls were quiet during the session focusing on disclosure (Module 6). They avoided eye contact, spoke softly, and covered parts of their face (e.g., with their hair or covered their mouth with their hands). Gina expressed that the "sharing what happened" portion of the session was difficult for her, and she remained extremely quiet during the discussion. As treatment progressed, both Gina and Suzy became more comfortable, as evidenced by their increased interaction with the group facilitators and participation in group activities. They were respectful to the other group member, who was visibly uncomfortable and reluctant to participate in treatment activities.

Mr. and Mrs. Kraller were active and interested participants in the parent group. Mr. Kraller missed only one group session due to working overtime. Throughout treatment, the Krallers demonstrated good insight and sensitivity about Gina's and Suzy's behaviors. During the initial group sessions, they expressed concerns to the group about not being the parents of Gina and Suzy; however, this difference did not affect how they were viewed by other group members. In discussing the girls' abuse, both Mr. Kraller and Mrs. Kraller expressed feelings of anger and frustration. Mrs. Kraller felt an additional burden because her sister was the perpetrator. She expressed anger toward her sister for not protecting Gina and Suzy from the sexual abuse. She also expressed guilt for not intervening earlier to help them. The therapists were able to normalize her mixed feelings and assure her that her feelings were common among caregivers of sexually abused youths. Mrs. Kraller's mixed feelings also provided an opportunity to draw parallels to many different feelings sexually abused children might have about their abuse. This approach seemed to enhance her understanding and empathy for the girls. Mr. and Mrs. Kraller's willingness to be emotionally open and honest facilitated their therapeutic progress.

During Module 3, Learning about Our Bodies, Mrs. Kraller disclosed that she had been sexually abused as a child. She was worried about the impact of her abuse history on her ability to be appropriately responsive to the girls' questions about sex-related matters. Her abuse history came up at other points during treatment. For example, she commented that she was able to relate to discussions that paralleled those held in the adolescent group about their feelings related to the abuse and offenders. The potential implications of her abuse history on treatment were addressed. For instance, the therapists validated her experiences and facilitated her understanding about how this experience, just as with her other experiences, may influence how she responded to Gina's and Suzy's feelings and behavior. Again, her acknowledgment of her feelings and questioning the relationship of her experiences to how she managed the girl's behavior was important to the therapeutic process.

WEEKLY ASSESSMENTS

Weekly rating forms were completed by the Kraller family, including Gina and Suzy, to monitor their progress in treatment. These forms were developed specifically for Project SAFE (Futa, 1998) with the intent of being sensitive to ongoing changes over the course of treatment. The child form consisted of statements (e.g., "I feel sad/" "I get along with my friends") and choices of seven responses on a scale from 0 (never) to 6 (all of the time). Gina and Suzy marked the response that best described their feelings and interactions during the previous week. The weekly rating form completed by parents was parallel to the rating form for the children. Mr. and Mrs. Kraller were presented with 15 statements about Gina's and Suzy's behaviors (e.g., "During the past 7 days my child appeared unhappy, sad, or depressed") and were asked to rate each statement on a scale from 1 (always) to 10 (never). During the course of treatment, Mr. Kraller completed these weekly rating forms for Gina and Mrs. Kraller completed them for Suzy. Both parent and child weekly rating forms consisted of a Total Problem Scale and five subscales of child and family functioning: negative mood, problem behavior, problem interactions with oth-

ers, abuse-related emotional and communication problems, and problem family functioning.

Over the course of treatment, Gina reported a moderate decline of total problematic behaviors, with the most substantial change in lower negative moods (e.g., sad and worried). Mr. Kraller's ratings were consistent with Gina's self report over the course of treatment, as he also reported an overall decline in problems. He also described one week (preceding Session 9) when Gina exhibited an increase in her negative moods, problematic interactions with others, abuse-related emotional and communication problems, and difficulties in family functioning. This increase in difficulties may have reflected Gina's anxiety about her anticipated trip to Alabama (to appear in family court to terminate her mother's parental rights). Mr. Kraller also reported that subsequent to Module 6 (i.e., sharing her abuse experiences), Gina was more unwilling to discuss abuse-related topics. However, by the end of treatment, Gina was not displaying any significant difficulties in this domain. Suzy's weekly ratings showed a global trend similar to her sister's, in that she reported a decline in overall problems over the course of treatment. In general, Suzy reported minimal problematic behaviors in all areas of personal and family functioning. Mrs. Kraller also indicated that over the course of treatment, Suzy's overall problematic behaviors decreased.

THERAPIST-CLIENT FACTORS

Treatment with sexually abused children involves important therapist-client factors. One factor is the sex of the therapist. Traditionally, therapists working with sexually abused youth were the same sex as the group members. The rationale for using same-sex therapists was to avoid predominantly female group members from feeling threatened by a male therapist. Project SAFE has used a variety of combinations of cotherapists' sex throughout its development, and clinical experience indicates value in using both male and female therapists. A male and female therapist cofacilitated the group in which Gina and Suzy participated. Presence of a male therapist provided both girls an opportunity to relate to an adult male in a safe and healthy manner. Further, interactions between the male and the female therapist as well as with the girls allowed modeling of healthy relationships (i.e., mutual respect, appropriate boundaries) between men and women. Gina and Suzy appeared to approve of this arrangement, as they reported liking the therapists. The parent group therapists were both male due to therapist availability. The presence of two male therapists in the parents' group may have influenced Mrs. Kraller's reluctance to disclose her abuse history, as this information was shared when the female child therapist checked in at the end of a session.

Although communication and trust within the groups were essential, communication and rapport between the parents and the child therapists were also very important to treatment. A key strategy to facilitating this communication and rapport was for one child therapist to check in with the parent group at the end of each session. While helping facilitate rapport between parents and therapists, this check-in portion incorporated some important therapist-client factors, including trust, engagement, and credibility. First, the check-in period provided the parents with a brief summary of

the children's group without violating the girls' confidentiality. The check-in also allowed Mr. and Mrs. Kraller to express any concerns to the child therapists about the girls' behavior or changes in the family (e.g., upcoming visit to Alabama). Similarly, the child therapists were able to prepare the Krallers for possible behavioral changes in response to session and address any questions or topics that might arise in the coming week (especially around the disclosure sessions). This exchange of information facilitated the Krallers' active participation in treatment and helped them to feel empowered in their parenting role. The Krallers were very attentive during the check-in and also shared relevant information with the child therapists. Finally, the check-in enhanced the credibility of the child therapists and reflected a team approach to treatment. The parallel groups in general and the check-in portion in particular sent a clear message to Mr. and Mrs. Kraller that they were integral to the girls' treatment and progress. This message was important for them to receive, given their expressed concerns about not being Gina's and Suzy's biological parents and their relatively recent involvement in the girls' lives.

COURSE OF TERMINATION

Although consistency in informants is important, issues of practicality were considered. The pretreatment assessments of both Gina's and Suzy's functioning were completed by Mrs. Kraller; however, Mr. Kraller was present for the post treatment and three-month follow-up assessments. Therefore, Mr. Kraller completed measures on Gina and Mrs. Kraller completed them on Suzy. Although different informants were used to assess Gina's adjustment, Mr. and Mrs. Kraller had generally demonstrated consensus in their views about the children's adjustment during the group process.

By the end of treatment, Gina was reporting less depressive and anxious symptomatology, as evidenced by her decreased CDI and RCMAS scores (T-score = 47 and 55, respectively). In addition, she reported fewer feelings of hopelessness (HSC score = 3). Although her feelings of loneliness and social inadequacy did not change after treatment (CLQ score = 47), her SEI scores increased to 78 at the end of treatment, showing improvement in her self-attitude. Mr. Kraller's report on the CBCL was consistent with Gina's self-report, as her Internalizing scale scores fell within the normal range (CBCL Internalizing Scale T-score = 49). Mr. Kraller also reported substantial decreases in Gina's externalizing problems (CBCL Externalizing Scale T-score = 42). Her PTSD scale score on the CITES-R dropped to 20, whereas there were no significant changes in her fears about situations (CFRV score = 56). Another remarkable change occurred with Gina's sexual behavioral problems: At post treatment, these had essentially stopped (CSBI score of 2).

Suzy's self-report scores remained essentially the same. At the end of treatment, her PTSD scale score dropped to 19, reflecting a reduction in posttraumatic symptoms. Mrs. Kraller reported decreases in Suzy's global externalizing behaviors (e.g., aggression), as indicated by the CBCL (Externalizing Scale T-score = 64) and in sexual behavior (CSBI score decreased from 26 to 20).

At the post treatment assessment session, Mrs. Kraller was referred for individual therapy at the clinic where Project SAFE was being held. She was experiencing increased stress related to her family and parenting roles. In addition, she had a history of depression and fibromyalgia, a syndrome distinguished by chronic pain in the muscles, ligaments, tendons, or bursae around joints. She expressed concern that she was at increased risk for experiencing another depressive episode. She recognized

that she might benefit from assistance to deal with the adoption and anticipated stressors associated with integrating her nieces into the household on a permanent basis.

Toward the end of treatment, changes had occurred in the family environment. Both Gina and Suzy began seeing an individual therapist in the community. They were dealing with their mother's forfeit of her parental rights and the loss of this part of their family, as well as adjusting to the adoption and establishing a permanent place within the Kraller family. Interestingly, at the end of treatment, Gina and Suzy began calling Mr. and Mrs. Kraller "Dad" and "Mom." Project SAFE cannot anticipate all of the complex issues that arise in sexual abuse cases, but treatment attempts to provide children with opportunities to process their abuse experiences and learn effective ways to cope with stress and future difficulties.

FOLLOW-UP

After group treatment ended, the Kraller family was seen for a three-month follow-up assessment. Overall, they reported that the family was functioning well. The girls had terminated individual therapy based on their therapists' recommendation that treatment was no longer clinically warranted. Mrs. Kraller remained in individual therapy at the clinic to continue addressing stressors associated with family matters. The adoption of Gina and Suzy was still in process.

At follow-up, Gina and Suzy were reevaluated with the same measures used at earlier time points (i.e., intake and post treatment). Gina's scores from both parent- and child-report measures (e.g., CDI, CBCL) remained essentially unchanged from post treatment, suggesting her treatment gains were maintained at follow-up. Her score on the CFRV decreased from 56 at post treatment to 49 at follow-up, indicating that she was experiencing less fear about situations that many sexually abused children may find distressing. Her SEI score returned to pretreatment level, dropping from 78 at post treatment to 58 at follow-up. This score suggested that she was experiencing a poor self-concept in social, academic, family, and personal areas. Given that her scores on other measures fell within the normal range and remained stable over time, this decrease was unexpected. However, this score may be accounted for by situational factors (e.g., recent termination of her mother's parental rights) rather than a permanent change in her self-attitude. Alternatively, it is possible that the improvement in her self-attitude at the end of treatment was transient, and self-concept may take more than 12 weeks of group treatment to improve. Gina did indicate during treatment that in the future she would like to be able to stop putting herself down. Therefore, her high post treatment SEI score may be a result of situational factors (e.g., felt accomplished at finishing group). Her increase in her SEI score at post treatment may have been more transient and her self-esteem would continue to be bolstered after more successful experiences and a longer period of family stability.

Consistent with results at intake, Suzy and Gina displayed divergent clinical presentations at follow-up. While Gina's posttraumatic stress responses remained essentially unchanged, Suzy showed a continued decrease in scores on the PTSD subscale of the CITES-R (PTSD subscale score = 10). Most notable among the differences between them were Suzy's continued internalizing and externalizing behavioral problems. On the CBCL, Mrs. Kraller reported that Suzy was displaying attention prob-

lems (T-score = 69) and delinquent behavior (T-score = 70). Mrs. Kraller also observed signs of withdrawal, anxiety, and depression in Suzy's behavior. Whereas Gina's sexual behavior problems substantially diminished by follow-up (CSBI score of 24), Suzy's sexual behavior increased (e.g., tries to kiss adults and other children on the mouth). This shift in the girls' problems was also reflected in Mrs. Kraller's verbal description of the girls toward the end of treatment. She described Gina as someone who liked to stay at home, whereas she had more concerns about Suzy's potentially risky behavior (e.g., flirting with boys at a local convenience store).

MANAGED CARE CONSIDERATIONS

Project SAFE is a university-based research and clinical intervention project, and so participating families are not charged for services. Therefore, managed care considerations did not impact the Kraller family's access to Project SAFE, nor did managed care influence decisions about modality of service, length of treatment, or assessment of progress. If treatment for Gina and Suzy were offered in a community setting, however, managed care demands would be important factors. The Project SAFE model has some advantages over traditional outpatient therapy in the managed mental health care environment. The 12-session protocol is consistent with the brief treatment model that Kent and Hersen (2000) identified as the key factor in managed mental health care. The cost efficiency and clinical efficacy of group treatment have led a number of managed mental health care programs to emphasize the group modality over individual therapy (Kent & Hersen, 2000). In addition, the assessment completed prior to initiating treatment offers objective data for a managed care company to use in a preauthorization process. In some cases, assessment results are likely to present a strong rationale for authorizing services. For instance, Gina's intake assessment results suggested clinically significant problems that many companies would value as a justification of the need for treatment. Finally, Project SAFE measures outcomes at treatment completion and three-month follow-up, offering objective support for claims of goal accomplishment.

Despite these positive considerations, implementation of Project SAFE in the managed care environment is likely to share the challenges faced by other child and family treatment programs. For example, the full cost of the Project SAFE assessment procedures is unlikely to be covered in a pretreatment authorization process, even though such thorough assessment is indicated by the increased risk of behavioral and emotional problems associated with child sexual abuse and the diversity of clinical presentations seen among child survivors of abuse (Chaffin, 1998). Many behavioral health care management companies employ independent screeners who use their own assessment procedures, which are typically brief and involve limited interaction with the client. Some psychologists have suggested that part of the function of such screening evaluations is to restrict access to treatment, but there is also evidence that screening may select participants less likely to discontinue treatment early (Howard & Bassos, 2000). Gina and Suzy were both quiet during the discussion of abuse-related issues in Project SAFE, covering their faces, averting their eyes, and generally indicating uneasiness with disclosure. It seems highly probable that they, like many sexual abuse victims and families, would find a preauthorization screening

evaluation by an independent screener threatening. After a medical examination and a child protective/law enforcement investigation, interacting openly with a screener whom they are unlikely to see again may be intimidating.

Authorization of Project SAFE services would not necessarily be assured in all managed mental health care environments. First of all, sexual abuse is not a mental disorder (Chaffin, 1998) and, thus, does not independently suggest that treatment is medically necessary. Although Gina's initial assessment results indicated a treatment need, many of Suzy's responses suggested few problems in functioning, despite her endorsement of symptoms of PTSD on the CITES-R and CFRV. Even if Gina's and Suzy's participation in the adolescent group of Project SAFE was authorized by their managed care company, their aunt's and uncle's participation in the parallel treatment group for nonoffending parents might not be authorized. Frequently, managed care companies reimburse only services provided directly to the identified patient and not to family members, especially when the identified patient is not an active participant in the family intervention.

OVERALL EFFECTIVENESS

Childhood sexual abuse presents a variety of stressful challenges to the victims and their families. Treatment of sexually abused children has received increased attention in research domains and clinical practice as improved incidence studies in recent decades have revealed disturbing information about its occurrence (National Center on Child Abuse and Neglect, 1996; U.S. Department of Health and Human Services, 2000). Group treatment has been recommended as one of the preferred modalities in working with child victims of sexual abuse (e.g., Hansen et al, 1998; Reeker et al, 1997), and the involvement of nonoffending caregivers in treatment has been identified as an integral part of positive treatment outcome for sexually abused children (e.g., Celano et al, 1996; Damon & Waterman, 1986). In addition to its therapeutic benefits, a time-limited, standardized group treatment protocol is a promising option in managed care environments. The present chapter documents a parallel group treatment for Gina and Suzy and their nonoffending caregivers, Mr. and Mrs. Kraller.

In general, the group treatment of Project SAFE was effective in reducing Gina's and Suzy's emotional and behavioral symptoms following disclosure of their sexual abuse experiences, and the Kraller family believed that treatment was helpful and pertinent to their situation. At the end of treatment, Gina reported fewer internalizing (i.e., depressive and anxious symptoms, feelings of hopelessness) and posttraumatic stress symptoms. Mr. Kraller reported similar reductions in Gina's emotional problems as well as noticeable decline in her externalizing and sexual behavioral problems. Although Suzy did not self-report difficulties in most areas of functioning during the intake assessment, there was a decrease in her report of posttraumatic stress symptoms over the course of treatment. Suzy did indicate that she learned not to blame herself for the abuse after completing Project SAFE treatment. Mrs. Kraller also reported that Suzy's externalizing and sexual behavioral problems decreased at the end of treatment. Improvements in functioning generally continued at follow-up and no further treatment for the girls was indicated.

This case study suggests that caregivers' involvement is an important treatment factor from both the children's and caregiver's perspectives. Gina and Suzy said that

one of the best things about Project SAFE was participation of Mr. and Mrs. Kraller in the simultaneous group for nonoffending caregivers. Mrs. Kraller shared similar feelings, stating that she liked how she and the girls were attending the groups simultaneously. Mr. and Mrs. Kraller noted that another strength of the Project SAFE group format was the opportunity to share with other caregivers who had similar experiences. Overall, the supportive treatment empowered them in their new role as caregivers to Gina and Suzy by helping them learn that they could manage their parenting roles and by facilitating communication with the girls as well as each other.

The current case study suggests several directions for future clinical practice and research. The importance of thorough assessment is indicated by the different presentation of symptoms for Gina and Suzy, as well as by the diverse constellation of emotional and behavioral symptoms found in literature on sexually abused children. Future research should use such comprehensive assessment data to improve understanding of symptom profiles associated with sexual abuse and related contextual factors, and the relation of these profiles to treatment approach and response. The complex needs and positive responses to treatment of Gina, Suzy, and Mr. and Mrs. Kraller argue strongly that future research and practice should continue efforts to better understand and improve the adjustment of victims and families following disclosure of sexual abuse. Additionally, it is important to comprehensively evaluate standardized treatment protocols for sexually abused children and their families that may be broadly disseminated and replicated.

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