

Children Traumatized in Sex Rings

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Contents

Foreword by Jon R. Conte, Ph.D. v

1. Overview of Child Sexual Abuse 1
Ann W. Burgess, R.N., D.N.Sc.
Ilsa Lottes, Ph.D.
Results of Recent Studies on Child Sexual Abuse 2
Table 1: Sexual Victimization of Children 3
Figure 1: Cycle of Violence 3
Prevention and Treatment of Child Sexual Abuse 5
Purpose of This Handbook 5
2. Sex-Ring Crimes Against Children 7
Ann W. Burgess, R.N., D.N.Sc.
Solo Sex Rings 7
Transition Sex Rings 9
Syndicated Sex Rings 10
Parental Reaction 12
Table 2: Types of Sex Rings 13
Figure 2: Drawing by a Sex-Ring Victim 14
3. Health Assessment of the Child Victim 15
Christine A. Grant, R.N., Ph.D.
History Taking 15
Interviewing the Child 16
Physical Examination 17
Psychological Evaluation 19
Table 3: Laboratory Tests in the Physical Examination 19
4. Response Patterns of Traumatized Children 21
Ann W. Burgess, R.N., D.N.Sc.
Carol R. Hartman, R.N., D.N.Sc.
Phase 1: Pre-Trauma 21
Phase 2: Trauma Encapsulation 21
Phase 3: Disclosure 22
Phase 4: Post-Trauma Outcome 22
Summary 24
Figure 3: Information Processing of Trauma Model 25

5. Interviewing with the Event Drawing Series 27
Ann W. Burgess, R.N., D.N.Sc.
Wendy A. Wolbert, M.A., A.R.T.
Carol R. Hartman, R.N., D.N.Sc.
Christine A. Grant, R.N., Ph.D.
Event Drawing Series Procedure 27
Event Drawing Series Analysis 29
Use of the Event Drawing Series 30
Post-Court Intervention 34
Reentry to School 35
Figures 4-11: Drawings by Sex-Ring Victims 28-35

 6. Treatment Issues in Child Sexual Trauma 37
Ann W. Burgess, R.N., D.N.Sc.
Carol R. Hartman, R.N., D.N.Sc.
Developmental Periods 37
Intervention for the Child Victim of Sexual Exploitation 38
Intervention Efforts and the Child's Parents 39

 7. Legal Aspects of Sex-Ring Crimes Against Children 41
Linda S. Laibstain, Esq.
Criminal and Civil Cases 41
Table 4: Proving the Case of Child Sexual Exploitation 41
Trying the Civil Case 44
- End Notes 47

Foreword

The latest outcome of the productive careers of Ann Burgess and her colleagues, like the long line of previous manuscripts, helps professionals in many disciplines expand their knowledge about the extent and nature of adult sexual use of children. *Children Traumatized in Sex Rings* provides the reader with concise introductions to key aspects of work with children abused in sex rings including health assessment, behavioral responses of traumatized children, the use of an innovative assessment procedure developed by Dr. Burgess and her colleagues in which children draw a series of pictures, the mental health treatment of children abused in sex rings, and legal issues in these cases.

As this handbook illustrates, sexual abuse of children in rings is not a unitary phenomenon. Rings have different features. An understanding of these features is likely to be important not only in learning how to identify sex rings but, most importantly, in understanding the experience of the children victimized in various kinds of rings and consequently how to treat the children.

There are many aspects of this handbook that will be helpful to professionals who come in contact with or **should** come in contact with the child victims of sex rings. Indeed, the handbook will be of general use to all professionals working with sexually abused children.

Among the most important features of the material, however, is the rare capacity of the authors to communicate to the reader the experience of the abused child. Thanks to the authors, the reader is helped to understand what is traumatic about abuse in sex rings, why disclosure is so difficult, and how such abuse impacts the young child. In a field that is developing as quickly as is child sexual abuse, keeping closely connected to the experience of child victims is a fundamental beacon for professionals. Dr. Burgess and her colleagues have produced such a beacon for us all.

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1. Overview of Child Sexual Abuse

In the decade of the 1980s the sexual exploitation of children was identified as a major public-health and criminal-justice problem. Tremendous strides have been made in shifting the traditional balance of the criminal-justice system in this country from an offender orientation, focusing on the apprehension, prosecution, punishment, and rehabilitation of wrongdoers, to the concerns of victims, witnesses, and their families. Although it is evident that the justice system cannot function without the assistance and cooperation of victims and witnesses, in the past little recognition was given to their rights and little effort was made to assist them in overcoming the frustrations and economic sacrifices involved in criminal proceedings. This attitude began to change in the 1980s with the emergence of a strong national victim- and witness-assistance movement, which was successful in establishing programs to assist victims and witnesses and in increasing the public's awareness of victims' rights. At the national level, President Ronald Reagan appointed a Task Force on Victims of Crime on April 23, 1982, and the U.S. Congress enacted the Federal Victim and Witness Protection Act of 1982.¹

In studying the experiences of victims of crime, the President's Task Force on Victims of Crime discovered that the causes of—and solutions to—family violence are often much more complex than are those related to crimes committed by unknown persons. Therefore, the Task Force recommended that a separate study be undertaken to give this social problem individual consideration. The Attorney General's Task Force on Family Violence was appointed in September 1983.

Important policy recommendations were made in the report of the Task Force on Family Violence. Recommendations related to child sexual victimization called for judges to consider treating incest and molestation as serious criminal offenses and adopt special court rules and procedures for child victims such as permitting hearsay evidence at preliminary hearings, appointing a special advocate for children, accepting the presumption that children are competent to testify, allowing children's trial testimony to be presented on videotape with agreement of counsel, advocating more flexible courtroom settings and procedures, and protecting the child's privacy in the press. The Task Force recommendations also called for development of more effective prosecution techniques for cases of child sexual assault in order to minimize the additional trauma for the victim created by court procedures; development of law-enforcement techniques to investigate sex crimes against young victims; and determination of how child molesters select victims, what strategies they use, and in what circumstances children are at most risk of assault.

In October 1984, a national symposium on child molestation was sponsored by the U.S. Department of Justice's Office of Justice Assistance, Research, and Statistics.² This gathering of dedicated leaders had the two specific goals of sharing experiences and ideas in order to produce better strategies for addressing child sexual abuse throughout the country and conveying to professionals and the public as a whole that child molestation is a serious criminal offense and will be treated as such by the highest criminal-justice agency in the country.

In one of the symposium presentations, FBI Supervisory Special Agent Kenneth V. Lanning outlined three major areas of concern regarding child sexual victimization. The first area, **sexual abuse of children**, involves sexual activity between an adult and a child. This activity can involve nonviolent sexual abuse, in which the child is pressured into sexual acts through attention, affection, and bribery. The cooperation of the child is gained through seduction techniques. On the other hand, the sexual activity can be violent, as when the child is physically forced to engage in sexual activity. A certain amount of this sexual-abuse activity involves incestuous relationships. The second major area of child sexual victimization is the **sexual exploitation of children**, which includes **child pornography** (the permanent record of sexual

abuse of a child) and **child sex rings** (involvement of multiple children in sexual abuse with or without commercial gain or exchange of money). The third major area, **missing children**, includes runaways and the abduction of children by parents or nonfamily members.³ These children can be vulnerable to sexual exploitation and assault. (See Table 1, page 3.)

Child sexual victimization can begin with the **cycle of violence** in a family. The child experiences physical or sexual abuse within the family which can lead to missing-child episodes and further exploitation and abuse of the child. The abused child can then mature into an adult who abuses or exploits children. (See Figure 1, page 3.)

Concurrent with the efforts of the U.S. Department of Justice, C. Everett Koop, the Surgeon General of the U.S. Public Health Service, planned and sponsored a workshop to study violence as a public-health issue. After releasing the *Final Report of the Workshop on Violence and Public Health*, Dr. Koop encouraged smaller conferences in major cities on the subject, emphasizing that the health professions use an interdisciplinary approach to solving the problem of interpersonal violence.⁴

Results of Recent Studies on Child Sexual Abuse

The sexual abuse of children is not a rare event. Law-enforcement professionals, social workers, clinicians, nurses, and survey researchers have amassed considerable evidence documenting both the common occurrence of child sexual abuse and serious disorders associated with its victims. Estimates of yearly rates of child sexual-abuse cases range from 50,000 to more than 1 million.⁵ In a review of 19 studies of the prevalence of child sexual abuse, rates varied from 6 percent to 62 percent for females and from 3 percent to 31 percent for males.⁶ Both researchers and clinicians in the child-abuse field agree that the majority of child sexual-abuse cases remain undetected.⁷

When exploitation is not recognized or acknowledged, children suffer from lack of special help or treatment. A related problem is that undetected child abusers will continue to molest children. In a study of 200 non-incarcerated child molesters, it was found that child molesters involve themselves not only in child molestations but also in various other deviant sexual behaviors. Molesters with the greatest incidence of molestation are those who molest boys. Offenders who commit incest and have never been involved with other sex crimes are rare; most are also involved with children outside their homes.⁸ (**Note:** Both men and women can be offenders but, as men are most commonly reported, this handbook uses the masculine pronoun when speaking about offenders.)

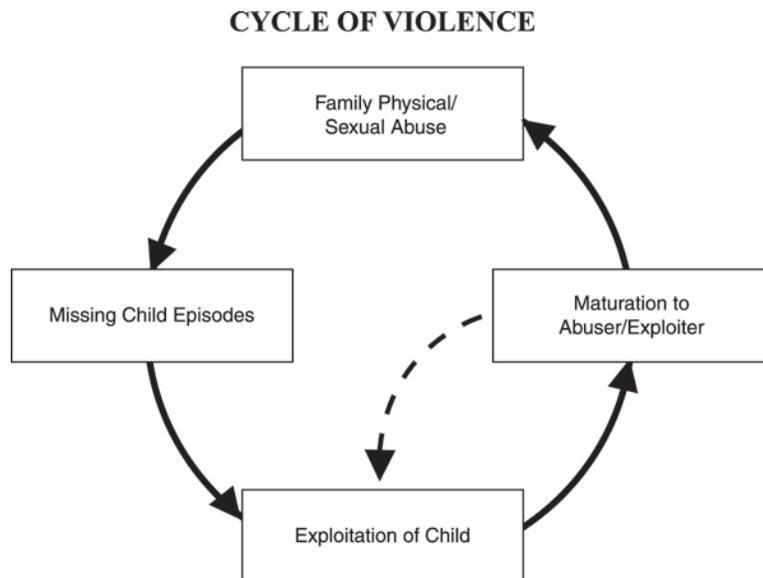
Effects on the Child Victim The destructive effects of child sexual abuse can create a number of long-term problems for the child victim. Both controlled⁹ and uncontrolled¹⁰ retrospective studies of sexually exploited children indicate a variety of long-term emotional, behavioral, social, and sexual problems. Symptoms include physical problems such as headaches, stomach aches, and sleeping and eating disorders; psychological reactions of fear and anxiety, depression, mood changes, guilt, and shame; social problems such as school truancy, declining grades, and fighting; and sexual problems such as heightened sexual activity, compulsive masturbation, exhibitionism, and preoccupation with sex and nudity. Running away from home, adolescent prostitution, suicide attempts, substance abuse, gender-identity confusion, sexual dysfunction, and socially deviant behaviors have also been identified as possible consequences of untreated childhood sexual abuse.¹¹

Table 1
Sexual Victimization of Children

I Sexually Abused Children	II Sexually Exploited Children	III Missing Children
<p>A. Victims</p> <ol style="list-style-type: none"> 1. Extent and effect <ol style="list-style-type: none"> (a) girls/boys (b) age 2. Indicators 3. Investigative difficulties <p>B. Victim/Offender</p> <ol style="list-style-type: none"> 1. Relationship <ol style="list-style-type: none"> (a) stranger (b) relative (c) acquaintance 2. Violence 3. Seduction process <p>C. Offenders</p> <ol style="list-style-type: none"> 1. Situational <ol style="list-style-type: none"> (a) regressed (b) morally indiscriminate (c) sexually indiscriminate (d) inadequate 2. Preferential (pedophile) <ol style="list-style-type: none"> (a) seduction (b) introvert (c) sadistic 	<p>A. Pornography</p> <ol style="list-style-type: none"> 1. Commercial/homemade 2. Technical/simulated 3. Child erotica <ol style="list-style-type: none"> (a) evaluation 4. Collection <ol style="list-style-type: none"> (a) fantasy (b) validation (c) souvenir 5. Use of computers <p>B. Sex Rings</p> <ol style="list-style-type: none"> 1. Ongoing access 2. Offender-victim bond 3. Types <ol style="list-style-type: none"> (a) historical (b) multidimensional <p>C. Prostitution</p> <ol style="list-style-type: none"> 1. Runaways 2. Gender and age 3. Life span 4. Customers <ol style="list-style-type: none"> (a) situational (b) preferential 	<p>A. Runaways (Homeless)</p> <ol style="list-style-type: none"> 1. Thrownaway/lured away 2. From abuse (sexual?) 3. To exploitation (sexual?) <p>B. Lost/Injured</p> <p>C. Parental Abduction</p> <ol style="list-style-type: none"> 1. Mother/father (?) 2. Good/bad parent (?) 3. Unlawful Flight to Avoid Prosecution <p>D. Abduction</p> <ol style="list-style-type: none"> 1. Nontraditional 2. Profit 3. Ransom 4. Sexual <ol style="list-style-type: none"> (a) keep (b) return (c) discard (d) kill 5. Child killer <ol style="list-style-type: none"> (a) organized (b) disorganized (c) parent 6. Miscellaneous criminal

Table by Kenneth V. Lanning, Supervisory Special Agent, Federal Bureau of Investigation.

Figure 1



High-Risk Groups Given this clinical evidence, what are the sociological conditions of child sexual abuse that demand our attention? One of our most pressing tasks, argue researchers David Finkelhor and Larry Baron, is to identify the group of children who may be at high risk. Such an identification will help focus prevention efforts and determine the causes of sexual abuse. Toward that goal, Finkelhor and Baron carefully reviewed a number of surveys concerning a given person's relative risk of experiencing sexual abuse during childhood. Interestingly, the surveys did not find an association between child sexual abuse and socioeconomic status or race. Several other conditions, however, have been associated consistently with higher risks of abuse. These conditions are

- When a child lives without one of the biological parents
- When the mother is unavailable to the child either as a result of employment outside the home, disability, or illness
- When the child reports that the parents' marriage is unhappy or conflictual
- When the child reports having a poor relationship with the parents or being subject to extremely punitive discipline or child abuse
- When the child reports having a stepfather¹²

Offender Studies Any study of child sexual abuse is incomplete without thorough research on offenders. One research area suggests that responsibility for abuse lies with offenders.¹³ Exploring this perspective, Finkelhor suggests that four conditions must exist for sexual abuse to occur. First, there must be an offender with the motivation to abuse sexually. Second, the offender must overcome internal inhibitions against abuse. Third, the offender must overcome external obstacles to abuse. Fourth, the offender must overcome resistance by the child.¹⁴

Sexual Abuse of Boys Although virtually all studies have found higher abuse rates for girls, a substantial number of boys are sexually abused. The average rates of child sexual abuse from eight random community surveys indicated that about 70 percent of the victims were girls and 30 percent were boys.¹⁵ In a study of 148 child molesters, 51 percent selected only girls as victims, 28 percent selected only boys, and 21 percent selected both boys and girls as victims.¹⁶ Researchers and clinicians believe, however, that boys are less likely to report sexual abuse than girls. Possible reasons for not reporting are that boys are taught to be self-reliant and keep complaints of injuries to themselves; the stigma of engaging in homosexual activities prevents boys from reporting sexual abuse by men; since boys are socialized to seek sexual experiences with females, they are inhibited in reporting unwanted sexual experiences initiated by females; boys may fear they would lose their access to greater independence and unsupervised activities if they reported their sexual victimization experiences; since boys are socialized to enjoy sexual interactions, their victimization clashes with their perceptions of masculinity and they are discouraged from reporting their sexual abuse; and the media have focused their attention primarily on the abuse and vulnerability of girls rather than boys.¹⁷

Recent studies of special populations indicate that the sexual abuse of boys is not uncommon. In a sample of nearly 3,000 male college students, 216 reported a sexual experience before the age of 14 that was classified as abusive by the researchers.¹⁸ A study of 41 incarcerated serial rapists revealed that 56 percent had experienced sexual abuse as children;¹⁹ and a study of incarcerated child molesters revealed that more than 50 percent had childhood histories of abuse.²⁰ In a Canadian sample of 89 male runaways seeking shelter, 38 percent reported having been sexually abused.²¹

Studies have also identified special characteristics of molesters of boys. Compared with molesters of girls, abusers of boys are more likely to continue molestation activities, start their offenses at an earlier age,

refrain from sexual activity with adults, and confine their sexual interests to male children.²² Thus, research, prevention, and treatment programs must concentrate on the sexual abuse of boys as well as girls.

Prevention and Treatment of Child Sexual Abuse

The number of reported cases of child sexual abuse is increasing. This prompts questions as to whether this increase is due to better reporting by victims, a more responsive criminal-justice system, or increased sexual deviance. To address the causes of this rise in reported cases, we need reliable information about the nature of child sexual abuse, its consequences, and what steps we can take to treat the victims of sexual abuse and control the abusive activities of offenders. The public must take a strong stand against sexual exploitation, and therapists must properly evaluate victims and follow up to ensure that the victims have the resources and support to rebuild their lives. At the same time, offenders must be appropriately monitored.

The following background assumptions were made regarding prevention efforts for child sexual abuse at the Surgeon General's Workshop on Violence and Public Health.²³ First, child sexual abuse is everyone's business. The physical health, mental health, and economic costs associated with abuse affect all people. Second, prevention should be directed both at the public and groups at high risk of sexual abuse. Third, primary prevention should be designed to stop abusive behavior before it occurs; secondary prevention should be concerned with early identification and treatment of the victims of abuse. Fourth, culturally sensitive approaches to child sexual abuse must be integrated into all recommendations. Fifth, society must realistically confront the phenomenon of child sexual abuse. Implicit in these recommendations is the understanding that our foremost priority must be the protection of the child.

Purpose of This Handbook

Children Traumatized in Sex Rings describes a type of child sexual abuse that involves both boys and girls as victims. The crimes involve larger numbers of victims than single offender/single victim crimes. The offender is usually a trusted adult who is not a family member and who abuses children in small groups—thus, the label of **sex-ring crime**.

We are just beginning to fully understand the extent of the trauma that sexually abused children experience and way they think about and respond to the experience. Historically the approach to the problem of child sexual abuse has been to assess the abuse and its effects on the child, and then to offer solutions oriented toward legal considerations and interventions within the physical-health, mental-health, and social-service systems. This approach offers only a partial solution to the problems of safety and protection of the child. A comprehensive solution to the problem involves learning ways to influence offenders to stop their behaviors. Controlling offenders involves both the medical professions—through treatment—and the criminal-justice system.

The following chapters present a model for understanding the meaning of the traumatic event to the abused child, provide guidelines for assessing the child's physical and mental health, outline legal approaches, and suggest an intervention for assessment and treatment of both the child and family.

Note: For the purposes of this handbook, we use the layman's definition of **pedophile**: "one who has a sexual perversion in which children are the preferred sexual object." A **child molester** has been defined as "a significantly older individual who engages in any type of sexual activity with individuals legally defined as children." The National Center for Missing & Exploited Children, however, suggests the use of the term **preferred child molester** in lieu of **pedophile**. See Kenneth V. Lanning, *Child Molesters: A Behavioral Analysis*, 3rd ed. (Alexandria, Virginia: National Center for Missing & Exploited Children, 1992).

2. Sex-Ring Crimes Against Children

The study of the sexual victimization of children has previously focused on incest or family-member (intra-familial) abuse of female children. Recently, reports have indicated a growing number of abusers who are outside the family (extra-familial) and who abuse both males and females. Furthermore, reports from both the United States²⁴ and the United Kingdom²⁵ emphasize the need for health professionals and law enforcement to increase their efforts concerning sex-ring cases involving multiple victims of the same offender. A study reporting on 11 child sex rings throughout the United States included 14 adult male perpetrators and 84 identified child victims ages 8 to 15. A United Kingdom study reported details of 11 child sex rings in which there were 14 adult male perpetrators and 175 child victims ages 6 to 15. These studies indicate a need for increased attention to the child sex-ring problem.

Sex-ring crime is a term describing sexual victimization in which there are one or more adult offenders and several children who are aware of each other's participation. There are three different types of child sex rings. The solo sex ring involves one adult perpetrator and multiple children.²⁶ There is no exchange of photographs, nor are there sexual activities with other adults. By contrast, a syndicated ring involves multiple adults, multiple child victims, and a wide range of exchange items including child pornography and sexual activities. At a level between these two types of rings is the transition ring in which the children and pornography are exchanged between adults, and often money changes hands.²⁷ These three types of rings are further described in this chapter with actual case illustrations. (*See also* Table 2, page 13.)

Solo Sex Rings

Solo sex rings are characterized by the involvement of multiple children in sexual activities with one adult, usually male, who recruits the victims into his illegal behavior by legitimate means. This offender can be assessed by his methods for access to and sexual entrapment of the children, his control of the children, his maintenance of the isolation and secrecy of the sexual activity, and the particulars of ring activities. The events surrounding disclosure of the ring and the victims' physical and psychological symptoms are also important elements of the ring. Victims can be both male and female, and their ages can range from infancy to adolescence. Victims are found in nursery schools, babysitting and daycare services, youth groups, and camps.

Access and Entrapment The sexual abuse of a child is a consciously planned, premeditated behavior. The adult is usually someone known both to the child and parent and who has ready access to the child. The offender has a relationship of dominance over the child, exploiting the child's vulnerability to suggestion and authority. After gaining access to the child, the adult engages the child in the illicit activity through the abuse of adult power as well as the misrepresentation of moral standards.

In our first case study, Case 1, the adult offender was an authority figure held in high esteem because of his position as a youth-group leader and as a result of his community service. So highly regarded was he that parents strongly encouraged their sons to stay in the youth group with this leader even when faced with their children's resistance to attending group meetings.

Control, Isolation, and Secrecy In order to continue sexual activity and maintain access to the children, the offender needs to control the children in some way. The children are manipulated and coerced into keeping the abuse secret, compelled to continue in the abusive relationship, and discouraged from acting against the abuser. The abuser selects strategies particular to each child—isolating them from those who

could help—and attempts to place the burden of guilt and blame for the abuse on the child. In Case 1, the boys were introduced to the ring at ages 8 to 12. The ring was in operation for at least 12 years, as noted from testimony at the criminal trial.

When an offender is successful in abusing his victim, he must try to conceal his deviate behavior from others. More likely than not, he will try to pledge the victim to secrecy in several ways. Secrecy strengthens the adult's power and control over the child, isolates the child from others, and helps perpetuate the sexual activity. It is important to understand that this technique is usually successful: Some children never tell anyone about sexual abuse. There are many reasons why the abuse is kept secret. The child is afraid of encountering disbelief, facing blame for the activity, or suffering punishment for disclosure. The child may fear that the adult offender will carry out his threats, or the child may even wish to protect the abuser.

In Case 1 the boys were warned not to tell anyone and told, "This is our secret." It was clearly implied that telling would be disastrous and told, "We'll both be in big trouble." For many of the boys, this message implied that they too were responsible for the sexual activity, and therefore they were highly susceptible to feelings of guilt when the ring was disclosed. The power of the adult was tested when one boy told a parent about the abuse. Authorities who were notified by the parents discouraged any criminal action saying, "It is your boy's word against the word of an esteemed adult."

There were several ways that the offender controlled the children and assured the secrecy of the ring activity. First, the offender used physical sensation and excitement to bind the boys to the ring. The fact that this excitement involved homosexual activity, moreover, made the boys fearful of disclosing the abuse. Second, the abuser used threats of retaliation. The boys believed they would be held accountable for the ring activities if they revealed their behavior, since part of the "membership" process involved recruiting younger boys into the ring and having sex with them. Fear and intimidation were other methods for maintaining secrecy. Several of the children who were abused, threatened, and controlled by older boys felt they were being watched and would be beaten if they told. Moreover, the boys were introduced into other adult activities (cigarette smoking and liquor consumption) that could be used as blackmail. They were also photographed in the nude performing sexual acts and using alcohol and cigarettes, and these photographs were used as blackmail.

Sex-Ring Activities There is a wide range of sexual behaviors that occur between adults and children in combination with psychological pressure or physical force. There may be a slow progression of advancing sexual acts characteristic of sexual seduction, or the acts may be forceful and sudden (rape).

In Case 1 the sexual abuse is best characterized as rape. Several of the boys independently reported their first experience with the adult. The offender would take the boy into the bedroom where the boy would see nude boys engaged in sex, reading pornographic magazines, and using vibrators to stimulate themselves sexually. As the boy watched he was encouraged by the other boys to engage in the activity. The adult then quickly and directly performed fellatio on the boy who, caught unaware by the attack, become immobilized, frightened, and confused.

Disclosure of the Ring Disclosure of child sexual abuse is either accidental or purposeful. In accidental disclosure a third party may note symptoms of the abuse in the child. In purposeful disclosure a child consciously decides to tell a parent or trusted person about the abuse. More often than not, the first attempts at disclosure involve only certain aspects of the activity—not the full story. When disclosure is made, the child must deal with the reactions of parents, friends, and authorities to the discovery of the abuse. It is critically important that these trusted persons believe the child, understand the confusion and fear that pervade the experience, and take protective action on behalf of the child.

Disclosure of the child sex ring in Case 1 occurred gradually. One of the boys told a parent, and police were notified; yet the boy was still not believed. Subsequently, another parent discovered that his boy had learned about sex from his youth-group leader. Gradually, parents began to uncover the ring activities, and authorities could no longer ignore the complaints. Investigation of the allegations led to the arrest of the abuser and a second adult.

The boys were terrified of disclosure. Part of the disclosure phase in Case 1 was the immediate reaction of the boys to the fact that other people suspected or knew of the ring activity. They had a wide range of responses including denial, withdrawal, physical symptoms, and risk-taking behaviors. When some of the boys were interviewed by detectives, they initially denied any knowledge of or participation in the sex ring.

There were signs, however, that some boys had tried to break away from the ring. Some of the boys acted up at home (avoiding chores or homework, fighting, and arguing), and for punishment parents restricted their youth-group participation. Other boys would attend large group activities but would not interact individually with the leader.

Symptoms of Child Sexual Abuse There were clear signs of the severe distress experienced by the boys in Case 1 both before and after public disclosure of the ring through the arrest of the leader. The boys and their parents described physical symptoms such as stomach aches, headaches, and changes in appetite. Psychological symptoms included difficulty sleeping, nightmares, flashbacks, mood swings, phobias, and depression. Social symptoms were noted in an avoidance of school, declining school grades, increased peer fighting, running away, and fear of adult males. Behavioral symptoms included abusive and sexualized language, withdrawal, suicide attempts, sexual activity with other boys as well as with animals and younger children, antisocial acts such as lying and stealing, and sexually aggressive behaviors. On follow-up, the Event Drawing Series (*see* Chapter 5) revealed consistent themes of death and foreboding thoughts of the future (*see* Figure 2, page 14). The above symptoms have been noted in male victims where there is combined sex-ring abuse, pornography, and an extended length of time in the ring.²⁸

Transition Sex Rings

In the **transition sex ring**, multiple adults are involved sexually with children, and the victims are usually adolescents. The children are tested for roles as prostitutes and thus are at great risk of advancing to the next level of sex ring, the syndicated ring. The organizational aspects of the syndicated ring are absent in transition sex rings.

It is speculated that children enter transition sex rings by one of several routes. Some children may be initiated into solo sex rings by the type of pedophile who has a sexual interest in and preference for children who are younger than 13 years of age. These types of pedophiles, who lose sexual interest in the child as he or she approaches puberty, may try, through an underground network, to move the vulnerable child into sexual activity with those types of pedophiles with sexual preferences for pubescent youth. The children may be incest victims who have run away from home and need a peer group for identity and economic support, or they may be abused children who come from families in which parental bonding has been absent and multiple neglect and abuse are present. Finally, victims may be missing children who have been kidnapped and forced into prostitution.

It is difficult to identify clearly this type of ring because its boundaries are undefined and the child may be propelled quite quickly into prostitution. Typically, the adults in these transition rings do not interact sexually with each other but, instead, have parallel sexual interests and involvements with the adolescents who exchange sex with adults for money as well as for attention or material goods.

Progression from a Solo Sex Ring Case 2, concerning a male prostitution ring, illustrates the progression from the solo sex ring to the transition ring. In the apartment of a man who had an extensive history of convictions for child molesting, investigators found numerous photographs of naked youths as well as pornographic films. Sixty-three of the depicted youths were located and interviewed, and 13 agreed to testify before a grand jury. It was believed that the ring had been in operation for at least five years. From this testimony, additional men (many with professional and business credentials) were indicted on counts of rape and abuse of a child, indecent assault, sodomy, and unnatural acts.

At the trial of the first defendant, testimony from four prosecution witnesses revealed the linkages between the two types of rings. According to news reports, the first witness, a man who was serving a 15- to 25-year term after pleading guilty to charges related to a solo sex ring, admitted to having sexual relations with boys as young as 10 during the years he had rented his apartment. He testified that he could be considered a “master male pimp” and that he became involved in the sex-for-hire operation after meeting one of the other defendants. He said that initially no money was involved, but after a few months expenses increased. As a result, the men were charged a fee, and the boys were given \$5 to \$10 for sexual services.

Newspapers reported that another prosecution witness admitted visiting the apartment more than 40 to 50 times over a five-year period. He denied being a partner in a scheme to provide boys for hire but admitted taking friends, who paid to have sex with the boys, with him to the apartment. A third witness, a 17-year-old boy, testified to being introduced into homosexual acts by the first witness, who had told the boys they could make all the money they wanted. “All we had to do was lay there and let them do what they wanted to us,” he said.

The fourth witness testified that at age 12 he had met the third witness through friends. He received gifts of clothes and money for going to the adult offender’s apartment. While there, he would drink beer, smoke pot, and watch stag movies. He brought his younger brother to the apartment, and they both had sex with the man. At age 14, he was charging \$10 for oral sex and \$20 for anal sex. The jury, sequestered for the 19-day trial, deliberated three days before reaching a verdict of guilty.

Syndicated Sex Rings

Syndicated sex rings are well-structured organizations involving the recruitment of children, the production of pornography, the delivery of direct sexual services, and the establishment of an extensive network of customers. The solo or transition ring may, depending on various factors, constitute different stages in the evolution of a syndicated child sex ring, or they may represent only a loosely organized association of adults exploiting small groups of children. The age of victims that might be involved in a syndicated ring generally ranges from 11 to 16. The victims may also be transported across state lines.

Organization The organized components of the syndicated ring include the items of trade, the circulation methods, the suppliers and distributors, the self-regulating mechanism, the system of trades, and the profit motive.

Items of trade include the children, photographs, films, and tapes. The degree of sexual explicitness in the images may vary, as may the sexual activities. For example, photographs can range from supposedly innocent poses of children in brief attire taken at public locations to carefully directed movies portraying child subjects in graphic sexual activities. In the films the child is often following cues provided by someone standing off camera. Also, in audiotapes the children may be heard conversing with age-appropriate laughter and noise as well as using language that is highly sexual and suggestive of explicit behaviors.

Various **circulation methods** for child pornography include the mails, audiotapes, videotapes, CB radio, telephones, beepers, and computers. The mail is a primary mechanism for the circulation of child pornography and often facilitates a laundering process for money transactions. Buyers send their requests to another country; the mail, received by the overseas forwarding agent, is opened, and cash or checks are placed in a foreign bank account; and the order is mailed back under a different cover to the United States. This procedure ensures that the subscriber is unaware of the operation's origin and inhibits law-enforcement investigation.

Suppliers of child pornography include pedophiles, parental figures, and professional distributors. Pedophiles with the economic resources may organize their own group to have access to children and cover their illegal intentions, or they may work within the framework of existing youth organizations.

Parental figures who supply children for pornographic and prostitution purposes include natural parents, foster parents, and group-home workers. The supplier may operate a foster home, as in a case of a self-proclaimed clergyman who, by his own estimates, sold approximately 200,000 photographs per year with an income from this operation in excess of \$60,000. The technique he used was to force older boys to engage younger boys in sex acts. If the child did not submit, he was beaten and abused by the older youth. After the child submitted, he was photographed in the sexual acts, and the man would then use the boys for his own sexual purposes.

Professional **distributors** include pornographers with access to an illegal photographer operating a clandestine film laboratory. While these photo laboratories can provide services for many illegal operations, they also present some problems to the professional pornographer, who may be purchasing photographs or films already released to someone else. The professional procurers who supply children also provide photographs and films through wholesale distributors and adult bookstores.

Another source of professional distribution is the photographic processing facility. A photographic development laboratory often has a storefront business that handles legitimate orders, while its mail-order business is advertised in magazines. One such facility had a mail-order division that promised confidential photo development through its advertisements in "adult" magazines. These advertisements were also found in periodicals catering to readers with special sexual interests.

Syndicated child pornography operations do not have recourse to law-enforcement or civil remedies for settling disputes that arise in matters of theft or unauthorized duplication of photographs. Thus, a **self-regulating mechanism** develops for the expulsion of members guilty of actions deemed unfair or against the best interests of the syndicate. Subscribers to classified ads are screened carefully through the grade of paper, typewriter keys, and number of letters as well as by the sincerity and insistence of their correspondence. Letters are kept as a security measure. Disputes between syndicate members can become extremely bitter, and fellow members are urged to chastise the guilty party through correspondence. Members of the syndicates remain alert to law-enforcement efforts against sex rings in general or their syndicate in particular.

One rule in trading pornography is that members of the syndicate assist each other in finding items of interest to other collectors. Through a **system of trades**, photographers held by syndicate members are evaluated and exchanged.

The **profit motive** of child pornographers appears to be a highly individual one. Some collectors trade items only for their personal use, and others trade items for commercial as well as personal use. To some, the financial lure is great. Frequently collectors sell duplicate copies of items in their collections thereby increasing their income to purchase additional photographs from other sources.

Essential elements to the operation of syndicated rings are time, storage space, dual identity, shared sexual preference for children, and child-erotica and pornography collections. Time is needed for the syndicate member to develop numerous contacts and extensive child-erotica and pornography collections.

Syndicate members need large blocks of time for keeping records and maintaining correspondence with the 20 to 30 other members who write on a constant basis.

Storage space is needed for the correspondence and child-erotica and pornography collections. People living alone devote large amounts of residential space to housing their collections. Highly sophisticated record-keeping and data-retrieval systems are often discovered, including file cabinets containing cards cross-indexed to secondary files, which hold information about the identity of the contributor.

Pornography collectors and syndicate members often lead double lives. The threat of discovery encourages the use of dual identities, fictitious names, and post office boxes. Usually only first names or false names are used in correspondence with other syndicate members.

There is a strong need for collectors of child pornography to express their shared sexual preference for children and relate their sexual activities to other sympathetic adults. This sense of camaraderie and mutual secret interest has been noted in other deviate behaviors.

Collectors are also obsessed with increasing the size of their **pornography and erotica collections**. No matter how large or sophisticated the collection, the collector always wants additional photographs. It appears that until collectors are personally threatened by discovery, they will maintain and increase their collections by whatever means available. When they are discovered, the loss of the collection is experienced psychologically as a traumatic event.

Development of a Syndicated Sex Ring Case 3 illustrates the development of a syndicated sex ring. More than 300 girls had been enticed, over a seven-year period, into posing for photographs on the promise that they would become movie stars. The modeling, however, soon turned into nude photo sessions.

A 55-year-old businessman would meet young girls in fast-food restaurants and ask them to come, with their mothers, for a modeling session. The mothers would accompany the girls; but gradually the girls would become accustomed to the modeling session, and the mothers would stop attending. Older girls would be present, and, after being given drugs, the younger girls would pose nude.

Police investigation uncovered boxes of photographs featuring children in sexual positions as well as a diary in which the offender detailed his sexual activity with the girls and customers. Among the six additional men indicted were an interior decorator, a gift-store proprietor, a restaurant owner, a lawyer, and a business manager.

The defendant claimed he was the victim of a discriminatory prosecutor whose reelection campaign was sagging. The trial had a change of venue, and the defendant eventually was sentenced to life in prison. One year later, a district-court judge suspended the sentence, credited the offender with the seven months he had served, and placed him on five years' probation.

Parental Reaction

There is a wide variety of parental and family reactions to the news of disclosure of any type of sex ring involving their children. Anger, rage, and anxiety are the usual reactions. Parents also respond by rationalizing, "It was better it was a group"; avoiding the facts by saying, "I didn't want to know the details"; and minimizing the activity by saying, "I'm thankful it wasn't forced on the kids." If the child denies any involvement to law enforcement, parents may reiterate the denial and perhaps conceal information. Parents involved in Case 1, who had reported the abuse to authorities, were angry and frustrated when no action was taken by saying, "Police were afraid of this man. He was an important community figure. Our kids didn't count."

Families respond to their overwhelming feelings about the sex ring by blaming someone—usually the offender, the child, or themselves. Many families react with strong negative feelings toward the offenders

saying, “I have no sympathy for him. He knew what he was doing. He conned his way with the kids.” Parents may blame their child indirectly, especially if the child has recruited a sibling into the ring activities. Parents also blame their children for the company kept by the children saying, “I don’t like to pick friends for my son, but when I read who else was involved, I got very angry. He knows how I feel about that one boy.”

Some parents, on the other hand, acknowledge responsibility for their child’s involvement by blaming themselves for not supervising their child closely enough or following through on their suspicions about the offender saying, “I did think it was unusual that he spent so much time with the boys.” Parents who had trusted the offender were angered by the fact they had been conned saying, “I trusted him. He was their youth-group leader.” News of the sexual exploitation of one’s child can also trigger past memories of the possible abuse or trauma in the parents’ own lives, which adds further stress to the situation. One father illustrated this by saying, “I knew this happened to my boy because it had happened to me at his age.”

Table 2
Types of Sex Rings

Solo Sex Ring	Transition Sex Ring	Syndicated Sex Ring
One adult offender, usually male Multiple child victims, from infancy to adolescence No exchange items	Multiple adult offenders Multiple child victims, usually adolescents Abducted children Runaways Victims of family violence, abuse, and sexual exploitation Often precedes syndicated sex ring or sex-for-hire operation (child prostitution)	Multiple adult offenders Multiple child victims, ages 11 to 16 Exchange items (child pornography and erotica) Highly structured organization Items of trade Circulation methods Suppliers and distributors Self-regulating mechanism System of trades Profit motive

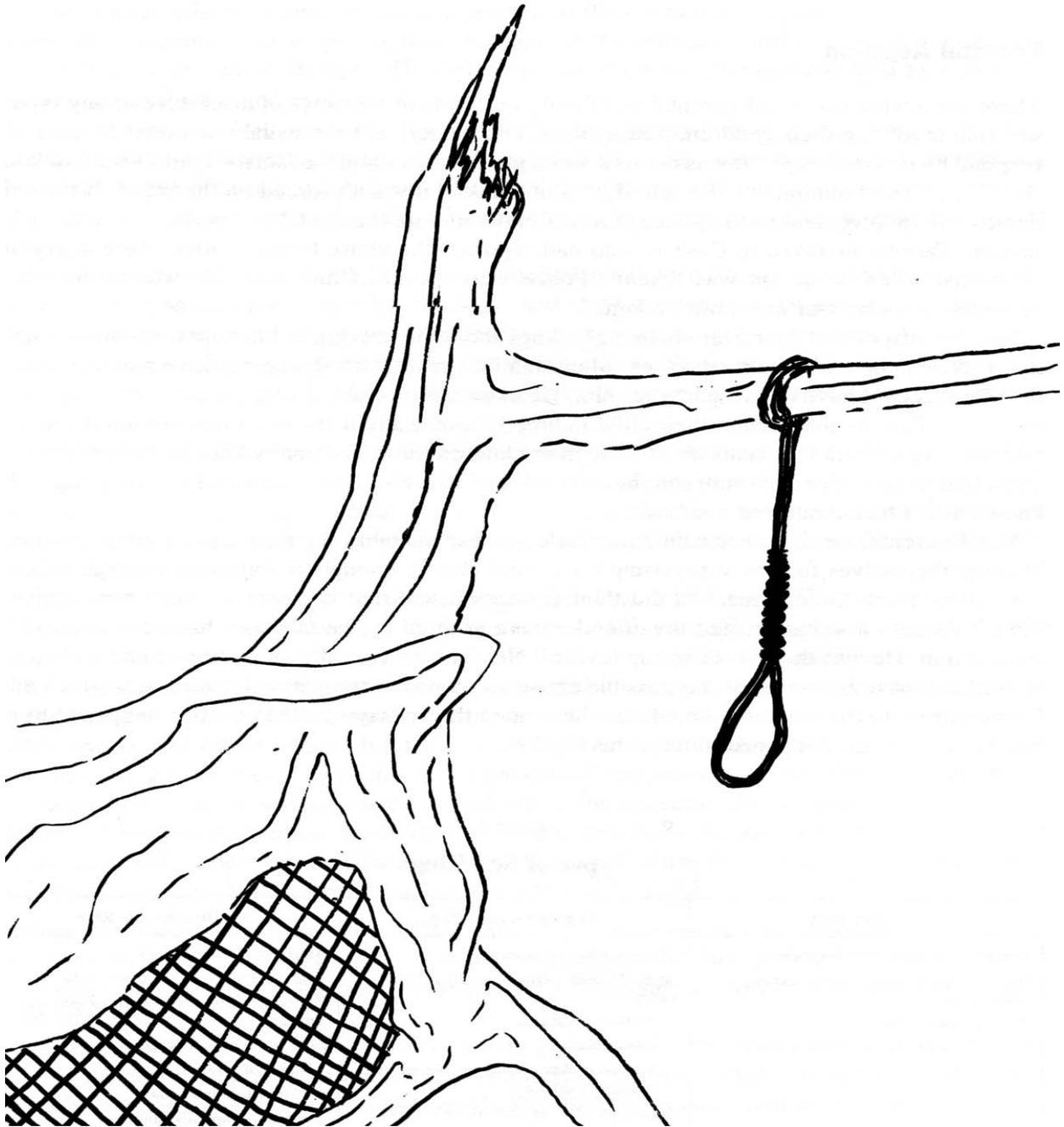


Figure 2. This drawing, made by a boy involved in a child sex ring, shows a death theme and general sense of foreboding.

3. Health Assessment of the Child Victim

Professionals trained in the medical and nursing treatment of child sexual victimization are often the first professionals treating the child and evaluating needs and can serve as witnesses in court proceedings. The primary objective of any medical intervention for the child is to provide a physical examination, a psychological evaluation, and legal evidence for future proceedings.

Children who have been sexually exploited come to the attention of nurses and physicians in a variety of ways. The child may be seen by a private physician or a nurse practitioner in the emergency department of a hospital. Large cities often have designated hospitals that serve child victims of sexual assault and exploitation with trained, experienced doctors, nurses, and social workers. Families may be requested (or even required) to travel some distance in order to have their child examined and evaluated at one of these specialized healthcare facilities. Another way in which a child may come to the attention of the healthcare system is through the school nurse, the community or public health nurse, or community clinics and outpatient services. Identified or suspected cases of child sexual exploitation may also be seen first by law-enforcement officials—who will then refer the child to the appropriate healthcare facility for examination.

Upon arrival at the healthcare clinic, the child and family will be met by a triage nurse or records clerk. Parents or guardians will be asked for the **presenting complaint**—the reason they brought the child to the clinic. Many designated facilities now have rape or sexual trauma protocols that provide specific guidelines for examining the child. Often, emergency departments with rape protocols provide separate waiting rooms staffed with volunteers from local rape-crisis centers. Trained volunteers can provide emotional support to families and practical information about the process the child will undergo during the health examination. Children who are known or suspected to have been sexually exploited are usually priority cases and seen immediately by the designated staff.

The health assessment of the sexually abused child has several steps. These include history taking, interview of the child, physical examination, and psychological evaluation.

History Taking

The initial step in the health assessment is the history taking. The parents or guardians are asked to provide details about the child's growth and development to establish a basis for evaluating the child. History taking helps engage families in conversation before they are asked to provide details about the sexual assault. The person who records the history should be the same person to record the details of the assault. It is important that this continuity be preserved so that families do not repeat their stories needlessly. Information that the medical professionals will need from the parents will include particulars about the child's developmental stage, past health history, disclosure of the sexual abuse, and behavior since the disclosure. The content of this interview will vary with the style of the clinician and hospital protocol. Parents are always encouraged to inform staff members about any information that they feel will be pertinent and helpful to the examination and interview.

The healthcare staff may exclude the child from all or part of the parents' interview. Some clinicians will separate the child from the parents in order to observe the child alone. The child may be taken to a playroom or another exam room. Many nurses and staff members take this opportunity to talk with the child about nonthreatening topics such as favorite subjects at school, hobbies, or play activities. These interactions allow clinicians to observe the child's demeanor and any anxieties or fears as well as permit the child to become accustomed to the clinician.

Children who will not leave their parents should be interviewed with parents present. A reluctant child may warm up to staff members if the parents are initially welcomed in the room. The child may allow the parents to leave once the interview has begun.

Interviewing the Child

Following the family's history taking is the interview of the child. Interview questions will vary depending on the child's age and level of development. The interviewer will assess the child's language skills and psychological and emotional development. The interview will generally begin with questions that test the child's knowledge about family members, familiar events, and personal data. For example, the interviewer may want to establish that the child knows his or her name, date of birth, and grade in school. From these answers, the interviewer will determine the best way for the child to talk about the assault.

Practical Interviewing Techniques The interviewer should remain as neutral and objective as possible in questioning the child. The setting of the interview should be nonthreatening and accessible to the child and family. Interviewing aids such as dolls, puppets, coloring books, and drawing paper should be available in the room. The interviewing area, however, should not include too many toys to distract the child from the interview. The furniture in the room should be appropriate to the child's size, and the interviewer should avoid the behind-the-desk position with children.

Certain persons should not be permitted in the interview room. For example, questioning a child in front of the alleged offender or interviewing a child in a room full of adult strangers is stressful and will limit dialogue with the child. A parent or guardian in the room may be reassuring for the child and, after the child becomes comfortable with the interviewer, the parent is often able to exit quietly.

An appropriate tone should be set in the interview from the beginning. A proper introduction of everyone present is necessary, as is a coherent, understandable explanation of why the interview is taking place. The interviewer should ask for, not assume, cooperation, and reassure the child that the interview will be as comfortable as possible. The child must be given permission to ask questions about anything that is not understood. A successful interview is one in which the child is given some measure of control, even if it simply means a choice of a toy. Many children who have been sexually abused have lost a sense of power and control over their own bodies and behavior and have learned to be overly compliant and passive.

The interviewer should establish a general rapport with the child before trying to obtain specific information about the victimization. It is often helpful to start by playing with toys or asking the child to draw a picture. It is during this initial period that it is most appropriate to ask the child's full name. The interviewer may want the child to write it on the drawing paper.

The child should not be pressured to open up immediately; instead the interviewer should try to determine what is preventing the child from talking about the abuse. For instance, a parent may be angry and confused because a child is making allegations about a boyfriend. That parent may have intimidated the child prior to the interview or may have threatened the child with removal from the home. It may be necessary for the parent to leave the room in order for the interviewer to obtain certain information.

Questioning the Child The interviewer's questions should not be misconstrued as leading, suggesting, or reinforcing. This takes considerable skill and can often frustrate even the most seasoned interviewer. **Leading questions** are those that indicate or suggest the answer to the child. Examples of leading questions are, "He touched you on your penis, didn't he?" or "That hurt, didn't it?" It is best not to use such questions with children because it could be argued in court that the child's responses were based on the interviewer's suggestions. Interviewers usually resort to leading questions when a child is reluctant to talk, thinking that

leading the child will help overcome the fear and resistance to the interview. Rather than use such questions, however, interviewers should allow plenty of time for the interview and, if necessary, schedule additional interviews. Children should not be asked to disclose the abuse before they are ready to do so.

The interviewer should also determine the child's knowledge of body parts and functions. Anatomical dolls may be used so that the child can point to various body parts and describe their functions. Coloring books with pictures of animals that have body parts may also be used. Puppets, stuffed animals, and drawing paper give the child freedom to depict the event.

The child should be allowed and encouraged to give a description of the abuse in his or her **own** words. Interviewers can gain a better understanding of a child's terminology by asking the child to clarify what a word means through drawings, pictures, or play. Children in early childhood may not use the same terminology as adults. The interviewer can establish details of the assault by asking the child to describe where he or she was when the incident occurred (inside or outside the house), what the weather was like (summer or winter), and when it happened (day or night).

The clinician should monitor the child's concentration and anxiety level and, if necessary, offer a rest period. It is difficult for young children to focus on one topic for more than 20 minutes. Interviewers should allow the child to indicate when a break is needed, as a quick drink of water or trip to the bathroom can revive a faltering interview. Give the child permission to say, "I don't know what you mean" or "I don't feel like talking about it." Children need to understand that the best answer to give is the **true** one, even if that means saying, "I don't know." Interviewers should establish with the child that he or she need not guess at answers, nor does every question necessarily have an answer.

As the interview progresses, assure the child that disclosing the abuse was the right thing to do; it was "okay to tell." If possible, a parent may reassure the child that he or she will be safe and no one is angry at or blames the child.

Questions should be kept open-ended; those with **yes** or **no** responses should be avoided. Children will seize any opportunity to be vague with their responses, as disclosing sexual abuse can be very embarrassing and frightening. A **no** response to a question does not mean that the incident did not occur; it may mean that the question was not specific or detailed enough. For instance, asking the child if the event happened in a house may elicit a **no** response if the child was abused in an apartment. Thus, a wide range of questions stated in different ways is critical when interviewing children. Dates and specific times are nearly impossible for children to pinpoint, but noting the season of the year, events in the child's life at the time, or even what was on television when the incident happened can assist in framing the event.

Physical Examination

The sexually exploited child will be asked to consent to a physical examination. Make sure that the procedures are carefully explained before the exam. Anatomical dolls may be used by the emergency department staff to explain and demonstrate how the exam will be conducted. If possible, the child should be allowed to participate in giving a doll an "exam"—including the taking of cultures and blood samples. For older children, the use of diagrams, wall charts, or plastic medical models of the body may be helpful.

It is important to give the child the impression that he or she is involved in the examination and given some measure of control over what will happen. Providing the child with something to hold, such as a cotton swab, will help contain the anxiety over the exam. If the child is resistant, the examination should be rescheduled. No child should be forced to undergo this type of exam, as forcing reenacts the situation of an adult controlling the child. Cultures or specimens are secondary to the psychological health of the child.

General Physical Examination The first step in the health assessment is a complete general physical exam which should include a measure of height and weight, a check of vital signs, and careful assessment of the skin for any bruising, lesions, or scarring that may indicate abuse. This general exam also gives the child time to become comfortable with the examiner. The examiner will make a complete assessment of the child's general health and write this statement in the medical record.

The examiner will also document the child's behavior and reactions to the physical exam, asking general questions and noting any unusual behavior. For example, children who demonstrate a complete lack of shyness during the exam, pose, or seem willing to display their genitals are possibly reenacting activities that they had been required to perform for the abuser.

Genital/Rectal Examination Following completion of the general physical examination, the medical staff will inspect the genital/rectal area of the child. The examiner may request that the child assume a frog-like position or even sit disrobed in the mother's lap (or another staff member's lap) with the genitals visible.

The examiner will document any bruises, tears, lacerations, bleeding, or discharge. The size, location, and estimated age of the lesions, bruises, and tears should be indicated. Photographs may be taken of the genital area for forensic purposes after the parents have given informed written consent. The examiner may use a Wood's ultraviolet lamp to illuminate the genital area, as sperm show up prominently under fluorescent light. If necessary, the clinician may use instruments to examine the pelvic area, but these instruments should be child-sized and an explanation given to the child before insertion. A colposcopy examination of the external vaginal area and perianal region may be used to confirm injuries not easily visible. (**Note:** The use of **colposcopy**, a means of magnified visual inspection, is explained by pediatrician Bruce A. Woodling, M.D., in the context of the medical examination of the sexually abused child.²⁹) A manual examination of the vagina may also be done to detect any internal trauma. In the pubertal female child, the examination may assess for the possibility of pregnancy. The male child should have the shaft of his penis as well as the urinary opening carefully examined for trauma. The rectal area is inspected for any signs of tears, bruising, and bleeding. A digital as well as visual exam may be indicated.

Cultures and Samples Cultures are collected from the vagina, mouth, and rectal area. The child may be able to participate by holding the swab with the examiner and looking at the area to be swabbed. A blood sample as well as a urine sample also should be collected. In some cases, the examiner may collect a specimen from the vaginal area for a Pap smear. If the examiner suspects internal injury from foreign objects placed in the vaginal or rectal area, X-rays or ultrasound studies may be conducted. Suspicion of physical abuse may also warrant X-rays of arms, legs, chest, and head. (*See also* Table 3, page 19.)

Preliminary Diagnosis Upon completion of the examination, a preliminary diagnosis is made by the examiner and discussed with the parents or guardians (unless the parent is suspected of being the abuser). This diagnosis may be consistent or inconsistent with the presenting complaint. A full diagnosis of sexual abuse is generally not given at this time but is contingent on the results of the laboratory tests. The examiner may, however, prescribe medications or treatments for the child at this time. Medication should be explained thoroughly to the parents and child. Treatment for sexually transmitted diseases may require injections of penicillin. The concern with possible transmission of the the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) may be initiated by a child or parent. Special counseling is necessary to address these concerns and provide information regarding testing. Follow-up blood samples may be required in four to six weeks to detect any further need for medication. In some cases, the examiner may determine that it is necessary to admit the child to the hospital.

Psychological Evaluation

Psychological evaluation of the child may be a part of the health assessment. The child may be referred for further evaluation using artwork or treatment with a psychiatric nurse, psychologist, psychiatrist, or social worker. Some children may require in-patient hospitalization if they exhibit symptoms of extreme depression or aggression.

The psychological evaluation is a vital aid to the speedy recovery of the child. The child initially needs support care and crisis intervention and later on may need comprehensive treatment to assist in the resolution of the assault. The medical staff may be able to provide psychological treatment for the child or refer the child to other agencies within the area. It is important that medical professionals enlist the cooperation of parents in the process of psychological treatment. Some healthcare facilities will follow up with families and children to note their progress and provide ongoing support.

A full health assessment is necessary in order to determine the health of the child victim of sexual exploitation, his or her psychological functioning, and need for further treatment. A sensitive and thorough examination by trained medical personnel will give the child a chance for a speedy recovery and the opportunity for normal development.

Table 3
Laboratory Tests in the Physical Examination

The laboratory tests noted below may be indicated following the sexual exploitation of a child.

Cultures *	Serologic Tests *	Pap Smear	Presence of Semen
1. Gonorrhea 2. Herpes simplex virus type 2 3. Chlamydia 4. Trichomonas vaginalis 5. Gardnerella vaginalis 6. HIV * Follow-up cultures may be indicated.	1. Syphilis 2. HIV 3. Pregnancy test * Follow-up blood samples may be indicated.	For females	1. Acid phosphatase test for seminal fluid 2. Wood's lamp to fluoresce seminal fluid 3. Wet-slide preparation to note presence/absence of sperm and motility versus non-motility 4. Slide preparation with gram stain or hematoxylin and eosin to document presence of sperm

4. Response Patterns of Traumatized Children

Child-care practitioners will find it helpful to examine a model for understanding the possible responses and outcomes associated with child sexual abuse and exploitation. This model, which we call the **information processing of trauma**, has been derived from clinical work with children in which sexual abuse was confirmed both by criminal trial and subsequent admission of guilt by the abuser. The “information processing of trauma” model will help medical professionals understand the child’s ways of dealing with the experience of sexual abuse, as the child’s behavior after the abuse is a direct result to a coping and survival process.

The “information processing of trauma” model is described in terms of four major phases. Phase 1 is the pre-abuse or pre-trauma time period. Phase 2 is the trauma encapsulation period. Phase 3 includes disclosure of the abuse. Phase 4 is the post-trauma outcome.³⁰ The intervention component is discussed in Chapter 6. (See also Figure 3, page 25.)

Phase 1: Pre-Trauma

Phase 1 encompasses the time period prior to the child’s sexual abuse. Important factors include the age of the child; the child’s personality development; the structure of the child’s family (intact, separated, or reconstituted); sociocultural factors; and the child’s history of prior traumatic life events.

Phase 2: Trauma Encapsulation

Phase 2 includes all activities relevant to the abuse and exploitation of the child. In Phase 2, the “input” is the offender’s behavior. Key characteristics of **offender behavior** include how the offender gained access to the child (through a trusted relationship, a consistent and progressive contact such as a family member, or a sudden and unpredictable encounter); how the child was controlled (through threat, pain, fear, drugs, or a combination of these); what the range of sexual activities was; whether the child was forced to witness activities or exploit others; and what the strategies to maintain secrecy and prevent disclosure were (whether the child was threatened, intimidated, or judged too young to tell and be believed).

These offender behaviors are responded to and filtered by the **cop ing and defensive responses** of the child (the “thruput”). The primary objective of the defensive response is to preserve the child’s physical and psychic integrity by psychologically warding off the offender’s behavior. The responses of the child include the psychological defense mechanisms of dissociation, denial, repression, fragmentation of the sense of self, arousal disharmony, and splitting.³¹

In Phase 2 the child’s response to offender behavior also involves **trauma learning** (the “output”), in which the child stores unprocessed information (sensory, perceptual, and cognitive) regarding the abusive event. This trauma learning becomes the basis for certain self-defeating patterns of behavior. For example, the child may avoid experiences that in fact help him or her cope with life. These patterns may socially alienate others from the child. The stored information and self-defeating behaviors result in a feedback loop of general anxiety symptoms such as new fears, onset of day and night wetting, nightmares, and physical complaints.

Often, one of the first indications of abuse in a traumatized child is though **trauma replay** or the child’s reenactment of the victimization experience. These reenactments are direct expressions of what has happened (and may still be happening) to the child. The intrusive thinking triggers the reenactment—a mechanism similar to a flashback in adult victims.

If the reenactment or the child's attempt at direct communication about the abuse is not addressed, the child may advance into repeating the sexualized behavior with increased aggression. The child may initiate acts that were done to him or her using either animals or other children. A third type of trauma replay is displacement, usually observed as the symbolic representation of the abuse later in life, especially through disorganized thinking or sexual aggression.³² The fact that the child's play behavior involves sexual references to the victimization indicates the child's attempt to master the anxiety associated with the abuse.

Trauma learning, which is grounded in the reenactment, repetition, and displacement of the traumatic event, is a process that keeps the child constantly preoccupied with the victimization. When the trauma is not addressed, the child remains in a state of continual tension. Although the abuse may not always be within conscious awareness, it is not processed as non-traumatic information, integrated, or stored in past memory (forgotten).

When sexual abuse is not disclosed and the abuse continues, the trauma is "encapsulated." The encapsulation process is reinforced in two ways. First, the offender demands silence and secrecy about the abuse. Second, the child sets up defenses to disguise the abuse and avoid any possible detection. The child, forced simultaneously to maintain his or her everyday activities, essentially leads a dual life by keeping the abuse a secret.

Trauma encapsulation depletes the child's psychic energy and thus disrupts the continuity of development of other areas of the child's life. Of particular concern is its effect of distorting and diminishing the victim's sense of right or wrong; sense of self, arousal, and inhibition capacities; awareness of body states; sense of personal power; and sense of self-comforting, -preserving, and -protective behaviors.

Phase 3: Disclosure

In Phase 3, the abuse is disclosed. The concept of information processing indicates that children who are assaulted over a prolonged period of time store the abusive activities partially in past memory. Thus, **disclosure** may be upsetting to the child, as it requires a breakdown of the child's defensive structures in order to retrieve the information. If disclosure is made by someone else, the child may respond with anger toward that person, which is a defensive reaction that attempts to protect the child's adjustment to the long-term abuse. With disclosure, the child is forced to bring into awareness details of the abuse, which may result in the reenactment of painful sensations for the child. With disclosure also comes the stressful interaction with family, peers, school, the treatment process, the criminal investigation, and the legal system.

Phase 4: Post-Trauma Outcome

Either Phase 2 or Phase 3 will advance to Phase 4. The post-trauma outcome is characterized by symptom responses and behavioral patterns. The symptom responses and behavioral patterns can be described as integrated, anxious, avoidant, disorganized, aggressive, or delinquent. (**Note:** In the following case histories, which provided examples of these patterns, the children's names have been changed.)

Integrated In the **integrated** pattern, the trauma is adequately processed and the child masters the anxiety about the abuse. When asked about the event, the child neither avoids nor encourages discussion, but he or she is able to talk of the event with reasonable objectivity. The memory of the event is minimally distressing. The child believes the abuser was not only wrong but was also fully responsible for initiating the behavior. Criminal prosecution of the adult is viewed positively by the child. The child is oriented toward the future, reestablishes friendships with a new peer group and shows evidence of making adjustments with peers, family, and school. Furthermore, the child has conscious control of aggressive and sexual thoughts.

For example, Mary, age 14 at the time of her disclosure of a sex ring she had been involved in with five other girls for a year, separated from the other girls in the ring and developed new friends in a new neighborhood. Initially dropping out of school, she returned to complete high school and maintained a part-time job. She began dating boys her own age and has plans for marriage and a family.

Anxious In the **anxious** pattern, initially acute symptoms are prolonged. The symptoms may be related to the abuse, or they may be a compound reaction that involves other traumatic events. There may be a cumulative reaction to additional stressful events such as the separation of parents, the death of a family member, or family conflict. The child's anxiety over feeling powerless is increased, and the child is unable to master or control this anxiety.

When asked about the victimization, child victims in this pattern show great anxiety. They feel guilty and blame themselves—not the adult offender—for the victimization. These children are not in control of their thoughts about the event. Family relationships are often unstable, peer relationships may not be reestablished, and the victims are not successful in socializing with children of the same age, often preferring the company of younger children. They may drop out of school, continue sexually explicit behaviors, and be victimized again. They believe that they should have stopped the victimization themselves. In addition, they are oriented to the past and may be hopeless about the future, feeling that it is impossible to make up for what happened.

For example, Sherry, a 15-year-old girl, was involved in a sex ring for three years. She dropped out of school in the ninth grade due to a pregnancy and was arrested several times for shoplifting. She reported that she felt very depressed, was unable to live at home with her parents, and had thoughts of committing suicide.

Avoidant In the **avoidant** pattern, the child's anxiety about the abuse is suppressed, either consciously or unconsciously. When asked about the event, the child denies it and may not even have a clear memory of it. The child often has a stoic demeanor and actively avoids discussion; the child is afraid of the offender and tends to be oriented to the present. When not under stress, the child manages life as if nothing had happened.

Stress and a breakdown of the avoidant pattern may elicit such behaviors as running away and substance abuse. Relationships with peers may be terminated, family relationships may be strained, school difficulties may persist, and minor antisocial acts may surface. The child in this pattern of behavior has no sense of right and wrong. Unconsciously, the child feels responsible for the victimization and feels that he or she has injured both self and family.

For example, Jimmy, age 17, was introduced through a sex ring to drugs and sex at age 12. He dropped out of school in the eleventh grade and became heavily involved with drugs. He was arrested three times for breaking and entering. Although he did not make a connection between the ring activities and the deterioration of his behavior, he viewed himself as “bad and a loser.”

Disorganized It is in the **disorganized** pattern that the most profound behavioral aberrations are noted. The children are unable to distinguish between illusion and reality. The traumatic event is buried in delusional symptoms—for example, they may associate bodily odors to a rotting brain.

For example, Claire, the daughter of a sex-ring offender, was an incest victim and impregnated by her father. The father/offender was sexually abusing inside and outside his family. The son born to her was raised as her father's child. Claire began showing symptoms of bizarre sexualized behavior by age 16. She would create a disturbance so that police would be called; when the police arrived, she would remove her

clothes, try to embrace the officers, and grab at their genitals. She developed sexualized delusions, became paranoid, and required psychiatric hospitalizations.

Aggressive In the **aggressive** pattern, the child assimilates the anxiety caused by the abuse by impersonating the aggressor. The child is transformed from the victim into the abuser. The child masters anxiety by exploiting others and adopting an antisocial position toward peers, school, and family.

In talking about the event, the child who identifies with the abuser minimizes the exploitation and resents the interference of the authorities. The child maintains emotional, social, and economic ties with the offender and feels sorry or angry that the abuser was exposed.

Delinquent In the **delinquent** pattern, the youth extends the aggressive patterns and has difficulties with authorities, especially in school. Use of drugs and alcohol, which is often part of the sexual abuse, continues and increases. The delinquent acts often bring the young person into contact with police.

For example, Jay, age 15, involved in a sex ring for three years, was arrested by police for arson, breaking and entering, and car theft. He was suspended from school numerous times and in one year had been absent from school for more than 100 days.

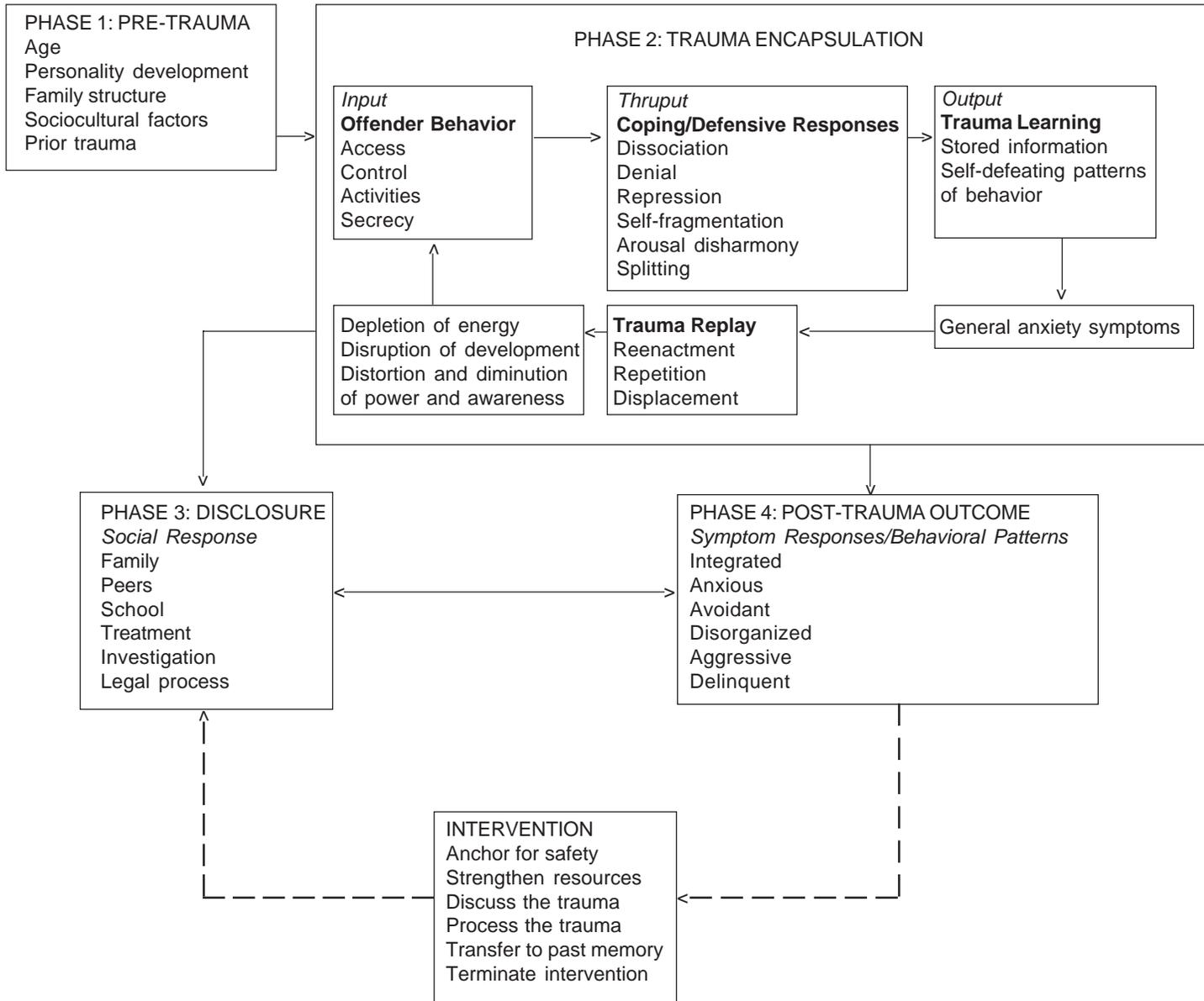
The delinquent behavior can advance into criminal behavior, including sexual deviations, as in the following case. Billy, a sex-ring victim, at age 16 was arrested for rape and assault of a 15-year-old female classmate whom he had dated. After the girl refused his sexual advances, Billy raped her and battered her head with a hammer.

Summary

The experience of sexual abuse produces trauma and information that is processed by the child victim and stored in recent memory. In thinking about the abuse, the child must cope with considerable anxiety. The child thereby employs defenses that may ensure survival during the abuse but that become maladaptive in non-abusing situations and other areas of life. The abuse, when ongoing and undisclosed, becomes encapsulated, thereby creating trauma learning.

The “information processing of trauma” model describes how trauma learning is processed by child victims and linked to specific outcomes or effects on the child. The developmental age of the child is an important consideration in assessing response patterns. When a traumatic event is not resolved by the child, the diagnosis of **post-traumatic stress disorder** is generally considered by the clinicians. The central feature of this disorder is that the individual reexperiences fragments of the original trauma both unconsciously and consciously. This reexperience phenomenon is expressed in intrusive, uncontrolled, and disturbing thoughts and images; dreams and nightmares; dissociative states (memory failure, failure to hear); and in unconscious symbolic or behavioral reenactment of the traumatic situation as either the victim or aggressor.

Figure 3
Information Processing of Trauma Model



5. Interviewing with the Event Drawing Series

A child's expressing a traumatic event through artwork as a part of the interview process has a strong tradition within pediatric and child-psychiatric settings. Art is a process by which abstract concepts and relationships and intangible emotions can be translated into concrete images. Expressing themselves through symbols in drawings, children increase their awareness of life and understanding of themselves.

For the sexually abused or exploited child, the drawing process offers a nonthreatening medium for self-expression within a supportive environment. Various elements in the drawings can reveal a child's thinking process, sexual and aggressive anxieties, disturbed body image, and self-image. The creative process of drawing allows the expression of strong feelings and conflicts that may be too threatening for children to indicate directly.

This chapter describes a technique the authors have used successfully with traumatized children. A series of drawings, called the **event drawing series**, is obtained from the children during the interview. This event drawing series is a graphic presentation of the child's thinking about a specific event and can be used in several ways. First, the series may be evaluated by the individual therapist working with the traumatized child for assessment and treatment-planning purposes. Second, the series may be videotaped (with the permission of the parent and child) and used for outside evaluation. To illustrate one use of the event drawing series, we present in this chapter Case 4, which involves 12 girls for whom the event drawing series was employed.

Event Drawing Series Procedure

The task of completing an event drawing series should be the only task asked of the child during a particular session. Although the length of time needed to complete the drawings will vary, the drawing process may be upsetting and tiring for the very young child. The child is told the session will consist of drawing seven pictures; only when the child agrees to do the drawings does the session begin.

The opening phase of the session—asking the child's permission to make the series of drawings and otherwise engaging the child in conversation—alerts the therapist to the child's demeanor, verbal and nonverbal behavior, and means of defending and coping to minimize anxiety about the traumatic event. Having a task, such as drawing, helps the child to reduce the normal anxiety caused by talking about an emotional experience, and the drawing itself provides the therapist with valuable information.

The therapist introduces the task to the child by saying, "I would like you to do seven drawings during our time together. I will ask you to draw each one on a separate piece of white paper. After you finish each drawing, I will ask you a few questions about your picture. You may use a pencil, crayons, colored pencils, or pens. Are you willing to do that?"

While the child is working on each drawing, the therapist records on a separate piece of paper everything the child says and does during the drawing task. After the child finishes, he or she is asked to identify the persons, objects, and other items in the picture. Then the questions noted below are asked and the responses recorded.

Drawing 1: Draw your favorite weather.

1. What kind of weather is it?
2. Why is this your favorite weather?
3. Does this weather differ from the weather right now? If so, why?

Drawing 2: Draw a picture of your whole self (not a stick figure) as a younger child.

1. How old is the younger self?
2. What is the younger self doing?
3. What is the younger self thinking?
4. What is the younger self feeling?

Drawing 3: Draw a picture of your whole self as you are now.

1. How old is the current self?
2. What are you doing?
3. What are you thinking?
4. What are you feeling?

Drawing 4: Draw a picture of you and your family doing something. (This allows for representation of family configuration and themes of family interaction.)

1. What is each family member doing?
2. Who isn't in the picture, and why?
3. Who helps whom in the family?

Drawing 5: Draw a picture of what happened to you. (The therapist should try to be as non-leading as possible. For example, the child is being asked to draw a picture of what happened—that is, the reason he or she is talking to the therapist. If that does not elicit a picture, the therapist asks for a drawing involving the identified person and the child.)

1. What is each person in the drawing doing?
2. What are they thinking?
3. What are they feeling?
4. What happened to each person?

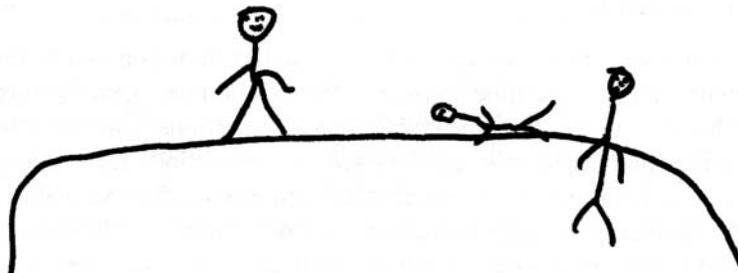


Figure 4. Drawing the event of sexual abuse can be highly traumatic for the child victim. In this drawing by a 12-year-old boy, the stick figures are sketchy and indistinct. The child, in anxiety, crumpled up the drawing and threw it into a wastebasket, where it was later found.

Drawing 6: Draw a picture of a house and tree.

1. Tell a story about the house (who lives in it, in what condition it is).
2. What is the house like to live in?
3. What kind of tree is it?
4. How old is the tree?
5. In what condition is the tree?

Drawing 7: Make your own drawing.

1. Tell a story about your picture. (The child is encouraged to be as descriptive as possible in the story.)

Event Drawing Series Analysis

Some of the ways the drawings are reviewed are discussed below. **WARNING: Drawings should be analyzed only by those professionals trained to interpret artwork of sexually abused children.**

Favorite Weather This drawing, as an introductory task, helps the child feel comfortable with the therapist and art medium and helps the therapist evaluate the mood of the child. For example, the weather drawn may match the current weather or may differ from the current weather possibly reflecting the child's mood or emotions.

Younger Self and Current Self The two drawings are compared for the child's self-representation in terms of organization, body image, and sense of self. For example, there may be no difference in size or organization, or there may be marked differences between the two selves.

Family This drawing provides information about the child's perceptions of protection, safety, nurturance, and family support. It may reveal conflicts in the family and provide an estimate of support available to the child.

Event of Sexual Exploitation Drawing the event of sexual exploitation assists memory and recall of the reported event, at the same time retrieving the emotion and anxiety surrounding it. This drawing helps the therapist understand the child's thoughts, actions, and possible defenses during the event. It assists the child in reflecting on the event and the actions surrounding it. The drawing of the event may be classified in terms of neutral affect (minimal anxiety, sexuality, and aggressions); presence of anxiety, sexuality or aggression; presence of a theme such as rescue; avoidance of drawing the reported event; or an exaggerated attention to detail regarding the event. *See* Figure 4, page 28, for an example of a child's drawing of the event of exploitation, a sketchy piece with stick figures. This child, in anxiety, crumpled up the drawing and threw it in the wastebasket.

House and Tree The house and tree drawing is used to measure the child's organization of thinking. This drawing follows the event drawing and may illustrate intrusive thinking from the event drawing.

Draw and Tell a Story This drawing, which the child can choose, closes the interview by giving the child control and choice. It also provides a measure of the child's mood as well as evidence of continued intrusive imagery triggered by drawing the reported event. The child's story is analyzed in relationship to its relevance to the event.



Figure 5. In this picture of the younger self, the tiny figure suggests feelings of alienation, vulnerability, and helplessness. Symbols such as the “hill” beneath the child are unusual in artwork by 6-year-old children. Note anxiety, particularly in the treatment of the grass.

Use of the Event Drawing Series

The 12 sexually exploited girls involved in Case 4 ranged in age from 6 to 9 years old at the time of assessment for a civil trial.³³ They had attended kindergarten at the time of the abuse. The abuse continued over a four-month period for each of three years for each kindergarten class that rode a particular school bus. Two girls were sisters; eight children were from two-parent families; two children were from stepparent families; and two children were from single-parent families.

One year prior to the civil case, the offender, a 43-year-old, married school bus driver, was convicted of molestation. The sexual activity was committed on the school bus with other boys and girls present. Typically the driver would call the child by name up to the front of the bus where he would expose himself, fondle the child, and attempt to penetrate the child either digitally or by holding the child on his lap. The driver kept the boys at the back of the bus and had ordered the children to sit separately.

Parental confidence in the bus driver was so great that some parents who were told of the abuse tried to discredit the child by saying, “She must be making this up.” Unbeknownst to the parents, the man had a 20-year history of complaints of child molesting, with no complaints from children acted on legally. For example, court testimony from a 23-year-old woman revealed that 18 years previously the offender, then employed as a school custodian, had molested her. Her complaints were reported to a teacher. The offender was dismissed but was later rehired as a bus driver.

Prior to the disclosure made by the 12 girls, a kindergarten teacher reported to the school principal that when the school bus arrived the children became anxious, could not pay attention in class, and seemed compelled to get on the bus. Her complaints were made known to the bus driver who, it was learned later, further abused the girls for “telling.”

Children continued to tell their parents about the abuse; others developed physical symptoms (vaginal bleeding) that attracted parents’ concern. Although the children were attended by a physician, their condition did not lead to discovery of the molestation. Eventually, one 5-year-old child’s report to her mother, supported by her 9-year-old sister’s verification, resulted in the eventual exposure of the victimizer and legal action against him.

At the criminal trial, five children testified. For the civil trial, the three critical intervention phases of pre-court, post-court, and reentry to school were identified. The pre-court phase required that all witnesses (parents and children) be prepared to testify and have had all required assessments completed. The analysis of the 12 girls' event drawing series follows.

Favorite Weather While the majority of the 12 children reported that their favorite weather was sunny and warm, there were numerous indicators of anxiety (clouds in the sky), insecurity (drawing a tiny sun on the paper), and isolation of affect (child's swing set without children playing).

Younger Self and Current Self For the drawing of the self at a younger age, six girls identified their own age, 4 to 5 years old. Five girls identified an age as a baby or toddler, and one was unable to provide an age. For the current-age drawing, five drew a self-portrait the same size as in the younger drawing; three drew a current self looking younger or more helpless than the younger self, or drew transparencies of self (the body is seen through the clothes, indicating vulnerability); and four had clear differences in size between younger and current ages. (See Figure 5 on page 30 and Figure 6 below.)

Family Seven children drew the family eating, a common family scene. Family members included parents and siblings as well as extended family members and family pets. One girl who had told her parents—but was not believed—drew herself separated from her family. (See Figure 7, page 32.)



Figure 6. In this picture of the current self, the child's uncomfortable stance and her sundress tied low on her chest with an emphasis over the breast suggest a preoccupation with body and sexuality.

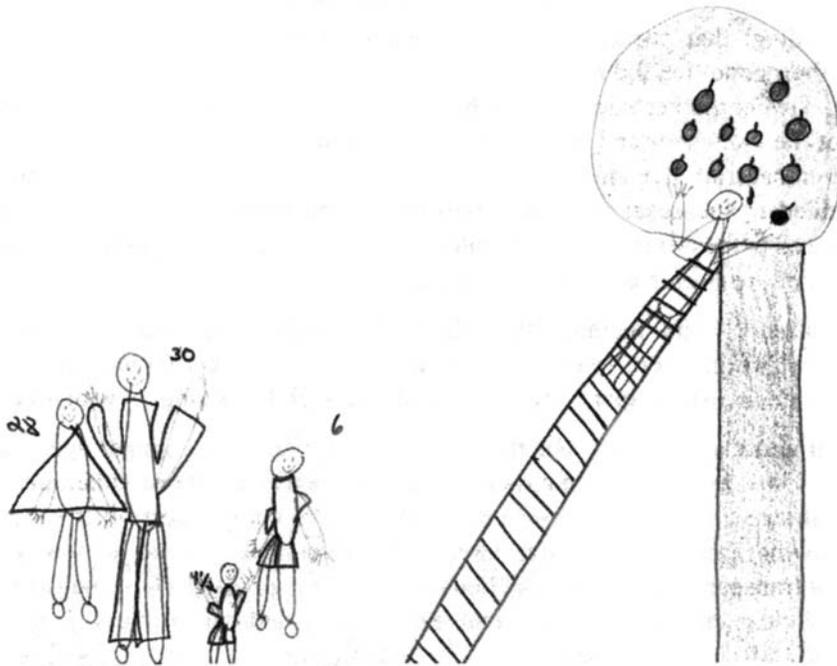


Figure 7. Separating herself from the family, this 8-year-old girl places herself at the top of the ladder. The child disclosed the abuse to her mother, but was not believed. The drawing reflects a feeling of alienation and need for protection. Note the transparencies (the body is visible through the clothing), which indicate feelings of vulnerability.



Figure 8. This drawing of a house and tree shows disorganized thinking (an uprooted rose) and obsession with fears and secrecy (no windows in house). Note the distorted comparative heights of the tree and flower, another indication of disorganized thinking. Personality “splitting” is evident in the double-image house.

Event of Sexual Exploitation Drawing the event clearly presented the child with a great deal of anxiety, and defense mechanisms surfaced. The children divided evenly on those who initially resisted the instruction and those who complied and began the task. The six girls who resisted used different strategies to indicate the resistance. Some questioned the task by saying, “What do you mean?” or verbally refused by saying, “I can’t draw that”; “I don’t know how to draw that.” Some nonverbally refused (child put hand to face, stared up, and looked as if she were about to cry), or negotiated by saying, “Can I just draw a bus?” The six girls who agreed to the task generally showed blocking within a short time by saying, “Oops, I smeared it”; “I can’t remember if he had a moustache or not”; “I forget the number of the bus”; “Oh, I messed up on him.” Two girls drew the courtroom—placing themselves in a safe environment with the offender—but were unaware that they avoided drawing the event. Only one girl was able to provide more information about the abuse by saying, “I used to always cry when it was time to ride the bus. The teacher used to talk about the bus getting there early, maybe 10 to 15 minutes each day. One time he asked me to zip up his zipper, and I said **no**.” Another girl drew the bus located at the school with a **Help** crying out from her. (See front cover.)

House and Tree This drawing elicited a number of examples of psychological stress regarding the memory of the trauma. Two girls said they were tired and unable to attempt the drawing. Several drawings showed disorganized thinking. These drawings had unusual features such as trees with roots exposed, the absence of ground lines, and houses without windows—suggesting fears and secrecy. (See Figure 8, page 32.)

Draw and Tell a Story The final drawing also revealed indicators of disorganization in the children’s thinking and emotional state. Seven children showed disorganization through fragmentation of body parts such as a head separated from a body. (See Figure 9 below.) Some children were unable to complete the last drawing.

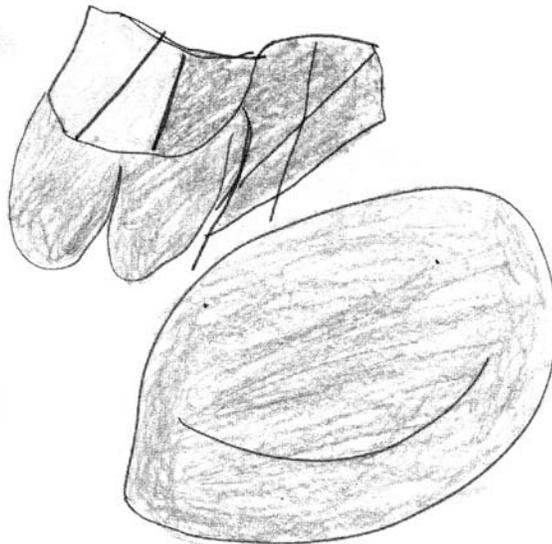


Figure 9. This drawing is regressed and disorganized. Separation of body parts reflects the child’s inability to integrate the experience of sexual victimization. Denial is suggested by the smile and the X.

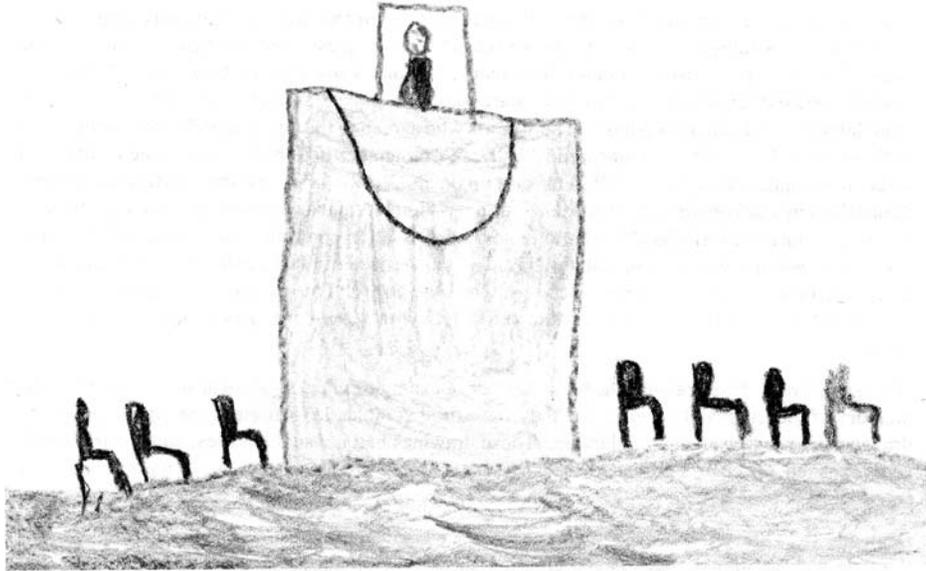


Figure 10. The judge's bench overshadows the tiny witness chairs indicating the child's sense of helplessness and alienation during the legal process.

Testifying in a court proceeding is an anxiety-producing situation that has the potential to reactivate specific traumatic symptoms in the child. The therapeutic challenge is to focus on accessing children's personal resources for self-preservation. The pre-court clinical assessment through the use of an interview and the event drawing series served as the prototype for exploring thoughts and feelings after the court appearances as well as at reentry into school.

Post-Court Intervention

The most significant outcome of therapeutic intervention following the civil session was that the parents learned ways in which they could comfortably discuss the event with their children. They were most interested in the children's responses to the court proceedings. During the post-court proceedings the children were asked to draw their experience in court and talk about and share this event.

Examination of the children's drawings revealed either an absence of people or, if people were present, those depicted in states of displeasure or distress. For example, some drawings of the courtroom depicted only the furniture; in some drawings, the judges' bench monopolized the scene, overshadowing the witnesses (*see* Figure 10 above), indicating how the children felt separated from and overwhelmed by the judicial process. Subsequent discussion revealed the children's belief that the judge was against them. In court the children had witnessed their attorneys arguing motions before the judge and felt intimidated by the judge's stern demeanor and voice. Furthermore, the defense counsel's cross-examination was distressing to the children. One child, after testifying, ran into the bathroom to vomit. In one courtroom picture, a child drew herself with a bucket next to her "in case she got sick in the courtroom."

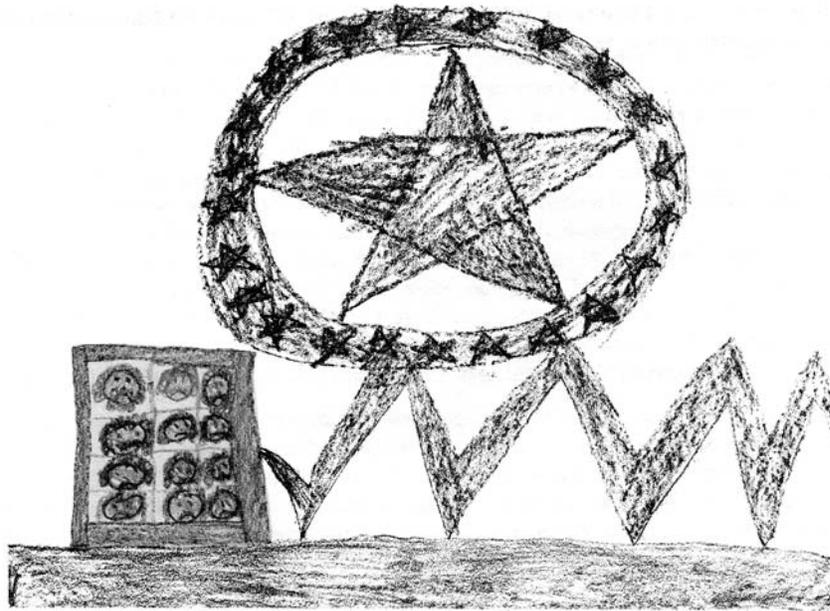


Figure 11. The victims' feelings of guilt about the sexual victimization are evident in this drawing which depicts the 12 victims together in a box. The artist called this drawing the FBI's "Most Wanted List."

The court proceedings left the children with a wide range of feelings such as betrayal, fear, victimization, and self-blame. The children's fears were projected onto the authority figures. The victims' self-blame was noted in one child's spontaneous drawing of 12 little faces in boxes—the child victim/witnesses. The child said the drawing was an FBI "Most Wanted List." (See Figure 11 above.)

Reentry to School

The third stage of intervention occurred after the settlement from the civil litigation had been made and the children had returned to school. The structured settlement allowed an initial sum of money to be paid for treatment expenses, to be followed at specific times with a set amount for the children's education and further treatment. Parents and children met in separate groups with the therapists. In the children's group, each child was asked to produce and present three drawings (what happened since the last meeting, their thoughts about the settlement money, their thoughts about returning to school). The children also worked on a mural together to promote a greater sense of group cohesiveness. At the meeting with both parents and children present, the children discussed the mural as well as their individual drawings. The therapeutic strategy was to air the issues that had arisen from the settlement of the civil case. The meeting also provided a basis for determining how the children had shifted their priorities from the sexual abuse event to the court experience.

In summary, the surfacing of an unresolved traumatic event during court testimony illustrates that cognitive defenses were developed during the trauma encapsulation phase. When the children were asked to recall what happened, clinicians noted the latent power of the unresolved event to disrupt and impair the children's performance and social interaction as demonstrated through the series of drawings. Case 4 also suggests that children who are victims of sexual molestation are in critical need of intervention, as are their parents.

6. Treatment Issues in Child Sexual Trauma

Developmental Periods

This chapter, written for experienced clinicians who treat children traumatized in sex rings, highlights some of the critical issues in information processing of trauma, with emphasis on the intervention component. (See Figure 3, page 25.)

The therapist must consider the response of children to traumatic events within the context of their developmental capabilities. Age helps to shape a child's response to the event. The developmental periods important in evaluating children abused in sex rings are the preschool, school-age, and adolescent periods.

Preschool Period Very young children are highly vulnerable to traumatic situations. The trauma intensifies their sense of helplessness and dependence upon others. Most important, they are limited in how they can verbally express what has happened to them. During this period, there can be rapid onset of general anxiety symptoms of a physical and psychological nature. Agitation, stomach aches, headaches, appetite or weight change, genital and anal complaints, bedwetting, and masturbatory behavior are all possible symptoms. Young children have a limited sense of time, which contributes to their fear that the abuse can recur at any moment.

Because they lack the language skills to describe the abuse, preschool children express their reactions to traumatic experiences through behavior and action. They directly act out their anxiety, outrage, and terror. Sexually abused children are also sensitive to the aspects of their environment that remind them in some way of the event. In all extra-familial cases involving young victims, the parents' detailed observations of the child are critical to therapeutic intervention.

School-Age Period Further development of language skills in school-age children usually allows them to verbalize and communicate the experience of sexual exploitation. During this period, they often blame themselves and wonder why the abuse happened to them. They feel a sense of victimization. The child's behavior usually indicates a distortion of perception, which adversely affects school performance and learning. Organization and integrity of thinking have been disturbed. There is an inability to concentrate and learn; the children are preoccupied with intrusive images.

In this developmental period, reenactment and elaboration of the trauma through aggression are noted. Because the children are aware of social opinion, they avoid talking about the event. There may also be general anxiety symptoms, which can include sexual and aggressive thoughts and behaviors, sleep problems and nightmares, flashbacks to the events, fears and phobias, nervousness and irritability, temper tantrums, mood swings, and confusion about sex. Abused children may avoid their usual social activities, develop erratic grades, withdraw from people, feel different from others, and begin alcohol and drug use.

Adolescent Period In the adolescent period the youth may feel responsible for participation in the sexual activities. Avoidant and antisocial behaviors are noted such as running away, cheating in school, chronic lying, truancy, physical violence, arson, and sexually explicit mannerisms and language. There may be a serious tendency to self-directed violence and use of drugs and alcohol to self-medicate as a reaction to painful memories.

The trauma may critically interfere with the youth's psychological defenses, and the adolescent may develop unreal thinking and fear losing his or her mind. In such cases the adolescent is humorless, lacks the capacity for pleasurable experiences, and may develop an aversion to age-appropriate sex.

Intervention for the Child Victim of Sexual Exploitation

Although intervention efforts may differ among therapists, certain steps are generally accepted.

- **Anchor the child for safety.** The traumatic experience of sexual abuse shatters the child's sense of safety and protection. The first step in therapy is to ensure that the child feels safe in all environments, including home, school, and daycare, as well as in the therapy session. Using age-appropriate language, the therapist tells the child why he or she is coming for treatment and who will be present during the session. The therapist should also explain his or her professional background. The child needs the option of having people or objects (a favorite toy or stuffed animal) available to enhance a sense of safety.
- **Build on the resources of the individual.** Building the child's personal resources requires assessing the strengths or coping skills of the child. Give particular attention to exercises that allow the child to relax. Because talking about the abuse will generate anxiety, the therapist needs to know prior to such discussion how the child handles tension and anxiety. Depending on the developmental level of the child and the child's preferred mode of expression, this step may include play, drawing, storytelling, and verbal communication. In one case a 4-year-old child was having difficulty feeling safe even though the offender was in jail. As part of her therapy, she drew pictures of police which she carried around with her and hung on her bedroom wall to help her feel protected.
- **Discuss the trauma.** Once the abused child's coping skills and sense of safety have been assessed and fostered, the therapist will attempt an orderly discussion of the abuse. It is critical at this stage that the child have the ability to institute self-comforting mechanisms in order to deal with the resurfacing of the trauma. In this step, the event drawing series (*see* Chapter 5) will serve as one way to discuss the trauma. The younger the child or the more delayed in the development of language and comprehension, the more the therapist will rely on the observation of the child's overt actions for exploring the impact of the abuse.
- **Process the trauma.** Processing the trauma is the working phase of therapy and begins when the child is able to acknowledge the abuse directly and can talk about it. First, the therapist's task is to reconstruct a description of the abuse from the child's symptoms and begin to link the child's behavior and other symptoms to the event. This is a further exploration of the trauma than was addressed in the step above. Then, as the child begins to feel secure, the therapist helps the child recognize that the self-protective behaviors are no longer necessary because the child is now no longer in a vulnerable position. The trauma experience is separated from its fear-induced symptoms. The therapy then becomes focused on altering the negative behaviors that resulted from the abusive situation.
- **Move trauma to past memory.** During this stage the child is reintroduced to strategies for filing the experience as a memory. Creative imagery or play may be used. For example, the therapist might ask the child to draw all the memories about the abuse on a piece of paper, and then put the paper in a "jail"—with the child holding the key. This permits the child to control what aspects of the memory he or she wishes to recall and let out.
- **Terminate the intervention.** The last several sessions of therapy are designed to terminate the intervention process. During this time, the therapist reviews with the child what has been useful and meaningful to the child and what wishes the child has for the future. Concerns or anxieties about the

future are explored, and the therapist helps the child identify his or her own personal resources for coping with problems in the future. Information about self-protection and safety measures is reviewed. The therapist should reinforce the value of therapy and, most importantly, emphasize the personal accomplishments and positive future of the child.

Intervention Efforts and the Child's Parents

The family is critical to the recovery process of the child victim of extra-familial sexual abuse. The therapist will spend time reviewing the concerns of family members, educating them about the child's response to the trauma, eliciting their thoughts and feelings, and instructing them in their role in the therapeutic process. Therapists often use the sequence noted below for parents in assisting in the child's therapy.

- **Allow parents to respond.** Parents need an opportunity to express themselves and be assessed and evaluated for their reaction to the disclosure of the sexual abuse of their child. Part of this self-expression might be a review of past traumas and victimization in their own lives. The therapist should focus on how the parents coped with their abuse and what can be learned from the experience that will be helpful to their child. If a parent still has unresolved problems over a past traumatic event, referral for additional therapeutic intervention for the parent should be made.
- **Explain the therapeutic intervention for the child.** In this step the therapist will explain the overall protocol used with the child. The parents' awareness and cooperation are critical as they will be the primary monitors of their child's symptoms between sessions. The therapist will suggest methods for communicating with the child and help parents in dealing with their own reactions to upsetting information. Parents should recognize that their participation in the program can be a positive way of learning more about themselves and helping their child.
- **Support the discussion of the trauma.** Many of the behavioral effects (sexual behaviors) of sexual abuse and exploitation are disturbing to parents. In this step, parents are taught child-management skills that help support the child's recovery from the trauma and control problematic behavior. Most importantly, parents should learn to help the child institute positive coping mechanisms when anxious.
- **Help move trauma to past memory.** In this step, parents are taught the strategies used to help their child process and move the trauma to past memory. Therapists will encourage parents to use various methods to support the child in this process. Concurrently, parents need assistance and reassurance to file their own memories of the abuse into past memory.
- **Terminate the intervention.** Parents themselves may need some special attention at the termination of therapy, emphasizing the significance of all they have accomplished. After termination of intervention, parents should have available to them, either by telephone or periodic appointment, the opportunity to consult with the therapist and review the progress of their child over the years.

7. Legal Aspects of Sex-Ring Crimes Against Children

A sexually molested or abused child may be involved in different kinds of legal proceedings including either a criminal or civil case. This chapter gives an overview of the important aspects of these two kinds of cases and presents a case history to illustrate a civil trial without child-witness testimony.

Criminal and Civil Cases

A **criminal case** is an action brought by the government against an individual, charging the individual with the violation of a law. Cases of child molestation or sexual abuse usually involve state laws, ranging from taking indecent liberties with children to rape and different forms of sodomy. These cases are usually tried in the state circuit courts, but they can arise in domestic relations or juvenile courts. The prosecutor (often known as the district attorney) must prove “beyond a reasonable doubt” that the person charged with the crime violated the law. This is a difficult burden of proof because the jury (or judge) must be very certain that the person charged is guilty.

A **civil case** is an action brought by a private person against another (an individual, corporation, government agency, or other kind of entity) for money damages to compensate that person for expenses, physical harm, or emotional harm resulting from the wrongdoer’s actions. A party bringing a civil action may ask for punitive damages, which are damages awarded against another party to punish that party for its wrongful acts. These actions are usually brought in state courts and sometimes in federal courts. They may be brought against parties other than the person who committed the wrongful act if their acts or failures to act allowed the molestation to occur. In cases of child molestation, the victim or the victim’s family often sues those with the financial resources to pay for the victim’s damages (for instance, a school or daycare center) if they had responsibilities and obligations for the child’s care and well-being. In a civil action, the victims must prove by a “preponderance of the evidence” or the “greater weight of the evidence” that the act was committed, the victim suffered damages, and those damages were the result of the wrongful acts of the defendant(s).

Although the level of proof is different in criminal and civil cases, and other elements of proof may differ, the same facts and evidence are often necessary. For example, the parties in both types of actions must prove the specific act that was committed. (*See also* Table 4 below.)

Table 4
Proving the Case of Child Sexual Exploitation

Criminal Case	Civil Case
<ol style="list-style-type: none"> 1. Prove that act was committed. 2. Prove violation of law “beyond a reasonable doubt.” 3. Penalty is punishment, fine, and/or rehabilitative program. 	<ol style="list-style-type: none"> 1. Prove that act was committed. 2. Prove violation of duty—negligence, breach of contract, violation of contract—by “preponderance of the evidence.” 3. Penalty is amount of damages.

Child's Testimony In most states there is a presumption that children who are younger than the age of 7 are not competent to testify in courtroom proceedings. The purpose of this policy is to ensure that parties or witnesses who testify are indeed telling the truth. The presumption can be overcome by showing that the child can answer questions about past events, understands the difference between telling the truth and a lie, and knows that he or she must tell the truth in court. Lawyers have traditionally established children's competency to testify by asking questions to show that a child knows what it means to tell the truth.

In child sexual molestation cases lawyers might consider additional approaches. For example, an **expert witness** (psychiatrist, psychologist, psychiatric nurse, or other child trauma therapist) might testify that the child has the capacity to be truthful about sexual things done to him or her. Some states have enacted legislation permitting the use of videotapes of children describing what has happened to them. There may, however, be constitutional or evidentiary problems with the tapes, depending upon the circumstances under which they are produced.

Should the Child Testify? It is usually necessary for a child to testify in order for attorneys to prove what happened. This determination should be made by the attorney representing the child and the child's parents, together with the therapist.

Because U.S. law mandates that a criminal defendant has the right to cross-examine witnesses, the defense counsel is entitled to cross-examine a child who testifies. Although a child may be able to tell parents or other individuals about the abuse, the same child may become nervous and be unable to explain what happened when testifying in a courtroom setting. If a child is expected to testify, it is helpful for that child to visit the courtroom prior to the trial in order to become familiar with the surroundings.

Defense lawyers know that if the child cannot testify at trial, and if there is no other available evidence, the case usually cannot be proved. If the child does testify and successfully describes the abuse, or if the abuse is proved by some other means, there is a greater likelihood that a jury or judge will award an appropriate sum of money in a civil case or impose a severe penalty in a criminal case.

Other Means of Proof There are various ways of proving that a child was sexually molested or exploited, either in the absence of the child's testimony or in addition to this testimony. Parents are often called upon to describe what their children have said or done. Although such testimony may involve hearsay problems (the rules of evidence prohibit one person from testifying to what another person told him or her), there are exceptions to the hearsay rules. For example, courts often allow one person to testify to another's spontaneous exclamations made immediately after an incident. The reasoning behind this is that a statement made spontaneously and directly after the occurrence is likely to describe accurately what happened. Physicians, nurses, and therapists who have treated a child victim of sexual molestation are frequently allowed to testify about what the child told them on the first visit for diagnosis or treatment. They can testify about what they have observed in the child's physical or mental condition or behavior.

Parents can also testify to what they have observed. For example, in at least one case, parents testified that they watched their child mount a doll and move back and forth as though she were engaged in sexual intercourse. In addition, parents can testify to unusual actions such as a child asking a parent to rub her genitals. A parent may be able to testify that the child was unfamiliar with sexual behavior because he or she never witnessed the parents or anyone else having sexual relations.

In cases involving multiple victims, one child might be able to describe what he or she saw happen to another child. Evidence may also be developed through the investigation of yet another victim.

In some situations the person suspected or accused of committing the molestation may admit to a police officer or investigator that he or she has committed the act. If voluntary, such statements are admissible. In most states a guilty plea by a criminal defendant may be used in later civil proceedings to prove what happened.

Expert Testimony **Expert testimony** may be permitted to establish what happened to a child. Expert testimony strengthens a party's claim for damages. Although a parent can testify to a child's unusual behavior, it is more meaningful for a child-abuse specialist or therapist to connect the unusual behavior—such as migraines, nightmares, or bedwetting—with the sexual molestation. In the face of expert testimony, the defense lawyer cannot persuade the jury that such behavior is normal for children of a particular age.

There are several possibilities for expert witnesses. The treating physician or therapist is the first choice. Parents may also seek a psychiatrist, social worker, psychiatric nurse, or other therapist who has experience with sexually abused victims. An experienced therapist who has dealt with numerous victims is often in the best position to predict the effects on the child.

The expert's testimony is likely to withstand cross-examination better than that of a child or parent. For example, the defense lawyer may ask the witness, "How can you be so sure that the child will have future problems with developmental milestones such as puberty, dating, marriage, and parenthood?" An expert who has dealt with these situations in the past can base his or her testimony on the documented behavior of other victims in similar circumstances.

Development of Evidence Parents of sexually victimized children can assist in developing evidence for use during legal proceedings. Ways in which they can help include the items noted below.

- Cooperate with social-service workers and law-enforcement officers.
- Obtain a therapist immediately. If a case goes to trial, the child's therapist is in the best position to evaluate the present and future impact of the abuse on the child.
- Follow the therapist's advice regarding treatment. The defense counsel often will try to blame some of the child's problems on parents, saying they talked too much—or too little—about the incident. It is helpful for the parent to be in a position to testify that he or she relied upon the advice of the therapist.
- Keep detailed notes of your child's behavior. These notes can be used in conjunction with the child's treatment and for future use in explanations to a judge or jury.

Proof of Damages In a civil suit, the objective is generally to obtain a monetary award consistent with damages to the child or parent. A few states allow parents to recover for their emotional pain and suffering resulting from harm to their children as well as damages for emotional pain and suffering to the child. In order for a family to win the case there must be evidence regarding diagnosis of the child's problems, treatment provided, and prognosis for the child's future.

One form of evidence that is helpful in establishing a child's case for physical damages involves testimony regarding the extent of the violence involved. If there are signs of violence, this evidence can be introduced through the child or another witness. Parents can also testify about signs that they have observed such as unusual behavior or differences in behavior before and after the sexual molestation.

The more objective such testimony is, the more weight it will carry. Parents may be able to piece together, in retrospect, various events that indicated sexual abuse or exploitation. For example, a child may have asked a parent about sexual matters, or the child may have refused to go to the perpetrator's home

or a place where the abuse occurred. Behavioral changes (such as nightmares or bedwetting) may have developed slowly or continued over a period of time if the molestation occurred on numerous occasions.

Depositions A **deposition** is an interview of a party or witness under oath. Depositions are generally taken in an informal setting before trial. Lawyers question potential witnesses with a court stenographer present to record what is said. Although lawyers may cross-examine adult witnesses vigorously during depositions, they rarely resort to this in a child's deposition. It is generally in the defense lawyer's best interest to make the child as comfortable as possible to find out what the child knows and will say.

Trying the Civil Case

Case 5 involved a 3-year-old child who told her parents that she had been sexually molested. The parents were frustrated because the district attorney had said the case was impossible to prove because the child was too young to testify. Furthermore, the social-service agency had made an investigation and indicated that the charge was unfounded because the identified abuser denied having committed such acts. Nevertheless, the family's attorney undertook the case, hoping that the child would be able to testify when the case came to trial (when the child was more than 4 years old). Various means of proof were developed for trying this case.

The Parent's Testimony In the deposition the mother testified that she was lying on a couch watching television when her 3-year-old daughter got on top of her and started moving her hips. The mother asked what she was doing, to which the child replied, "I'm going to put my penis in your vagina." The mother, unnerved by this response, asked her child where she had heard this and whether anyone had touched her. The child answered in the negative.

A few days later the child, while naked after a bath, took a roll-on deodorant tube and started rubbing it on her genitals. When asked what she was doing, the child reported that it "felt good." In a third incident the mother observed her daughter lying on top of her doll, talking very softly to it and kissing it all over its body.

The mother again asked the child if anyone had touched her in that way. The child paused and then answered **yes**. When the mother asked the child to show her what had happened, the child lay on her bed, put her hands around her neck as if she were choking herself, and started screaming, "Don't, don't! You are hurting me! Please! Don't! Stop!"

In a fourth incident the child pulled her pants down and then tried to pull down the zipper of her father's pants. The mother's testimony indicated that the child subsequently identified the adolescent son of her babysitter as "playing games with her vagina."

The Psychologist's Report Material elicited from projective testing revealed that the child was experiencing disturbing, intrusive thoughts about threatening male figures, particularly adolescent and adult males. During the testing, the child claimed that the abuser was outside when she glanced out the window. Later, she noted spontaneously, "(name of the abuser) tie tight around my neck" and abruptly changed the subject by continuing to perform the task at hand. Further testing revealed that the child perceived boys as hurting girls.

The Therapist's Report The report by the examiner for the child-protection division of a social-service agency noted that the child had fears of going to the babysitter, had developed night terrors, was afraid to sleep in her bed, and woke up screaming for her mother.

Expert Testimony The child was evaluated by an expert on child sexual abuse who provided testimony in two parts. The expert explained the previously exhibited symptoms and behaviors of the child and results of her assessment and interview with the child. The first part of the testimony focused on normal development and behavior for a 4-year-old child. The expert emphasized points important to understanding the observations of the mother and her communication with her daughter. First, children can remember events and recall them in detail. Small children, lacking extensive language skills, will act out as well as use words to convey a past event. And, children reproducing and recreating actions of past events are simply communicating what is on their mind at the moment.

In Case 5, the mother noted with surprise the frank sexual aspects of her daughter's behavior. When the mother queried her daughter the first time, the child showed tension. Sensitive to the mother's alarm, the child refused to clarify or respond to the mother's questions. If the offender had threatened to harm the child if she revealed the abuse, she would likely have been even more reluctant to tell her mother. It is possible that the child was not consciously attempting to tell the mother, but was simply reenacting the memory of the frightening events with the offender. The mother's startled response made the child conscious that she had revealed something.

The mother tried to remain calm and, over time, the child felt comfortable in revealing in detail what had happened. The mother asked her child to show her how the abuse occurred. The "show me" question permitted the child to act out the event and use the language of the event.

It was important for the jury to understand that the child thought her parents knew and approved of the abuse because she continued to be taken to the babysitter. Thus, the child repeated in front of the parents the sexualized reenactment behavior (masturbation) and the repetition behavior (playing sexually with the doll).

In Case 5, the expert testified about the child's spontaneous comments made to her during an automobile ride from the airport to the attorney's office. The child talked of God being in the sky, of people dying, of being with God, and about breasts; she developed a stomach ache while being driven past her therapist's office; and she spontaneously named the boy and reported that he had hurt her. The expert testified that these comments were the associations of a child who has been told she will be talking with someone about her abuse. The expert related the child believed that being choked and tied by the neck would result in death. She thought about dying and connected this with God. The expert further testified that the child's sexual preoccupation with breasts and physical symptoms (stomach ache) emphasized her level of tension.

Case Outcome After the civil action was initiated, police reinvestigated charges against the youth and found that there had been other victims. Another little girl, not yet 2 years old, had been molested; a report had been made and determined to be unfounded. Evidence was also obtained from another child who was present when the victim was molested.

Despite attempts by the defense counsel to minimize the long-term effects of the abuse because of the victim's young age, the jury awarded \$838,000. Because the facts of each case are unique and the ability of young victims to relate what happened differs significantly, the outcome of an individual case is extremely unpredictable. Victims and their families are often required to become involved in lengthy litigation to obtain redress for acts of sexual abuse and exploitation.

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National Center for Missing & Exploited Children

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Children Traumatized in Sex Rings

Foreword by Jon R. Conte, Ph.D.

- 1. Overview of Child Sexual Abuse**
- 2. Sex-Ring Crimes Against Children**
- 3. Health Assessment of the Child Victim**
- 4. Response Patterns of Traumatized Children**
- 5. Interviewing with the Event Drawing Series**
- 6. Treatment Issues in Child Sexual Trauma**
- 7. Legal Aspects of Sex-Ring Crimes Against Children**

End Notes