

# SEXUAL ABUSE OF CHILDREN IN DAY CARE CENTERS

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**Abstract**—Sexual abuse of children in day care center settings has received considerable attention in the past decade. The nature and extent of allegations of sexual abuse in day care poses unique challenges to clinicians. Cases of sexual abuse in day care typically involve multiple victims and multiple perpetrators, and use of extreme threats to prevent disclosure. This article reviews the available research findings on the types of abuse known to occur in day care, the dynamics involved including the types of threats used to silence young victims, and patterns of disclosure. The impact of sexual victimization in day care on children and parents is discussed. Implications for the clinical evaluation of preschool-aged children in cases of suspected abuse in day care settings are presented. Developmental considerations related to psychosexual development and the development of memory and language are reviewed. Psychological defenses in repetitive trauma are discussed.

**Key Words**—Sexual abuse, Day care centers, Child sexual abuse.

## INTRODUCTION

THE NATURE AND extent of allegations of sexual abuse of children in day care settings in recent years has posed unique challenges to clinicians. Cases of sexual abuse in day care often involve numerous factors that differ from what clinicians are typically confronted with in cases of intrafamilial sexual abuse. These factors include the young age of the child victims, the involvement of multiple victims and multiple perpetrators, females as perpetrators, use of extreme threats, and in some cases, ritualistic activities.

Cases of sexual abuse in day care settings have received much attention from the media in the past decade, which has left the public with the impression that children are at increased risk of abuse in day care. Based on findings of their national study of sexual abuse in day care, Finkelhor, Williams and Burns (1988) concluded that a given child has a lower risk of being abused in a day care center than in his or her own home. Nevertheless, sexual abuse can occur in any setting where children are found, including day care centers.

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As a result of increased parental fear and heightened awareness of the indicators of sexual abuse, parents of children attending day care may suspect abuse when a child displays emotional problems, even in the absence of allegations of abuse. Thus, children are referred to therapists for evaluation of possible sexual abuse with varying degrees of suspicion. Pre-evaluation degree of suspicion can range from cases where parents are concerned because of unusual behaviors displayed by their child in the absence of disclosure to cases where children have made detailed disclosures of abuse.

As with any clinical problem that has recently been identified, we are currently experiencing a lag time between identification of the problem of sexual abuse in day care and empirical data on its prevalence, characteristics, and impact. This article will review the research currently available on sexual abuse in day care centers, with emphasis on research findings which are useful in the clinical evaluation of children abused in day care centers. Of particular importance for the clinical evaluation of children abused in day care settings are research findings on the types of abuse known to occur in day care, the dynamics involved, which included the types of threats used to silence young victims, characteristics of offenders, patterns of disclosure, and the impact of sexual victimization in day care settings. Results from studies (Faller, 1988; Finkelhor, Williams, & Burns, 1988; Kelley, 1989; Waterman, Kelly, McCord, & Oliveri, 1990; Waterman, Kelly, Oliveri, & McCord, 1993) on sexual abuse of children in day care and research findings related to developmental considerations in the evaluation of preschool aged children will be discussed.

It is important to note that there are characteristics of day care cases involving multiple perpetrators that set them apart from those cases involving single perpetrators (Finkelhor, Williams, & Burns, 1988). Seventeen percent of the cases in the Finkelhor, Williams, & Burns (1988) sample involved multiple perpetrators. Day care center cases involving multiple perpetrators had the largest number of victims, were more likely to involve allegations of sexual penetration, pornography and ritualistic abuse, forced sexual acts between children, women as perpetrators, and appeared to have the most serious impact on victims.

#### TYPES OF ABUSE

Clinicians need to be knowledgeable about the spectrum of abuse reported by children victimized in day care centers. In addition to sexual abuse, children abused in day care may report physical and psychological abuse, therefore, a multi-dimensional approach to evaluation of children sexually abused in day care is necessary.

##### *Sexual Abuse*

The types of sexually abusive acts committed in day care range from fondling of genitals to vaginal and rectal intercourse. Although fondling activity is the type of abuse reported most often (Faller, 1988; Finkelhor, Williams, & Burns, 1988; Kelley, 1989; Waterman, et al., 1993) highly intrusive forms of sexual abuse involving penetration are also prevalent in day care center abuse cases. Digital penetration of children's vaginas and rectums is a widespread form of abuse in day care center cases (Finkelhor et al., 1988; Kelley, 1989).

Insertion of foreign objects into children's vaginas and rectums is a sadistic type of abuse that has been commonly reported by children in day care abuse studies (Faller, 1989; Finkelhor et al., 1988; Kelley, 1989; Waterman, Kelly, Oliveri, & McCord, 1993). Finkelhor, Williams and Burns, (1988) found penetration with a foreign object to be more prevalent among female perpetrators, especially in cases with multiple perpetrators. Foreign objects used to penetrate children in day care center cases have included such items as pencils, needles,

knives, scissors, and crucifixes. In some instances, perpetrators purposefully distort the child's perception of what is being inserted inside them. For example, in one case a large butcher's knife was shown to children who were told, "I'm going to put this knife up your bum." The children were made to bend over and were therefore unable to view what was actually placed inside their rectums. Thus, when a finger was inserted instead of the large knife they were shown, the children continued to believe it was the large knife that was placed inside them. Thus, when children related to an investigator or therapist that a "big knife was put up my bum," their allegations were often treated as suspect particularly in the absence of physical findings. Not only was the allegation regarding the "big knife" not believed, but other, more "believable" allegations of abuse made by the child were then doubted. In some cases children are told that these foreign objects have "magical powers." For example, in one day care center, children were told "I'm putting a magic thermometer inside you." Other children were told, "I'm putting a magic wand inside you."

Vaginal, rectal, and oral-genital intercourse has been reported in day care center sexual abuse cases (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989; Waterman, Kelly, Oliveri, & McCord, 1993). Twenty percent of subjects in Faller's (1988) sample reported vaginal or rectal intercourse and 30% were involved in oral-genital sexual activity. Fifty-one percent of children in Kelley's (1989) sample reported vaginal intercourse, 49% reported rectal intercourse, and 74% reported oral-genital penetration. In Finkelhor, Williams, and Burns' (1988) sample, 12% of children reported vaginal intercourse, 14% reported rectal intercourse, 30% described fellatio, and 14% described cunnilingus. In Waterman et al.'s (1993) sample, 49% of the ritualistic abuse group reported vaginal intercourse, 40% reported rectal intercourse, and 63% reported oral-genital contact. In the nonritualistic sexual abuse group, 7% reported vaginal intercourse and 71% reported oral-genital activity. Thus, in addition to fondling activities, young children abused in day care often experience highly intrusive forms of sexual acts with the offender.

Fifteen percent of Finkelhor et al.'s (1988) sample and 70% of Kelley's (1989) sample reported sexual acts between child victims. Forcing children to sexually abuse other children can cause children to view themselves as perpetrators instead of victims. This perception may elicit intense feelings of guilt, since it is easier to view oneself as a victim than a victimizer.

Allegations of pornographic photographs and videos being taken of children in day care center cases sometimes surface (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989). In Finkelhor, Williams and Burns' study (1988) there were allegations of pornography in 14% of the day care center cases. Unfortunately, in very few cases have law enforcement officials been able to locate the pornography after the case has come to light.

##### *Psychological Abuse/ Threats*

The use of threats to silence child victims has been discussed extensively in the clinical literature in sexual abuse (Kelley, 1986; Summit, 1983). The use of threats to silence young victims is an integral component of abuse in day care settings. Threats used by perpetrators in day care settings appear to be of a different nature than threats used by family members. Threats used in day care center cases are more likely to involve threats of physical harm (Faller, 1988; Kelley, 1989; Waterman et al., 1993) as opposed to threats of loss of love or separation from family members which are often used in cases of intrafamilial abuse.

Threats of physical harm to children and their family members are the most widely reported technique for silencing victims in day care centers (Faller, 1988; Kelley, 1989; Waterman et al., 1993). In the studies conducted by Waterman et al., (1993) and Kelley (1989) the vast majority of children in ritualistic sexual abuse groups reported being told that they or

their families would be killed by offenders if they disclosed the abuse, and in Faller's (1988) day care study almost a third of the threats involved death threats.

Despite the fact that each of the day care studies conducted to date involved day care center cases from different parts of the country, the types of threats utilized by perpetrators are remarkably similar. The common theme of almost all of the threats is "something very bad will happen to you or your family if you tell." Most threats are very specific in terms of what the consequence of disclosure will be and how the threat will be carried out. In one day care center case children were told "a UPS truck will come to your neighborhood and run you over if you ever tell." In another day care center case which had a Christian religious affiliation children were told "Jesus will cut off your arms if you tell." Some children are threatened with harm from "scary" things such as monsters, demons, snakes, and spiders. In many multiple perpetrator day care center cases, the offenders kill small animals in front of the children and then state, "This is what will happen to you if you tell."

The use of such severe threats is obviously quite frightening to young children and is effective in preventing disclosure. In fact, it appears that threats used in day care center cases may go beyond what is usually needed to silence victims, and may in some instances be made for purposes of psychological terror in and of itself.

#### *Physical Abuse*

Clinicians need to be aware of the nature and extent of physical abuse which may accompany the sexual abuse of children in day care settings. The majority of reports of multiple perpetrator cases of sexual abuse in day care are also accompanied by disclosures of physical abuse (Faller, 1988; Finkelhor, et al., 1988; Kelley, 1989; Waterman, et al., 1993). The types of physical abuse reported include being hit, physically restrained, being deprived of meals, forced to ingest excrement and being drugged.

Although there are reports of children being given drugs in day care center cases (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989; Waterman, et al., 1993) it is difficult in most instances to determine which drugs were used. Drugs given to children in day care centers include, but are not limited to, barbiturates, hallucinogenic agents, and alcohol. Children are often told that the drugs are "magic medicine."

Drugs may be given to children for a variety of reasons, including an effort to make them less resistant to the abusive activities, to distort their perceptions and recall of events, and to make them fall asleep so they can be photographed for pornographic purposes.

#### *Ritualistic Abuse*

A particularly disturbing type of abuse that has been reported in day care center cases as well as in cases on intrafamilial abuse is the ritualistic abuse of children. Ritualistic abuse refers to the repetitive and systematic sexual, physical, and psychological abuse of children by adults as a part of group worship or sadistic group activities (Kelley, 1988). Most cases of ritualistic abuse in day care centers involve multiple victims and multiple offenders (Finkelhor et al., 1988; Kelley, 1989). According to Finkelhor et al. (1988), the hallmark of this type of ritualistic abuse is the existence of an elaborate belief system and the attempt to create a particular spiritual or social system through practices that involve abuse of children. Children who have been ritualistically abused describe participation in group ceremonies, use of chants and songs, adults dressed in costumes and masks, threats with supernatural powers often involving Satan or demons, the sacrifice of animals, the ingestion of blood, feces and urine, and murders (Kelley, 1989; Waterman et al., 1993).

#### *Offenders*

Clinicians who evaluate children suspected of having been sexually abused in a day care setting should be knowledgeable of the characteristics associated with perpetrators in day care settings. In the national study conducted by Finkelhor et al. (1988), a wide range of roles of the perpetrators were identified. The roles included teachers (30%); family members of staff (25%); directors or owners of the day care center (16%); nonprofessionals that included teacher's aids or volunteers (15%); and nonchild care staff that included bus drivers and janitors (8%) and perpetrators who were complete outsiders (5%) to the day care centers.

Because perpetrators are often family members of staff and outsiders including strangers, children may name perpetrators during clinical evaluations that are unfamiliar to the child's parents or authorities. This may initially be confusing to parents, clinicians, and investigators. However, clinicians should keep an open mind that individuals other than known employees of the center may have access to the children. Children may also disclose being transported to unfamiliar sites, and therefore may be unable to accurately identify sites where the abuse has occurred, as well as the individuals who have abused them.

Clinicians who evaluate children for sexual abuse in a day care setting must be open to the possibility of women as offenders. Although women in general commit fewer sex offenses against children than men, the proportion of women involved as perpetrators in day care centers is higher than in cases of abuse outside of day care settings (Faller, 1988; Finkelhor, et al., 1988; Kelley, 1989). In the day care center cases examined by Finkelhor, 40% of the offenders were female. In Faller's (1988) study, 50% of children were abused by both a male and a female perpetrator, 2.1% were abused by a female, and 48% were abused by a male. In Kelley's (1989) sample, 55% of perpetrators were female and 45% were male. As noted by Finkelhor et al. (1988), the involvement of females as perpetrators in day care settings should not be surprising, because women comprise the vast majority of day care center staff. Therefore, clinicians evaluating young children for sexual victimization in a day care setting should keep an open mind to females as possible perpetrators.

There were certain abuse characteristics found to be associated with female offenders in the national study conducted by Finkelhor, Williams, and Burns (1988). Forty-seven percent of day care center cases involving female perpetrators were multiple perpetrator cases. Seventy-three percent of female perpetrators abused children in the company of other offenders compared to only 19% of male offenders.

Day care center cases involving female perpetrators were more likely to involve abuse of multiple children over a period of time and were less likely to involve a single incident of abuse. Women were more likely than men to commit sexual acts that involved penetration, including oral-genital acts, and insertion of foreign objects and fingers into vaginas and rectums. Female perpetrators were also more likely to abuse younger children and to use physical force or threats of physical force. Female offenders were found to be more likely to have forced children into sexual acts with other children and to have participated in ritualistic abuse than male offenders.

#### *Intensity of Abuse*

Another troublesome finding in day care studies is that the children are subjected to a considerable number of different sexually abusive acts. The mean number of different types of sexual acts per child ranged from 5.3 sexual acts per child in Faller's (1988) sample to 6.6 different types of sexual abuse per child in Kelley's (1989) study. Children abused in day care are often abused by multiple offenders (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989; Waterman et al., 1993). In Kelley's (1989) sample the mean number of offenders per child was

3.4, with a range from 1 to 17 different offenders per child. In Faller's (1988) sample, the mean number of offenders per victim was 2.8, with a range of 1 to 8 offenders per victim.

Because of the young age of children at the time of onset of abuse in day care and time of disclosure, it is difficult to accurately determine with any degree of certainty the number of times a child was abused or the duration of the abuse. The available data indicates that the majority of children who were sexually abused in day care were abused on more than one occasion (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989; Waterman et al., 1990). The majority of children are abused over a time period ranging from one to twelve months (Finkelhor et al., 1988; Kelley, 1989). However, some cases involved a single abusive event while others lasted several years.

#### *Patterns of Disclosure*

Not unlike other situations in which sexual abuse occurs, abuse in day care is typically associated with delayed disclosure (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989; Waterman et al., 1993). Only 20% of all children in Finkelhor and colleagues' (1988) sample disclosed abuse on the same day that the child was abused. Almost 50% of all first disclosures occurred within a month after the onset of the child's abuse, and 32% of the cases were not disclosed for at least 6 months.

The majority (63%) of children revealed the abuse to their parents after their parents had noted some suspicious behavior or symptoms, and questioned or examined the child. In 51% of these adult-prompted disclosures, there were behavioral changes such as sleep disorders, sexual acting out, and fears that caused the parents to become suspicious. Thirty-seven percent of children disclosed spontaneously without parental prompting, and only 7% were detected by nonoffending staff at the day care center (Finkelhor et al., 1988).

Information gathered from therapists on patterns of disclosure by children in Waterman et al.'s ritualistic abuse sample indicate that 76% of the children disclosed sexual abuse within the first month of therapy, with the remainder making first disclosures over a period of months (Gonzalez, Waterman, Kelly, McCord, & Oliveri, 1990). Children tended to make vague disclosures before revealing more specific acts, to reveal less intrusive sexual abuse before more intrusive types, and to disclose ritualistic abuse after all other types.

#### *Impact of Abuse/Symptomatology*

Findings from the four day care studies reviewed empirically validate clinical observations that children who are sexually abused in day care are significantly impacted. It is important to note however that only two (Kelley, 1989; Waterman et al., 1993) of the four studies reviewed utilized standardized measures of child outcomes. The remaining studies (Faller, 1988; Finkelhor et al., 1988) relied on the ratings of symptoms by professionals in contact with the children and a description of symptoms by parents. Interpretations regarding the symptomatology of children abused in day care must therefore be made with caution until further data are available.

In a study on the impact of sexual abuse in day care Kelley (1989) compared the Child Behavior Checklist (Achenbach & Edelbrock, 1983) scores of a group of 67 children who were sexually abused in day care centers to a carefully matched comparison group of 67 nonabused children. Children who had been sexually abused in day care scored significantly higher than nonabused children on total child behavior problems, the internalizing and externalizing dimensions, and on each of the subscales which included depression, aggression, schizoid, social withdrawal, somatic complaints, and sexual problems.

In Waterman et al.'s sample, 49% of males and 44% of females from the ritualistic sexual abuse group scored in the clinical range ( $T$  score  $> 70$ ) on the total behavior problem scale of

the Child Behavior Checklist (Achenbach Edelbrock, 1983). In Kelley's sample 40% of the children scored in the clinical range on the total behavior problem scale. Only 2% of the general population would be expected to fall into this range, indicating far greater emotional problems in these groups of sexually abused children than would be expected in the normal population.

Children who have been abused in day care appear somewhat more internalizing than externalizing in their behaviors (Kelley, 1989; Waterman et al., 1993). In Kelley's (1989) sample 47% scored in the clinical range on the internalizing dimension while 25% scored in the clinical range on the externalizing dimension. Among the ritualistic sexual abuse group (Waterman et al., 1993), 42% of boys and 53% of girls scored in the clinical range on the internalizing dimension, while 33% of boys and 42% of girls scored in the clinical range on the externalizing dimensions. Among the nonritualistic sexual abuse group, (Waterman et al., 1993) 14% of girls and none of the boys scored in the clinical range on the internalizing dimensions while 14% of girls and 25% of boys scored in the clinical range on the externalizing dimension.

Sexual abuse in day care also has a negative impact on children's social functioning. Sexually abused children scored significantly lower in social competence than nonabused children in both studies (Kelley, 1989; Waterman et al., 1993). Eleven percent of the abused subjects in Kelley's (1989) sample and 22% of Waterman's ritualistic sexual abuse sample scored in the clinical range ( $T$  scores  $< 30$ ) on the social competence scale on the CBCL.

In Faller's (1988) study, symptoms reported by parents were categorized into seven problem areas: sexual behaviors, sleep problems, physical symptoms, emotional problems, behavior problems, phobias, and other problems. The most common problems reported were sexual behaviors (in 24% of subjects) followed by what was referred to as "emotional" problems (in 20% of subjects) which included mood disorders such as depression and anxiety. The distribution of the remaining types of sequelae are as follows: phobias, 16%; behavior problems, 15%; sleep problems, 13%; physical problems, 11%; and other, 3%.

In Finkelhor et al.'s (1988) study, victim impact was measured by the number of symptoms reported by professionals in contact with the abused children such as therapists, child protective workers, and in some cases day care teachers and police. The most commonly reported reaction was fear, with 69% of the children being reported as fearful. Sixty-eight percent of the sample experienced nightmares and other sleep disturbances. As Finkelhor, Williams, and Burns (1988) note, nightmares in children under three are uncommon, yet 87% of children under three years experienced nightmares and night terrors. Clinging behavior (53%) and sexual acting out behaviors (46%) were the next most commonly reported symptoms followed by bed wetting (36%), crying (52%), aggressive behavior (32%), distrust of adults (29%), school problems (27%), play behavior affected (26%), tantrums (25%), toilet training problems (19%), blaming parents (7%), and learning disabilities (5%).

#### *Fears*

In Kelley's (1989) study, 95% of the parents reported that their child was extremely frightened by the threats made by the offenders. And, despite the fact that an average of 2.2 years had elapsed since the abuse ended, 80% of parents reported that their children had persistent fears related to the abuse. Almost 70% of the children in Finkelhor, Williams and Burns' (1988) study exhibited symptoms of fear which included fear of going to day care, fear of being left alone, and fear of real or imagined objects or persons.

Waterman et al., (1993) utilized the Louisville Fear Survey (Miller, Barrett, Hampe, & Noble, 1972) a measure completed by parents, to determine the extent and type of fears displayed by children in their sample. Both the group alleging ritualistic sexual abuse and the

sexual abuse only group were significantly more fearful than the control group, and in fact, both abuse groups showed more fearfulness than phobic children. It is noteworthy that 37% of the group alleging ritualistic abuse were reported to have excessive or unreasonable fear of the Devil and 27% have excessive fears of Hell, while none of the control group reported such fears.

#### Children's Measures

Objective and semi-projective measures were collected from children in Waterman et al.'s (1993) study. On the Harter Self-Perception Profile for Children (Harter, 1985; Harter & Pike, 1984), there were no differences in self-concept between groups for the younger children; among older children (3rd grade and above), children reporting ritualistic sexual abuse showed significantly poorer self-concept than either the sexual abuse only group or the control group in terms of physical appearance and global self-worth. Similarly, on an Incomplete Sentences Blank, the ritualistic sexual abuse group showed more negative attitudes toward school, adults, and family than did controls. The children were also asked to draw a picture of a person, and their drawings were scored for emotional indicators by raters blinded to group membership according to a system developed by Koppitz (1968, 1984). Results showed that the group reporting ritualistic sexual abuse displayed significantly more emotional indicators in their drawings than either of the other groups, with their mean score falling in the clinical range.

#### Therapist Ratings

Children's therapists were asked to fill out a version of the Child Behavior Checklist in the Waterman et al. (1993) study. Both day care abuse groups had mean scores on internalizing symptoms in the clinical range, with the group alleging ritualistic sexual abuse scoring significantly higher than the sexual abuse only group on externalizing symptoms and total behavior problems. Additionally, therapists were asked to rate the children's level of functioning on the Children's Global Assessment Scale (Shaffer et al., 1985). There were no differences between groups alleging ritualistic sexual and sexual abuse only on this measure at time of most distress; however, by the end of therapy, the sexual abuse only group was significantly higher in global functioning than the group alleging ritualized abuse.

#### Variables Associated with Increased Impact

→ **Gender.** The child's gender does not appear to be a major influence on how the child is impacted by the abuse in day care (Faller, 1988; Finkelhor, et al., 1988; Kelley, 1989; Waterman et al., 1993). This finding may be related to the young age of the children at the time of abuse.

→ **Age.** Age at the time of the abuse in day care does not appear to be a major influence on victim impact. Kelley (1989) and Finkelhor, Williams, and Burns (1988) did not find age at the time of abuse to be related to impact of abuse. Faller (1988) reported that age was associated with increased impact in only two of seven symptom categories. Children experiencing problems categorized as "emotional problems" or "other problems" subsequent to the sexual abuse were on average older.

**Ritualistic abuse.** Ritualistic abuse was associated with increased impact in each of the three studies that categorized abuse as ritualistic in nature (Finkelhor, Williams, & Burns, 1988; Kelley, 1989; Waterman et al., 1993). This increased impact is most likely attributable to the

extreme physical, sexual, and psychological abuse associated with ritualistic abuse. Ritualistic abuse is associated with more victims per day care center, more offenders per child, greater frequency of sexual abuse, more intrusive forms of sexual abuse, and more types of abuse per child (Kelley, 1989).

**Intensity of abuse.** The number of types of maltreatment, number of threats, and number of perpetrators, were related to increased impact in Faller's (1988) study. In Finkelhor, et al.'s (1988) sample use of physical force was predictive of higher symptom scores. However, in Kelley's (1989) and in Waterman et al.'s (1993) studies these factors were not related to increased impact.

#### PARENTAL RESPONSE

Parental reaction to their children's victimization was an important influence on the child's response (Burgess, Hartman, Kelley, Grant, & Gray, 1990; Esquilin, 1987; Kelley, 1990; MacFarlane, Conerly, Damon, Durfee, Long, Waterman, 1986). Friedrich and Reams (1987) suggest that the symptoms seen in sexually abused children reflect not only the trauma they have experienced directly, but also their family environment, the amount of support the child feels, and the level of disruption that follows the disclosure of abuse.

Clinicians need to be knowledgeable of and sensitive to the parent's response to their child's victimization in day care centers. Kelley (1990) examined the stress responses of the parents of 67 children who were abused in day care centers. When compared to the parents of 67 nonabused children on the Symptom Checklist-90-R (SCL-90-R) and Impact of Event Scale (IES), it was found that parents whose children were abused in day care centers experienced significantly more psychological distress than parents of nonabused children. Parents of children abused in day care reported symptom profiles on the SCL-90-R and IES consistent with post-traumatic stress disorder.

Several factors were associated with increased impact in the parents of abused children (Kelley, 1990). Parents of ritually abused children displayed the most severe psychological distress. Maternal childhood history of sexual abuse was associated with increased impact. Mothers who were themselves victimized in childhood and whose children were subsequently abused in day care experienced more psychological distress than mothers without a childhood history of abuse, indicating a compounded stress reaction in these mothers. This finding indicates that clinicians need to elicit parental histories of childhood sexual abuse when assessing families of child victims and to provide appropriate support to adult survivors of sexual abuse.

#### CLINICAL EVALUATION OF PRESCHOOL AND RITUAL ABUSE

In undertaking evaluation of a young child for whom abuse in day care is suspected, the clinician must remember that children are at greater risk to be abused at home than in day care, and that most day care does not pose a high risk situation for children (Finkelhor et al., 1988). Children may present for evaluation after making disclosures about abusive acts in a day care center. More often, the child presents with symptoms which cause parental concern, and many factors besides day care abuse can contribute to the etiology of these symptoms. While clinicians must assist parents in determining when symptoms are a danger signal of abuse in day care, they must not err on the side of creating anxiety and distrust about day care when it is not deserved.

The comprehensive evaluation of preschoolers who have been abused in day care includes medical evaluation, psychological evaluation, and assessment of the child's parents and family situation. This section will focus on psychological evaluation of the preschool child.

The psychological evaluation of the preschool child poses many special challenges to the clinician because of the psychological immaturity of the child, the often complex nature of the abuse suffered by the child, and the nature of a young child's reactions and accommodations to the abuse. Research data on the types and impact of preschool abuse is very helpful in guiding the clinician. In addition, research about young children's memory of trauma, normal sexual development, and preschoolers' emotional and behavioral reactions must guide the clinical assessment.

During an evaluation clinicians must also acknowledge that sexual abuse of preschoolers usually occurs in the context of a relationship with a caretaker and affects the child's capacity to form trusting relationships with adults. The very young child continues to be dependent on adults in their environment. The influence of parents, evaluators, and other professionals on young children during an assessment must be carefully considered in order to maximize the child's capacity to communicate their own story and to minimize the influence of other involved adults on the findings.

## DEVELOPMENTAL CONSIDERATIONS

### *Behavioral and Verbal Memory*

Research and theory about young children's capacity to remember trauma has mushroomed in recent years as a result of increased clinical and legal focus on children who have been victims of or witness to violence (Goodman, 1984; Pynoos & Nader, 1989). Lenore Terr's preliminary retrospective study of 20 children who experienced trauma before age 5 resulted in findings relevant to the assessment of preschool abuse (Terr, 1988). Verbal and behavioral remembrances of children were compared to documentation of the trauma they experienced. Ages 28 to 36 months at the time of the trauma served as a cutoff point separating those children who could fully verbalize their past experiences from those who could do so in part or not at all. Terr documented the literal mirroring of traumatic events in "behavioral memories" established at any age, including infancy. The behavioral memories took the form of "post-traumatic play" and "reenactments" (Terr, 1979, 1981), personality changes related to frequent reenactments, and trauma-specific fears. Play, reenactment, and fears strikingly mirrored parts of the child's traumatic experience. Behavioral memories existed even when a child had no verbal recollection of a trauma. In cases in which the young child did have verbal memories of their traumas, the memories were often not detailed and complete by adult standards. Bits of verbal memory sometimes stood for the entire event. In other cases aspects of verbal memory associated with painful affect were suppressed resulting in a partial memory of the event. Memories were sometimes elaborated with developmentally meaningful symbols which made the verbal memory sound fantasized although it was in many respects true to the actual trauma. Also, as traumatic memories are stored, their meaning is often reworked and reappraised as the child develops. They are not static over time.

Although Terr's sample was small and her observations need to be replicated, her findings are relevant to the clinical evaluation of sexual abuse in very young children (Terr, 1988). Incomplete verbal memories of traumatic events can be a result of cognitive immaturity and suppression of painful affect. Failure of a child to recall many details of trauma, especially in cases of multiple repeated traumas, does not mean that the child did not experience the trauma. Terr's findings also underscore the importance of noting and recording nonverbal

communication in preschool children who are being evaluated (Terr, 1988). The content of repeated post-traumatic play, reenactments, and fears, can literally mirror aspects of the trauma a child experienced and can corroborate abuse of a child, even when the child has no verbal memory for a trauma. Finally, Terr's observation that a child may include developmentally appropriate symbols and fantasy material in a memory of an actual trauma reminds us of the complexity of the clinician's task of determining whether a child's recollection of a trauma represents fact versus fantasy (Terr, 1988). The presence of what seems like fantasy material in a memory does not necessarily invalidate that memory. One might also note that in some cases of preschool abuse, perpetrators purposefully incorporate costumes and fantasy figures into the abuse. These tactics may be utilized to involve the children in the abuse, to frighten them, and to influence their memories so they are more likely to be disbelieved.

### *Language and Cognition*

Preschoolers think concretely. They can describe an event in concrete terms ("Joe put a stick up my bum") and can provide idiosyncratic sensorimotor details about how things looked, smelled, tasted and felt. Drawings and dolls or puppets assist young children in showing concrete events that they experienced.

Children under 5 years recall less detail about experiences than older children and adults. This is not a function of memory deficit; rather it reflects the child's lack of experience, poor strategies for recall, and immature expressive language capacity (Loftus & Davies, 1984). Errors of recall in young children are more often errors of omission rather than commission (Goodman, 1984). Young children's recall can be assisted by the use of toys, props and drawings.

Preschoolers do not understand abstract concepts and do not have the same capacity as adults to organize their thoughts logically using constructs of space, distance, and time. The concept of historical time and sequence is not acquired until 10 years of age (Goldstone & Goldfarb, 1966). A 4- to 6-year-old may be able to tell you who did something and where it happened but will not be able to temporally order events. They can sometimes link events to special times (holidays, birthdays) and can be assisted in remembering whether it was hot or cold, day or night. Failure of a young child to be able to describe when something happened or the frequency of a trauma does not diminish the credibility of that child.

Preschoolers have an egocentric view of the world and understand events in terms of themselves. They do not easily understand motivation of others and consequences of actions. When interviewing a preschooler, the evaluator should focus on the child's direct experience and perspective. An interviewer will not get far by asking a preschooler why someone did something or how something happened (Waterman, 1986).

### *Development of Sexuality*

Many studies of children who are sexually abused note that the presence of precocious sexual behavior, play, and knowledge distinguishes these children from other clinical and normal populations (Finkelhor et al., 1988; Friedrich, Beilke, & Urquiza, 1988; Gale, Thompson, Moran, & Sack, 1988; Gomes-Schwartz, Horowitz, & Sauzier, 1985; Kelley, 1989; Waterman et al., 1993; White, Halpin, Strom, & Santilli, 1988; Yates, 1982). In order to determine what constitutes abnormal behavior in preschoolers, clinicians must know something about normal sexual development of young children. This becomes especially important since young children, according to Freud's theory of psychosexual development, are either in the anal stage of development (1 1/2 to 3 years) during which they focus on bowel and bladder control, or the phallic stage of development (3 to 4 1/2 years) during which they are increasingly aware of genitals, male-female differences, and sex-roles. Masturbation, genital

interest, sex play and sexual curiosity are common during this period (Gundersen, Melas, & Sklar, 1981; Sears, Maccoby, & Levin, 1957).

Research data on sexual development from direct interviews of children and direct observation is scant (Bernstein, 1976; Cohen and Parker, 1977; Victor, 1980). Existing data suggests that preschool children are interested in physical sexual differences between boys and girls and have increased awareness of differences in sex roles by the time they reach kindergarten. They are curious to learn where babies come from. On the other hand, it is unusual for a preschooler to have detailed knowledge about sexual intercourse and adult sexual functioning unless they have been involved in or witnesses to such behavior. Preschoolers may convey their knowledge verbally ("His dick got bigger, and yucky stuff came out of it"). They may also communicate their knowledge nonverbally in play and interactions, such as mimicking of sexual poses and postures. If a preschooler possesses such detailed sexual knowledge, a clinician must inquire how the child obtained it. Obviously, sexual abuse in a day care setting can be the source of precocious sexual knowledge and can eroticize a child. Clinicians must also be careful to inquire about the sexual practices of children's families and possible exposure of children to sexually explicit material in that context.

## REACTIONS TO ABUSE

### *Differentiating "Normal" Symptoms of Childhood and Symptoms of Sexual Abuse in Day Care*

Many of the nonspecific symptoms of sexual abuse noted in the research such as fears, nightmares, and separation anxiety, can occur during the normal course of development and can be secondary to factors other than sexual abuse. It is common for children who may have been abused in day care to come for evaluation because of parental concern about symptoms when no disclosure has been made. Clinicians will have to work with the parents and child to differentiate benign symptomatology from symptoms that may signal reactions to an abusive situation by exploring multiple aspects of the child's development and family situation, as well as the day care context. The clinician must also be sensitive to aspects of the parent's history, such as history of childhood abuse, which may predispose them to anxiety about their child.

For example, it is not unusual for a preschooler to occasionally show some separation anxiety or reluctance to go to day care. In most instances, these symptoms do not mean a child is being mistreated. By discussing concerns with parents and observing the child's behavior and play, a clinician can help determine whether a child's behavior may be related to feelings about leaving a parent or other concerns at home or in day care.

A single symptom is rarely diagnostic of an abusive situation. Rather the clinician should look for a pattern of symptoms over time correlated to context, development, and other life events of the child and family.

### *Reaction to Threats and Intimidation*

The use of intimidation and threats of physical harm to the child and family members make children fearful to tell about their experience. Disclosures are often delayed and gradual. Once children do begin to tell their story, their fear of retaliation may worsen with resultant increase in their anxiety and reluctance to speak. Evaluators must appreciate the extent to which many abused preschoolers may have been threatened and even terrorized. Often, one must inquire about the types of threats used to frighten a child and must go to great lengths to assure children that they and their families are safe in order to facilitate disclosures.

### *Reaction to Multiple Types of Abuse*

Some children abused in day care suffer multiple incidents of multiple types of physical, sexual, and psychological abuse which may be committed by multiple perpetrators (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989; Waterman et al., 1993). Perpetrators sometimes purposefully misrepresent the abusive activities to the children. A given child may be both a victim of and witness to the abuse of others. Children may also be encouraged to perpetrate abuse on other children. These complexities of the abuse experience may confuse the child, make them feel guilty and make it difficult for a child to tell a coherent story of what happened. In addition, in cases involving use of drugs to force and alter a child's perceptions, a child's capacity to remember and report abuse is undoubtedly compromised.

### *Psychological Defenses in Repeated Abuse*

Some clinicians have postulated that repeated and/or variable traumatic events are less fully remembered than single episodes of trauma (Terr, 1988). Therefore, a child who has suffered repeated abuse may be less likely to specifically remember what happened than a child who was abused on one occasion. It is possible that a pattern of absent, incomplete, delayed, and gradually emerging memories of abuse incidents is a function of the psychological defenses that a victim utilizes in order to psychologically survive repeated abuse that they cannot physically escape. The most extreme defense utilized under these circumstances is dissociation.

Increasingly the connection between dissociative disorders and severe repeated trauma is being documented. Several lines of circumstantial evidence suggest that children may be more prone than adults to use dissociation as a defense mechanism for coping with trauma (Putnam, 1985). Because of the use of dissociation and denial by some child victims of sexual abuse, it is possible that a child who has, in fact, suffered significant abuse may appear relatively asymptomatic and may have poor memory or amnesia for the abuse they experienced. Clinicians should be aware of those symptoms which may suggest that a child is utilizing dissociation as a defense. These would include: history of being called a "liar" because of disavowed behavior; autohypnotic trance-like behaviors; fluctuations in abilities, age-appropriateness, and moods; other evidence of amnesia; currently active imaginary companionship; disavowed polarized behavior; and disavowed witnessed behavior (Kluft, 1985).

Psychological defenses which create total or partial amnesia for abuse may remain operative for months or years after the abuse has stopped resulting in the phenomenon of delayed and gradual disclosure. The need for the defense may lessen once the child is in a safe situation. A child's remembrance of repressed memories of abuse may be accompanied by significant psychological distress and post-traumatic symptomatology, even if the abuse is not ongoing, and may result in referral of the child for evaluation.

### *Post Traumatic Stress Disorder*

As a result of clinical and research interest in youngsters who have suffered many kinds of trauma, there has been increased interest in the manifestations of post-traumatic stress disorder in children (Eth & Pynoos, 1985). Most impact studies of victims of child sexual abuse document discrete symptoms. More recently, researchers have asked whether child victims of sexual abuse suffer from post-traumatic stress disorder. Preliminary studies, which include children as young as 3 years, indicate that PTSD is a frequently observed disorder in sexually abused children (Deblinger, McLeer, Atkinson, Ralphe, & Foa, 1989; Kiser et al., 1988; McLeer, Deblinger, Atkinson, Foa, & Ralphe, 1988). In a retrospective study of 155 child inpatients three groups of sexually abused, physically abused and nonabused children were

compared. Among the sexually abused children, 20.7% met criteria for PTSD compared to 6.9% for physically abused children and 10.3% for nonabused children. Within the re-experiencing category of symptoms, sexually abused children exhibited significantly more sexually inappropriate and sexually abusive behavior than physically abused or nonabused children. They also showed a tendency to exhibit more symptoms in the avoidance/dissociative subcategory of PTSD (Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989). Interpretation of this data may be limited by the retrospective nature of the study and its limitations to an inpatient population.

A study by Kiser et al. (1988), further supports the applicability of the PTSD diagnosis to preschoolers. Their study evaluated 10 children aged 2- to 6- years who were victims of alleged sexual abuse in a day care setting, which included rape, threat of harm to children and parents, satanic acts, and killing of animals. Nine of the 10 children met the diagnostic criteria for PTSD. Their symptoms included visualization in the form of daydreaming, sexual acting-out, mundane and trauma-related fears, and nightmares. In the Waterman et al. (1990) study, 83% of the ritualistic sexual abuse group met criteria for PTSD diagnosis, while 36% of the sexual abuse only group met PTSD criteria.

The findings from these studies need to be corroborated by larger studies of outpatient and inpatient populations. The data does, however, suggest that the presence of post-traumatic symptomatology in a young child including sexualized behavior and play and avoidant/dissociative symptomatology may be corroborating evidence of a history of sexual abuse. In situations where young victims are reluctant or unable to disclose abuse, the trauma-specific PTSD symptoms can be especially useful in helping the clinician determine the etiology of the child's symptoms.

#### *Ritualistic Abuse*

One of the first complications in the evaluation of ritualistic abuse cases is the frequent disbelief and skepticism on the part of the professionals secondary to the bizarre and extreme nature of the allegations. As mental health clinicians and police investigators accumulate reports of ritualistic abuse from across the nation, and as adult and child victims disclose their experiences, evidence for the veracity of these cases accumulates. Another common professional reaction during evaluation is paranoia. Threats to evaluators may be communicated via the children or experienced directly. Even when no overt threat exists, the horrifying nature of the allegations can engender a fearful avoidant response on the part of clinicians.

Because of the use of extreme intimidation and threats which are often "programmed" into the children and reactivated by behaviorally reinforced "triggers" in the child's environment, children who suffered ritualistic abuse are unusually distrustful and fearful to disclose the abuse and if they do disclose, will become panicked that harm or death will come to them or their parents. The repeated and extreme nature of abuse usually activates extreme psychological defenses including denial and dissociation. Often disclosure of details of ritualistic abuse will be delayed and occur well into an evaluation or treatment process. As disclosures are made and memories become conscious, they are often accompanied by severe post-traumatic symptomatology including hypervigilance, intrusive experiences, and fearful and avoidant responses.

Symptoms and details of disclosures that should alert clinicians to the possibility of ritualized abuse include the following: preoccupation with urine and feces; fear and panic associated with toilet training; sadistic play; harm or killing of animals; mutilation themes; fear of a foreign object inside the body (resulting from "magical surgery" and suggestion); use of satanic symbols including the upside down cross, pentagon, swastika; use of numbers with satanic significance (666, 13); and descriptions of ceremonial robes, chalices, candles, masks,

and ceremonies (Gould, 1986). Children exposed to satanic practices may also be acutely aware of days of importance in the Satanic calendar when Black Masses or other "celebrations" occur, and may become very fearful or symptomatic at those times which include May 1 or Walpurgisnacht, Halloween, and the solstices and equinoxes (Kaye & Klein, 1987).

### THE EVALUATION PROCESS

Challenges to the credibility of preschool victims of abuse often arise in the medical-legal context. Some challenges focus on the impact of the evaluation process on the child and the extent to which young children are suggestible and subject to direct or indirect influence and "education" by the evaluator. Any clinical evaluation of a youngster involving allegations of sexual abuse in day care may, sooner or later, be involved in multiple medical-legal contexts including protective, criminal, and civil procedures. Therefore, the clinician must go to great pains to avoid bias, maintain their objectivity, and minimize practices which may inadvertently influence a child during an evaluation and call into question the objectivity of the evaluation.

#### *Suggestibility and Leading Questions*

Jones and McQuiston have reviewed the literature on suggestibility as it relates to evaluation of the sexually abused child (Jones & McQuiston, 1988). Both adults and children are subject to suggestibility. The experimental literature does suggest that leading questions may influence a child under certain circumstances (Dale, Loftus, & Rathun, 1978; King & Yuille, 1987). Questions may clearly lead, may be based on a bias towards a certain response, or may be based on preconceived notions of the adult interviewer. Relentless probing and pressuring of a child may also result in error. However, memories of central importance to the child are less subject to suggestibility by use of leading questions than memories of peripheral importance (Goodman, 1984). It is likely that at least some aspects of memories of sexual trauma would fall into the "centrally important" category, although what children and adults consider important does not always coincide.

Some children come for evaluation after they have made a disclosure to someone. When this is the case it is helpful to evaluate a child soon after the disclosure. Even under these circumstances, many children will be fearful to speak because of intimidation or fear and are unable to make a disclosure easily because of the operation of psychological defenses. The clinician will have to carefully weigh the need to get the details from a child for protective or other reasons with the tactics used which may influence the child's disclosure. Certainly giving a child an opportunity to develop trust and rapport with the examiner and assuring the child's safety from abuse, retaliation, and efforts to silence them, will assist in enabling a child to truthfully tell their story. Research has also shown that young children's memory for details can be enhanced through the use of props representative of everyday activities and objects, settings, and people which may have been involved in the abuse. There is evidence that their use can enhance memory, and no evidence that their use will distort memory (Jones & McQuiston, 1988). Evaluations should begin with observations of children's spontaneous statements and play since these may give clues about possible abuse. Questions should be initially open-ended.

#### *Anatomically-Correct Dolls*

"Anatomically-correct dolls" are used by some clinicians in the evaluation of preschool children. Since preschoolers can benefit from the use of these dolls to assist them in showing as



well as telling about their experiences and since the dolls may be a means of bringing forth an abused preschooler's inappropriate sexualized behavior, many clinicians feel they are very useful, especially with very young children. Yet others argue that the dolls are not a neutral stimulus and may influence a child. There is debate among clinicians about the appropriateness of the use of dolls, the extent to which they might be suggestive, the way in which the dolls should be used during an evaluation, and interpretation of children's interaction and play with the dolls (Yates & Terr, 1988a,b).

Experimental data comparing sexually abused and nonabused children's behavior with the dolls suggests that abused children are more likely to demonstrate sexualized play than nonabused children but the samples in many studies are small, and there are circumstances when sexually abused children do not show sexualized play and nonabused children do (Jampole & Weber, 1987; White, Strom, Santilli, & Halpin, 1986). In a more recent study Everson and Boat utilized a detailed protocol in a demographically diverse sample of over 200 2- to 5-year-old children. They also defined more precisely the nature of the "sexualized play" they observed. They found a 6% incidence of demonstrations of apparent sexual intercourse in their theoretically nonabused sample, and therefore argued that these dolls were not overly suggestive to young, sexually naive children (Everson & Boat, 1990).

Realmuto and colleagues reported on blind interviews using a standardized anatomical-doll protocol to assess a small group of children under 7 years, which included sexually abused children, non-clinic controls, and four psychiatric controls. Based only on data from the anatomical doll protocol, the clinician was able to accurately classify abused and nonabused children in only 53% of their cases. They caution that without other sources of information, clinicians should be very cautious in interpreting data based on the use of a single diagnostic instrument (Realmuto, Jensen, & Wescoe, 1990).

Clinicians who do use anatomically correct dolls must keep informed of the evolving literature in this area. If clinicians do use these dolls they should be one of many approaches utilized by the clinician. Evaluators should consider using the dolls later rather than sooner in an evaluation to minimize the likelihood that the dolls were suggestive influences. In any clinical report a clinician should specify how the dolls were used. Dolls may be used as a part of a standardized protocol, (e.g., Boat & Everson, 1986), during free-play, or may be introduced after a child has already begun to describe sexual abuse to facilitate their ability to recall their experience. The observations of a child's interaction with dolls should be interpreted conservatively within the context of the child's history and other clinical observations.

### SUMMARY

Research about the nature of sexual abuse in day care, perpetrators in that setting, and the reactions of young children to trauma can inform and guide the evaluation of preschoolers for whom possible abuse in day care is a concern. While many day care sexual abuse cases have features in common with sexual abuse cases in other settings, some characteristics of day care abuse merit special consideration. The proportion of women involved as perpetrators is higher in day care cases compared to cases of sexual abuse in other settings (Faller, 1988; Finkelhor et al., 1988; Kelley, 1989). Female perpetrators are more likely than male perpetrators to abuse with others. (Finkelhor et al., 1988). Cases involving women and multiple perpetrators are more likely to involve multiple victims, repeated abusive acts, allegations of penetration, forced sexual contact between children, and, in some cases, child pornography and ritualistic abuse. While these severe forms of child sexual abuse do occur in other settings, the clinician evaluating children in day care needs to be aware of these patterns of sexual abuse. Ritual abuse may influence the pattern and content of children's disclosures in that

they make the children seem unbelievable or incredible to clinicians who are not familiar with this type of abuse. Developmental considerations including psychosexual development and the development of language and memory and are important variables in evaluating preschoolers. Clinicians must be able to differentiate normal and pathological symptoms and sexual behaviors in young children, and must appreciate the child's capacity to show what they remember in action and play as well as words.

The reactions of young children to trauma will also influence their clinical presentation. Symptoms of sexually abused children, including precociously sexualized play and behavior, and post-traumatic play and reenactments can provide clues about the kind of abuse a child suffered, even when the children are unable to give verbal descriptions of their abuse. In cases of repeated and extreme abuse, denial and dissociation may diminish a child's capacity to remember traumatic events and result in delayed disclosure. Threats and intimidation can result in extreme fearfulness and also contribute to delays in disclosure.

Finally, clinicians must take great care that their method of evaluation does not negatively influence or compromise their findings. Although protective and legal concerns may create pressures for evaluators, clinicians must be careful to remain open-minded and to avoid leading questions and tactics which bias their evaluations.

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**Résumé**—Au cours de la dernière décennie, la problématique des abus sexuels dans les garderies a reçu une attention considérable. La nature et la prépondérance des allégations lancent un défi unique aux cliniciens. Les abus sexuels des enfants dans les garderies sont habituellement des cas qui impliquent plusieurs victimes et plusieurs agresseurs, lesquels ont recours à des menaces exceptionnelles pour taire leurs victimes. Cet article a passé en revue les écrits pour discerner quel type de mauvais traitements sexuels se retrouvent dans les garderies et les caractéristiques de cette maltraitance, y compris les types de menaces et les façons dont les signalements se font. L'article discute de l'impact sur les enfants et les parents de l'agression sexuelle dans les garderies et discute de l'évaluation clinique des enfants d'âge préscolaire dans le cas où on soupçonne qu'il y a eu abus sexuels. L'article considère aussi les aspects du développement psychosexuel de l'enfant et le développement de sa mémoire et de son langage et se penche aussi sur les défenses psychologiques qui se manifestent dans les cas de traumatismes répétés.

**Resumen**—El abuso a los niños en los centros diurnos de cuidado infantil ha recibido considerable atención en la última década. La naturaleza y el número de los alegatos de abuso sexual en la atención diurna le presenta desafíos especiales a los clínicos. Los casos típicos de abuso sexual en los centros de cuidado diurnos incluyen varias víctimas y varios perpetradores así como el uso de amenazas severas para mantener el secreto. Este artículo revisa los hallazgos de las investigaciones disponibles, sobre los tipos de abuso que se conoce suceden en los centros de cuidado diurno, la dinámica implicada, los tipos de amenazas utilizadas para silenciar a las jóvenes víctimas, y los patrones para descubrir el impacto de la victimización sexual que sucede en los centros diurnos tanto para los niños como para los padres. Se discute el impacto de la victimización sexual que sucede en los centros diurnos tanto para los niños como para los padres. Se presentan las implicaciones que tiene, para la evaluación clínica de los niños de edad pre-escolar, las sospechas de abuso en la situación del cuidado diurno. Se revisan ciertas consideraciones sobre el desarrollo psicosexual y para el desarrollo de la memoria y el lenguaje. Se discuten las defensas psicológicas en los casos de trauma repetitivo.