

Child Sexual Abuse in the United States: Perspectives on Assessment and Intervention

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Child sexual abuse (CSA) is a widespread problem the United States as it is in many areas of the world today. CSA can lead to a host of psychological and emotional difficulties and disorders that can cripple some children and youth for a lifetime. In this article the authors discuss the sexual abuse of minors in the United States. Risk factors involved in and potential causes of CSA are discussed. Signs and symptoms of CSA are summarized along with common consequences associated with sexual abuse. Characteristics of sexual perpetrators of children and adolescents are also examined. In addition, the authors discuss the problems children often have in disclosing the abuse, along with the individual, familial and societal challenges involved in reporting incidences of sexual abuse. Some assessment issues and tools associated with CSA are highlighted, and the importance of investigators and clinicians capturing children's narrative descriptions of their abuse, and various methods for doing so, are outlined. Finally, an overview of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children is presented, and common challenges for therapists in treating children who have experienced sexual abuse and their families are discussed.

Key Words: United States, child sexual abuse; assessment, intervention, prevention

Introduction

Child maltreatment in the United States is a pervasive problem that often results in immediate negative effects on children, followed by the potential for numerous problems throughout the lifespan (Goodyear-Brown, 2011; Wolf, Reinhard, Cozolino, Caldwell, & Asamen, 2009). Research has documented that child abuse and neglect hinder proper growth and development (Cicchetti & Toth, 2006; Goodman, Quas, & Ogle, 2010) and place children at risk for a host of mental health disorders, including anxiety, depression, anger, cognitive distortions, posttraumatic stress, dissociation, identity disturbance, affect dysregulation, interpersonal problems, substance abuse, self-mutilation, bulimia, unsafe or dysfunctional sexual behavior, somatization, aggression, suicidality, and personality disorder (Briere & Lanktree, 2008). Child sexual abuse (CSA) has its own unique set of parameters and characteristics.

Presently there is a scarcity of research from the views of children on trauma, including child sexual abuse (CSA) (Foster, 2011; McGregor, Thomas, & Read, 2006; Sar, Akyuz, Kugu, Ozturk, & Ertem-Vehid, 2006; Urman, Funk, & Elliott, 2001; Walker, Reid, O'Neill, & Brown, 2009). Most research in the United States has relied on adults' memories of

childhood sexual victimization (Goodman et al., 2010; Lindblom & Gray, 2010). Extensive literature has investigated CSA and problematic behaviors in adults (e.g., substance abuse and high risk sexual behaviors), yet substantially less research has focused on children and adolescents (Jones et al., 2013). However, there are a few studies in the U.S. that have used child victims themselves as the primary sources of information about CSA.

Current knowledge about CSA includes discussion of treatment outcomes for children. The experience of CSA can directly impact a child's functioning (Goldfinch, 2009; Tomlinson, 2008). Researchers agree that early intervention using evidenced-based practices is often successful in the reduction of child victims' trauma-related symptoms (Green, 2008). Furthermore, many children return to their pre-trauma level of functioning and flourish (Leckman & Mayes, 2007). However, the counseling and related literature has repeatedly documented numerous intrapersonal and interpersonal problems that manifest in many adult survivors of CSA, especially those who have not had an opportunity to process their trauma in a safe environment. Common challenges that impact the health and well-being of adult survivors include: (a) mental health problems (e.g., depression, anxiety, posttraumatic stress),

relational challenges (e.g., sexual health, intimacy, and increased risk for sexual assault and domestic violence), and spiritual concerns (e.g., shattered assumptions, or changed or changing belief systems, following trauma). Although many adults experience challenges related to CSA histories, some survivors demonstrate resiliency and posttraumatic growth (Wright, Crawford, & Sebastian, 2007).

This paper examines the sexual abuse of minors (children 0-18 years of age) in the United States, including CSA in family systems. Factors that put children, youth and families at risk for sexual abuse are presented. Causes of CSA are examined along with characteristics of sexual perpetrators of children and youth. Common signs and symptoms of trauma associated with the sexual abuse and the exploitation of children and youth are discussed, including the many potential concomitants and outcomes of sexual abuse. Difficulties children often have in disclosing sexual abuse and the challenges involved in reporting incidences of sexual abuse are also discussed. The importance of capturing children's narrative descriptions of their own abuse and various methods for doing so are outlined. Assessment issues and tools associated with CSA are highlighted, and the intricacies of clinical treatment of children who have experienced sexual abuse and their families are also covered. Finally, common challenges for therapists in treating children who have experienced sexual abuse and their families are summarized, as well as the self-care issues therapists may face in working with this type of trauma over time.

Definition of Key Terms

Child sexual abuse (CSA) is defined as the misuse of power and authority, combined with force or coercion, which leads to the exploitation of children in situations where adults, or children sufficiently older than the victim to have greater strength and power, seek sexual gratification through those who are developmentally immature and where, as a result, consent from the victim is a non-concept. Such gratification can involve explicit sexual acts, or may involve invasive and inappropriate actions not directly involving contact (Miller, Cardona, & Hardin, 2007).

Child sexual exploitation can involve the following: possession, manufacture and distribution of child pornography; online enticement of children for sexual acts; child prostitution; child sex tourism; and child sexual molestation.

Trauma is defined as "the realization of one's worst fears, the experiences that every human being would never want to have" (Klempner, 2000, p. 77).

Grooming is defined as methods used by perpetrators to earn trust and keep children involved in sexual acts. Common strategies for such manipulation include giving the victim gifts or special privileges, which is often a confusing experience for the child victim (Lanktree & Briere, 2008). Grooming may include special treatment or presents, which is frequently confusing for the victim. Abusers gain access to their child victims and attain their trust through the giving of special attention and time as well as the granting of certain privileges. Many perpetrators invest a great deal of time and energy into those methods designed to deceive the child and ensure that the abuse is kept secret.

Revictimization is that which places a person who was sexually abused as a minor at greater risk for further abuse in adulthood. Revictimization may occur in the form of unwanted sexual contact, physical abuse, and psychological maltreatment.

Sexual Assault is a class of sexual conduct prohibited by the law that includes forcible sex offenses such as rape and sodomy of a perpetrator toward or upon a victim. The victim may be a minor or an adult.

Trauma Narratives are written (and sometimes verbally documented) descriptions of sexual abuse that are completed in counseling by child and adolescent clients. These narratives are often divided into eight sections: (a) life before the trauma, (b) the first time the abuse occurred (in multiple incident traumas), (c) the worst memories, (d) disclosure, (e) investigation and court (if applicable), (f) how life has changed since the trauma occurred, (g) the counseling experience, and (h) future hopes and dreams. Understanding CSA from the perspective of the child using existing data in the form of trauma narratives has numerous implications for clinicians, counselor educators, counseling students, and communities both locally and nationally (Foster, 2011).

Prevalence of Child Sexual Abuse in the United States

The current understanding of CSA in the United States encompasses research data in the following three areas: (a) prevalence, (b) treatment outcomes for children, and (c) long term ramifications for adult survivors. Prevalence studies have been conducted in the United States to estimate the frequency of sexually abusive acts. In the U.S., one of the most widely published statistics indicates that one out of four girls and one out of six boys will be sexually abused before the age of 18 (Centers for Disease Control and Prevention, 2005). A meta-analysis of 65 studies including 22 countries reported that 7.9% of

men and 19.7% of women were sexually abused prior to age 18, which is more widespread than formerly thought (Pereda, Guilera, Forns, & Gómez-Benito, 2009). These statistics may not account for the number of children (1 in 5) who are sexually solicited while using the Internet (Finkelhor, Mitchell, & Wolak, 2001), and the high number of victims who never disclose their abuse (between 30% and 87%: See Kilpatrick, Saunders, & Smith, 2003; London, Bruck, Ceci, & Shuman, 2005; Ullman, 2003). Regardless of differences in prevalence rates across studies, child sexual abuse is a critical social issue in the U.S.

There are several challenges involved with attaining accurate prevalence statistics (Davidson, Shannon, Mulholland, & Campbell, 2009). Part of the challenge of attaining these figures in the U.S. is due to the variety of sexual abuse definitions found across the fifty states. What may qualify as sexual abuse in one state may not qualify as such in another. The lack of a single, universal definition of CSA hinders accurate collection of national statistics (Green, 2008). Additional confusion exists in the mental health field when the terms *sexual abuse* and *sexual assault* are used interchangeably to represent different types of victimization. The other primary challenge associated with gathering accurate information is due to the fact that many victims fail to report their abuse, which results in an underrepresentation of the phenomenon.

Family Characteristics and Child Sexual Abuse

In healthy families, children feel safe and secure as a result of the predictable patterns established by their parents or caregivers. When sexual abuse occurs in the context of the family, the child does not receive basic protection from their parents or caregivers, which results in an environment that is unsafe and unpredictable; hence, *betrayal trauma* results (Oz, 2005). Research indicates that the vast majority of sexually abused or assaulted children were victimized by someone they knew personally (e.g., friends, baby-sitters, individuals in positions of authority, and relatives) (Finkelhor, Hammer, & Sedlak, 2008). The likelihood that the child victim knew the perpetrator of the abuse is an important aspect to understanding CSA from the perspective of the child victim. In cases of CSA, children may be removed from their homes and placed in foster homes or group homes to protect them from abusive parents or caregivers. Whereas the safety of the removed child is ensured in such situations, the removal process itself may further traumatize the child (Feather & Ronan, 2009).

Familial abuse is generally thought of as involving a parent or caregiver as the offender and the child as the victim, but this is not always the case (Welfare, 2008). Sexual abuse can also occur between siblings. There is a dearth of research on sibling sexual abuse, despite the fact that it may be the most frequent type of sexual abuse within families. Sibling sexual abuse often involves aggressive behavior and force to make the victim comply with the abusive act, and penetration is also common in sibling sexual abuse (Tremblay, Hebert, & Piche, 1999). Victims are less apt to disclose sibling abuse than other forms of familial abuse (Carlson, Maciol, & Schneider, 2006).

Frequently, children abused by an immediate family member or relative do not tell anyone about their abuse (Arata, 2002; London et al., 2005). In some families, the non-offending members are unaware of the abuse, whereas in other families, those who do know turn a blind eye to it (Oz, 2005). The failure of family members to admit to and acknowledge the abuse leaves the child feeling alone and without protection. In both of these scenarios, the abuse may continue until it is discovered by someone who will protect the child or until the child discloses the secret to a family member or individual outside of the family who takes action to stop the abuse. Family members may protect the abuser and keep the abuse a secret for long periods of time.

Although the end of the abuse in the context of interpersonal relationships is positive for the safety and wellbeing of the child, it may not seem that way from the child's perspective. The victim's family frequently experiences its own set of crises immediately following the disclosure or discovery of the abuse (Oz, 2005). For example, family members must choose whether to believe the child or the perpetrator, resulting in ruptures in immediate and extended family relationships. Disbelief and denial are common responses in an attempt to maintain the false reality of a healthy, functioning family. When family members respond to the disclosure with denial, the child is often in danger of further abuse. When considering the perspective of the child, the failure of adults, especially family members, to respond in a protective manner can be extremely confusing, frightening, or upsetting to the child.

Understanding the child's experiences before, during, and after the abuse is an important step in decreasing the prevalence of CSA (Daugherty, 2011; Faller, 2007; Pipe, Lamb, Orbach, & Cederborg, 2007). Children's narratives may include descriptions of perpetrator's grooming behaviors, children's signs and symptoms of abuse, and the challenges of disclosure, which would be significant components to designing comprehensive educational programs (Mossige, Jensen, Gulbrandsen, Reichelt, &

Tjersland, 2005). Child sexual abuse prevention programs are needed which can be implemented in schools, hospitals, mental health agencies, religious organizations, and community centers. Such programs may decrease the prevalence of CSA, increase children's disclosure of abuse, and assist parents in responding in a timely, healthy and productive manner to disclosure.

Perpetrators of Child Sexual Abuse

Understanding perpetrators of CSA is pertinent to understanding the experience of sexually abused children because the perpetrator is central to the occurrence of their abuse. Perpetrators of CSA, also referred to as child molesters and/or pedophiles, represent various ages, genders, ethnicities, socioeconomic levels, sexual orientations (heterosexual, homosexual or bisexual), relationship statuses (single, married, or divorced), and experiences with children (i.e. those with or without their own children) (Finkelhor, 2008; Murray, 2000). Adults account for approximately 77% of sexual offenses and crimes with the other 23% perpetrated by juvenile offenders (Finkelhor et al., 2008). Perpetration of child abuse is thought to frequently begin in one's late teens (Murray, 2000).

Men account for 96% of reported cases of CSA (Finkelhor, 2008; Finkelhor et al., 2008) and one study found that male perpetrators of CSA are significantly more likely to have a childhood sexual abuse history (45%) than nonsexual criminal offenders (28%) (Connolly & Woollons, 2008). According to experts in the field, CSA by females is likely to be underreported and is only beginning to be identified as a problem in the United States (Synder, 2000). Female offenders are most likely to offend a child below the age of six (Crossen-Tower, 2009; Finkelhor et al., 2008). Similar to male offenders, female sexual abuse perpetrators tend to know their victims, work in positions with access to children, and have a history of childhood abuse or neglect themselves (Nathan & Ward, 2001; Vandiver & Walker, 2002). Some research indicates that both male and female perpetrators may choose victims that reflect their own abuse experience (e.g., the age and gender of the child they were when they were abused) (Murray, 2000).

Child sexual offenders come in various shapes and sizes and perpetrate on children for a variety of reasons. Studies have identified four common characteristics (in which one or more tend to be present) among those who perpetrate CSA (Ward & Beech, 2005). These include the inability to properly regulate emotion, a deficit in social skills, abnormal

sexual arousal patterns, and cognitive distortions (e.g., an inability to empathize with the victim's suffering). Children who have experienced sexual abuse may observe some of these characteristics and report them as they describe their perpetrators in their trauma narratives. Perpetrators were often abused themselves as children and often get away with the abuse. Some perpetrators use children as substitutes for adults within the family system, others are chronic sexual abusers of children, and still others are naïve or find children less threatening than adults. Further, there are offenders who are sadistic, violent, fixated, regressed, or just situational opportunists. Child sex offenders as a whole have a high recidivism rate and perpetual tendency to re-offend. Sexual abuse is often much more about power and control than sex per se. Victims experience a profound lack of trust in authority figures.

Perpetrators of CSA also tend to create specific rituals with their child victims. For example, perpetrators will utilize cues that signal to the child when the abuse will begin as well as end (Oz, 2005). Cues to initiate the abuse may include a gesture, a game or activity, or by taking the child to a designated location. At the conclusion of the abuse, an exit ritual signaling the end of the abuse may include a word or phrase that is repeated at the end of the abuse (for example, a perpetrator may tell the child to go clean up). Some perpetrators give the child money or a gift to signal the end. According to Oz, the use of cues creates predictability and therefore may increase victims' compliance.

Whereas some perpetrators utilize "loving" and playful methods to ensure compliance, others use violence and threats to control the child and increase the secrecy of the abuse being (Murray, 2000; Oz, 2005). It is not uncommon for children to be threatened with serious harm or death, or to have the child's family members or pets threatened with such harm. Due to children's' developmental levels and abilities to reason, many children believe that the perpetrator has the ability to carry out such acts of violence and therefore are more compliant and secretive with the abuse. In addition to violence and threats, perpetrators may also attempt to convince the child that he or she is at fault for the abuse (Oz, 2005). Statements of blame, which evoke feelings of guilt and shame, may be utilized to ensure that the abuse will be kept secret. Perpetrators often tell their victims that no one will believe them if they disclose the abuse to someone else. For children, the concerns that others will blame them or not believe that they are telling the truth are significant fears that often hold them captive in silence.

Disclosure of Child Sexual Abuse

Parents or caregivers may be hesitant to acknowledge abuse symptoms in their children which may be a result of denial or failure to know signs and symptoms of abuse (Lanktree & Briere, 2008). Additionally, parents or caregivers may "minimize the trauma or deny the emotional impact" or continue to associate with the alleged perpetrator in order to maintain the relationship and to prevent disruption (Lanktree & Briere, p. 23). According to Dyregrov and Yule (2006), children are significantly impacted by their parents' or caregivers' responses to the disclosure. Failure of adults to believe the child solidifies the child's worst fear that the abuser has the power not only over him or her but also over others in the child's world. The lack of an appropriate response to disclosure often results in further suffering for the child (Lanktree & Briere, 2008), leaving the child feeling completely alone and helpless in this situation, which decreases the likelihood of disclosing a second or third time (or beyond).

Some victims of CSA do not disclose their experiences. This can occur for a variety of reasons. Children may be dependent on the abuser for their basic needs (Klempner, 2000; Lanktree & Briere, 2008). Others understand the potential consequences of disclosure, such as the perpetrator being arrested and possibly convicted. This results in a hesitance to tell anyone about the abuse, especially if the child cares for the offender. Others are hindered from disclosing the abuse due to feelings of fear, guilt, shame, or anger. The children who risk disclosure may find that it results in them being silenced and left unprotected. Children are unlikely to disclose if they do not view their experiences as abusive. For example, boys whose perpetrator is an older female may view it as a positive experience in the development of masculinity (Hopton & Huta, 2012). Many children who disclose experience feelings of agony, grief, and sorrow following their disclosure (Crenshaw & Mordock, 2004). In fact, it is not uncommon for children to regret telling someone about their abuse (Oz, 2005). This may be confusing to those outside of the world of the trauma as it would appear that the end of the abuse would be a positive thing for the child. Yet, to the child, there is the potential for a host of new traumas and consequences as a result of the disclosure. As noted, there are several potential consequences associated with CSA disclosure. For example, breaking the silence of familial CSA often results in the loss of that relationship (e.g., incarceration of the perpetrator or the child's removal from the abuser's care) (Lanktree & Briere, 2008). In some cases, the child

may "forget" or deny the trauma experience in order to keep the family intact and protect the perpetrator from legal consequences (McNally, 2007). The individual accused of the abuse may face consequences if convicted, which results in further separation between the victim and perpetrator.

In situations of sibling sexual abuse, victims may minimize their trauma in an attempt to decrease or prevent their parents' suffering. In this type of abuse disclosure, parents or caregivers experience the difficult task of securing help for both the victim and offender. Both the child victim and child offender need their parents' or caregivers' emotional support and love, which is difficult for many parents and caregivers due to their own reaction to the trauma (Welfare, 2008). Welfare further asserts that there is both a need for accountability for the perpetrator and ultimately reunification of the family when all members are ready for this to occur.

Finally, in addition to the possibility of a lost relationship, another risk children face during disclosure is that the threats made by the perpetrator may be carried out (Oz, 2005). For example, perpetrators may not only threaten to kill the victim, the victim's family members, or household pets. As perpetrators use fear as a primary way to ensure that the abuse continues, many children come to believe that their perpetrator is capable of carrying out his/her threats, which makes disclosure extremely difficult and potentially dangerous.

The Potential Effects of Child Sexual Abuse on Children and Adolescents

Whereas numerous studies exist on the outcomes adult trauma survivors, there is a dearth of research on the effects of CSA on children (McGregor et al., 2006; Sar et al., 2006; Urman et al., 2001; Walker et al., 2009). Many experts in the field assert that the experience of CSA, along with other severe traumas, can leave children with "wounds [that] penetrate deeply to the core of their spirit" (Crenshaw & Hardy, 2007, p. 162). Child victims may experience a myriad of symptoms as a result of their trauma. According to Lanktree and Briere (2008), symptoms of trauma are likely to be heightened if the child (a) had a close relationship with the perpetrator, (b) experienced trauma that included violence or was intensive or invasive in nature, (c) experienced a loss as a result of the trauma (e.g., one of their parents is incarcerated), (d) was injured during the trauma, (e) believed he or she was to blame for what happened, (f) had a history of prior trauma, (g) had poor functioning (e.g., academic or social skills) or had a developmental delay prior to the experience, (h) had

poor attachment to his or her caregiver, (i) experienced the trauma at a young age, and/or (j) lived in poverty or an unsafe home/neighborhood.

There is a broad range of effects of CSA (Adler-Nevo & Manassis, 2005; Anderson & Hiersteiner, 2008). At one end of the continuum, about one third of children do not experience any symptoms immediately following the abuse, whereas at the opposite end of the spectrum, about half of the children develop severe psychiatric symptoms. Pre-existing factors such as age at the time of abuse, the child's disposition, family structure, and social skills may influence outcomes (Webster, 2001). Additionally, factors related to the abuse may impact the child's recovery (e.g., relationship to the perpetrator, severity and frequency, use of violence, and reactions of others to the disclosure) (Welfare, 2008).

Children who present for clinical treatment for CSA are frequently diagnosed with one or more mental health disorders. It is important to note that reactions to the CSA vary depending on the child's developmental stage, and these differences may impact their response to treatment (Feather & Ronan, 2009). The most common and widespread problems effecting children and adolescents who have experienced trauma, including CSA include: "(a) anxiety, (b) depression, (c) anger, (d) cognitive distortions, (e) posttraumatic stress (PTSD), (f) dissociation, (g) identity disturbance, (h) affect dysregulation, (i) interpersonal problems, (j) substance abuse, (k) self-mutilation, (l) bulimia, (m) unsafe or dysfunctional sexual behavior, (n) somatization, (o) aggression, (p) suicidality, and (q) personality disorder" (Briere & Lanktree, 2008; Chatterjee et al., 2006; Deb & Mukherjee, 2009; Reyes & Asbrand, 2005). Boys with a sexual abuse history are more likely to engage in unprotected sexual intercourse, cause a pregnancy, and have multiple sexual partners than boys who were not sexually abused (Homma, Wang, Saewyc & Kishor, 2012). Girls who have been sexually abused have an increased risk of sexual re-victimization at some point later in development (Arata, 2002). The experience of CSA also frequently obstructs a child's ability to complete developmental tasks (e.g., development of motor skills, cognitive abilities, school performance, and social skills), which negatively affects the overall well-being of the child, both at the time of the abuse and throughout the victim's lifespan (Reyes & Asbrand; 2005). Despite the many immediate and potential future negative consequences of the trauma, early intervention is often successful in treating the child's presenting symptoms (Dyregrov & Yule, 2006; Green, 2008).

Other common effects of CSA may include the following: (a) extreme guilt, shame, and self-loathing; (b) fear and rage; (c) emotional numbness; isolation and withdrawal from others; an inability to express and regulate emotions; (d) grief and mourning over the loss of one's childhood or adolescence and/or the lost love object (broken trust); (e) regression to a younger developmental age; (f) cognitive delays and impaired ability to learn and perform in school; (g) separation anxiety from caregivers and withdrawal from others; (h) hyper-vigilance; (i) low self-esteem and a de-valuation of self; (j) denial and minimization of the event(s); (k) idealization of the perpetrator; (l) confusion over one's own sexuality and gender identity; (m) deep sadness over and yearning for the injured child inside oneself; (n) an unhealthy maintenance of self and boundaries in current relationships; (o) possible (concurrently or after some time) perpetrating on others (boys especially) and future victimization (girls especially); (p) re-enacting the trauma in later intimate relationships; (q) substance abuse and others forms of self-medicating; (r) extreme sexual frigidity or sexual acting out; and (r) loss of faith or experience of anger towards God or a Higher Power. Children may also exhibit symptoms similar to those seen in adults, such as flashbacks, abreaction, trauma-related fears (which may lead to other anxiety symptoms and disorders), and a sense of hopelessness about the future (Ogawa, 2004). Other adult-related challenges that can manifest in children include: depression, anxiety, substance abuse (Cohen & Mannarino, 2008; Saywitz, Mannarino, Berliner, & Cohen, 2000), and eating disorders (Brewerton, 2007). Older children and adolescents may also grieve the loss of their childhood and innocence (Miller et al., 2007). It is not uncommon for children experiencing intense feelings of loss or grief to be diagnosed with depression.

It is important to remember that each child has a unique response to his or her trauma experience. As mentioned previously, boys may not perceive sexual abuse by a female perpetrator as abusive (Hopton & Huta, 2012). Other child victims may not view the event (or events) as traumatizing at all, or not until witnessing others' reactions to the sexual abuse, such as following an adult's discovery (Clancy, 2010). Another reason the abuse may not be perceived as traumatizing is because the experience may not have included violence or invoked fear in the child (McNally, 2007). On the contrary, the child may have felt love and/or acceptance from his/her perpetrator, thereby hindering the child from viewing the abuse as a distressing or harmful experience. The age of the child at the time of the sexual abuse may also result in

a failure to understand the extent of the betrayal or wrongful actions of the perpetrator. A number of children do not experience symptoms until later in their development when they are able to realize the ramifications of the abuse experience, such as a loss of innocence as a result of sexual abuse.

Finally, in the same way that children can experience negative outcomes as a result of CSA or fail to see the experience as traumatizing, children can also exhibit qualities of resilience (Jenmorri, 2006; Leckman & Mayes, 2007; Sandoval et al., 2009). In fact, Sandoval and colleagues assert that the majority of children are resilient and are able to cope with their trauma experience. Following a traumatic experience, some children can actually go beyond their normal level of functioning and flourish. Whereas some children are devastated by their trauma, others show no signs of poor functioning or mental health problems. Further research is needed to investigate the protective factors that increase children's resiliency following traumatic experiences such as CSA.

Assessment of Associated Trauma Symptoms of Child Sexual Abuse

Assessment is extremely important and potentially useful in providing the counselor or health provider with information from various perspectives on the child's trauma experiences, symptoms, and current level of functioning. Assessments can be utilized at multiple points throughout counseling and at termination to measure symptom reduction and treatment outcomes.

Along with time and attention devoted to establishing the therapeutic relationship, counselors also gather relevant information and history of the child victim (Cohen & Mannarino, 2008; Cohen et al., 2006). Non-offending parents or caregivers can be asked to assist in providing information by completing assessments such as The Trauma Symptom Checklist for Young Children (TSCYC) (ages 3-12) (Briere et al., 2001) and the Child Behavior Checklist (CBCL) for both young children (1.5 to 5) and children 6 to 18 years of age (Achenbach & Rescorla, 2000, 2001). The TSCYC (Briere et al., 1996) provides information on eight clinical scales: anxiety, depression, anger/aggression, posttraumatic stress-intrusion, posttraumatic stress-avoidance, posttraumatic stress-arousal, dissociation, and sexual concerns. It also yields a posttraumatic stress total score. The information may be used to help diagnosis children as young as five with posttraumatic stress disorder. The CBCL is designed for use with children ages 6-18. It measures a wide

range of behavioral and emotional problems occurring in the past three months. The teacher's version focuses on academic performance and adaptive functioning in addition to behavioral and emotional problems. The results of the CBCL provide information on six scales: affective problems, attention deficit/hyperactivity, anxiety, oppositional defiance, somatic problems and conduct problems. An additional version is available for parents or caregivers of children ages 1.5 to 5. In addition to attaining parents, caregivers or teachers perspectives, several instruments are available for children to complete regarding their perspectives of their behaviors and symptoms. The Child Behavior Checklist Youth Self-Report (CBCLYSR; Achenbach & Rescorla, 2007) for children ages 11-18 allows children to rate themselves on how true each item is of them in the last six months. For children with difficulties reading, the CBCL YSR can be administered orally. The test provides scores for internalizing, externalizing, and total problems.

Another useful self-report instrument is the Trauma Symptom Checklist for Children (TSCC) (Briere, 1996), which can be completed by children ages 8 to 17. The instrument is useful in assessing the affects of abuse and neglect as well as other forms of trauma (witnessing a traumatic event, major accident, or disaster). The 54-item assessment includes two validity scales (under-response and hyper-response) and six clinical scales (anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger). Children rate the symptoms listed in terms of severity on a Likert scale; the instrument takes approximately 10 minutes to complete.

In addition to formal assessments, questionnaires are also useful. A commonly used questionnaire is the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), which is appropriate for individuals twelve and older. The questionnaire consists of twenty-eight items in which clients select a response on a Likert scale. The assessment takes approximately five minutes to administer and is simple to score. The questionnaire provides an overview of clients' experiences related to several areas of victimization with subtests in the following areas: emotional abuse, physical abuse, sexual abuse, physical neglect, and minimization/denial.

The semi-structured interview is another assessment method that can be utilized in conjunction with a questionnaire. Lobbestael, Arntz, Harkema-Schouten, and Bernstein (2009) developed the Interview for Traumatic Events in Childhood (ITEC), which is specifically designed to gather information on childhood trauma. Using an interview format provides the counselor with the benefits of being able to probe, clarify, and ask additional questions. The

instrument provides an additional method of attaining relevant information from clients regarding their trauma histories.

Along with the collection and assessment of various types of child narratives, evaluation of possible sexual abuse of children typically occurs through the use of two other methods: parent or caregiver report and child interviews. One of the most commonly used caregiver report instruments is the Child Sexual Behavior Inventory (CSBI; Version 2). The 38-item CSBI was developed by William Friedrich (1997) to assess children who have been sexually abused or are suspected of having been sexually abused. The measure is designed to be completed by a female caregiver. It is one of the most widely used measures of sexual behaviors. It yields a total CSBI score, a Developmentally Related Sexual Behavior Score, and a Sexual Abuse Specific Items Score, with norms by age and gender for these scales. It also yields scores on 9 domains: 1) Boundary Problems, 2) Exhibitionism, 3) Gender Role Behavior, 4) Self-Stimulation, 5) Sexual Anxiety, 6) Sexual Interest, 7) Sexual Intrusiveness, 8) Sexual Knowledge, and 9) Voyeuristic Behavior. The CSBI is a revision of the CSBI-R and CSBI-1. It contains 22 of the items from the previous version, with the remaining items reworded for greater readability (Friedrich et al., 2001). This instrument was developed due to recognition that precocious sexual behavior is often related to CSA. Higher scores are indicative of greater likelihood that CSA has occurred. The CSBI discriminates between sexually abused and non-sexually abused children. Cultural context affects what behavior is permitted and what behavior is considered problematic, and different items and norms for the CSBI are needed for different cultural groups.

The work of K.C. Faller (1988, 1990, 1993, 2007) of the U.S. Department of Health and Human Services addresses the needs of professionals regarding CSA, describes professional practices, and discusses how to assist sexually abused children and their families. Treatment techniques for the victim, the non-offending parent or mother, and the offending father are offered, and research on reliability and suggestibility of child witnesses is reviewed briefly. The focus of the manual is on case management and substantiation and is designed to assist child protection workers, child abuse investigation and mental health staff, legal professionals, and education and health care professionals. Child interviewing techniques and sample questions are included. The document contains a glossary of important terms associated with CSA.

Experienced clinicians working in the area of CSA assert that most children are resistant to giving

false positive responses to leading and suggestive questions. When they do provide false positives, they are generally limited to a nod or a simple "yes." Older children are more resistant to suggestion than younger ones. As a general rule, children are much more likely to deny actual experiences, which are perceived as traumatic or unacceptable, than to make false assertions about events that did not occur.

An Overview of Trauma-Focused Cognitive Behavioral Therapy

Therapy (TF-CBT) with child victims of sexual abuse

There are two major goals in working with child victims of sexual abuse from a TF-CBT approach (see Briere & Scott, 2006; Cohen et al., 2006, 2012). First is to help the victim express and work through all of her/his emotions regarding the abuse, about and toward the perpetrator, in the here and now. The second goal is to help the child or adolescent move from victim to survivor to victor; i.e., the Resilient Self -- characteristics that include: independence, connectedness, creativity, insight, play and humor, morality, self-regulation, initiative, and spirituality (Wolin & Wolin, 1993). Here we discuss how TF-CBT can be implemented with victims of CSA in tandem with other therapeutic approaches. The discussion will include: (a) assessing child readiness and suitability for trauma work, (b) counselor readiness for work with child victims of sexual abuse, (c) establishing the therapeutic relationship with sexually abused children, (d) psycho-education, (e) inclusion of parents and caregivers in counseling, (f) family sessions, and (g) teaching positive coping skills.

The implementation of any therapy with sexually abused children is to determine whether the child is appropriate for trauma treatment and is ready to begin counseling. When working with children, it is important to remember that children often experience some ambivalence between having a desire to protect the secret of CSA as well as unburden their story to a safe and caring person (Crenshaw & Hardy, 2007). In order to begin the unburdening process, children must feel secure, supported, and believed about the abuse. According to Crenshaw and Hardy (2007), readiness for a child includes:

...timing, the child's internal resources, strengths, and coping abilities, the degree of additional stress in the child's external life at the time, the strength of the relationship with the counselor, and the availability of support for the child outside of therapy (p. 165).

Along with children's readiness, it is important for counselors to be prepared to hear the difficult and

often painful details of the CSA prior to beginning TF-CBT with a child. A prevalent issue in counseling today is the failure of counselors to directly address clients' trauma histories (Davidson et al., 2009). Some counselors fear that they will re-traumatize their child clients while others feel unprepared to treat child abuse victims at all. Those who are inexperienced or unprepared may unknowingly withdraw empathy and distance themselves from clients disclosing their trauma in a form of self protection (McGregor et al., 2006). Training and supervision help counselors learn that moving away from the topic of CSA or discouraging disclosure in counseling would be damaging to the client (Crenshaw & Hardy, 2007). Counselors must be willing to recognize the "invisible wounds" of children and respond with empathy rather than fear. In addition, the challenge of hearing clients' trauma stories (narratives) should not be minimized. "Hearing a person talk about trauma can stir up nearly every fear to which human beings are subject" (Klempner, 2000, p. 76). Working with trauma survivors makes counselors aware of their own vulnerability to pain, violence, and mortality. Counselors must be conscious of their reactions to the CSA victims' pain and respond with empathy and actively listening rather than pulling away; turning *towards* clients and offering hope can aid tremendously along clients' healing journeys (Jenmorri, 2006).

In addition to the child's and counselor's readiness, therapy begins with establishing a therapeutic relationship between the child and counselor. Developing a relationship with children who have experienced extreme trauma, including sexual abuse, has been described as "a harrowing feat" (Crenshaw & Hardy, 2007). Due to the nature of CSA, trust is a central issue: many children tend to respond to others with either blind trust (that does not distinguish between safe and unsafe people) or an inability to trust anyone in any circumstance. Many victims of CSA fear that the counselor will betray their trust or harm them again (McGregor et al., 2006). An important component to the healing process is for children to learn how to trust others again, a process which begins in the counseling relationship. With child victims of sexual abuse, trust is built over a period of time, and the length of time needed differs from child to child (Kaminer, 2006). Failure to establish a safe, trusting relationship often leads to the failure of any method or technique implored since the efficacy of counseling is directly related to the therapeutic relationship (Gil, 2006; Kaminer, 2006). Trust in the therapeutic relationship is central to counseling with child victims of sexual abuse.

Involvement of supportive parents or caregivers in treatment is recommended for children who have experienced sexual abuse (Lanktree & Briere, 2008). Involvement of the non-offending parent or caregiver improves treatment outcomes for children (Cohen & Mannarino, 2000; Feather & Ronan, 2009) and helps promote positive family relationships (McPherson, Scribano, & Stevens, 2012; Sheinberg & True, 2008). One of the major goals is to increase parents'/caregivers' ability to talk openly about the trauma with their child (Cohen & Mannarino, 2008). Many adults experience difficulty talking about sexual abuse, which often leaves children feeling isolated and alone. Adults may also fear that openly talking about the abuse will re-traumatize the child, and therefore they avoid the topic altogether (Ogawa, 2004). Children are aware of whether or not the abuse can be talked about openly with their parents, and they too may avoid the topic out of fear that it will make their parents sad or angry.

It is important to inform clients (in child friendly terms) that it is not uncommon during the healing process for some symptoms to worsen before they improve. Parents and caregivers should also be informed of the potential increases in symptoms and decline in functioning during treatment, at least for awhile. Parents or caregivers not only need to know what to expect but also how to respond to their child during this time. Although the increase in symptoms is often temporary in TF-CBT, it is important to address the risks and benefits of counseling openly.

Another aspect to helping children develop coping skills is to assist them in increasing their ability to express their feelings (Cohen & Mannarino, 2008). Many children have limited feeling word vocabularies and benefit from education and activities that improve their ability to accurately describe their emotions. Having the child draw specific situations in which the child recalls feeling different emotions is also helpful in increasing the child's range of feeling vocabulary. A strong vocabulary to identify and communicate emotions will assist children in expressing themselves during trauma resolution and integration when they write their narratives. Cognitive coping is also addressed during this stage of TF-CBT. Children and parents are introduced to the interrelationship of thoughts, feelings and behaviors through a variety of activities. Children are taught ways to identify dysfunctional thoughts and replace them with more functional ones. Initially, this focus is on general thoughts about self and others. Later in counseling, this skill is built upon during the exploration of the trauma narrative in which trauma related cognitions are identified and explored. Trauma work should not proceed until a

child has established healthy affective and cognitive coping skills (Cohen & Mannarino, 2008).

When children share trauma in the form of the narrative (verbally and/or by drawing or other expressive means), they are actively involved in the process of moving towards closure. Closure is defined as the survivor becoming free from habitually thinking about the trauma in such a way that causes distress (Klempner, 2000). During this process, children seek to understand their trauma and its impact, which may involve addressing why the trauma happened to them (Tuval-Mashiach et al., 2004). It also involves exploration of the ways in which the experience has changed their view of self, others, and the world. Children (when developmentally capable) can explore and discover personal meanings within the traumatic experience. The act of making meaning out of one's trauma often helps children attain some level of closure (Briere & Lanktree, 2008). Finally, integrating the traumatic experience into one's life is the last portion of trauma recovery (Sewell & Williams, 2001 as cited in Wright et al., 2007). For children, the ability to adapt and move forward often lies in their courage to face their pain and process the emotional impact of the abuse on their life, and for their family members to fully support them throughout this process. It is important to remember that they need ample time to successfully complete treatment.

References

- Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA Preschool forms and Profiles*. Burlington, VT: University of Vermont Research Center for Children, Youth, & Families.
- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms and Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.
- Achenbach, T. M., & Rescorla, L. A. (2007). *Manual for the ASEBA Youth Self Report*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.
- Adler-Nevo, G., & Manassis, K. (2005). Psychosocial treatment of pediatric posttraumatic stress disorder: The neglected field of single-incident trauma. *Depression & Anxiety*, 22(4), 177-189.
- Anderson, K. M., & Hiersteiner, C. (2008). Recovering from childhood sexual abuse: Is a "Storybook ending" possible? *American Journal of Family Therapy*, 36(5), 413-424.
- Arata, C. M. (2002). Child sexual abuse and sexual revictimization. *Clinical Psychology Science and Practice*, 9, 135-164.
- Bernstein, D., & Fink, L. (1998). *Childhood Trauma Questionnaire: A retrospective self-report manual*. San Antonio, TX: The Psychological Corporation.
- Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: Focus on PTSD. *Eating Disorders: The Journal of Treatment & Prevention*, 15(4), 285-304.
- Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC)*. Professional Manual. Odessa, FL: Psychological Assessment Resources.
- Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., & Ernst, V. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect*, 25, 1001-1014.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Newbury Park, CA: Sage Publications.
- Briere, J., & Lanktree, C. (2008). *Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth*. Retrieved from <http://johnbriere.com/articles.htm>.
- Carlson, B. E., Maciol, K., & Schneider, J. (2006). Sibling incest: Reports from forty-one survivors. *Journal of Child Sexual Abuse*, 15(4), 19-34.
- Centers for Disease Control and Prevention (2005). *Adverse childhood experiences study: Data and statistics*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
- Cicchetti, D., & Toth, S. L. (2006). Building bridges and crossing them: Translational research in developmental psychopathology. *Developmental Psychopathology*, 18, 619-22.
- Clancy, S.A. (2010). *The trauma myth: The truth about the sexual abuse of children -- and its aftermath*. Jackson, TN: Perseus Books.
- Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioral therapy for children and parents. *Child and Adolescent Mental Health*, 13(4), 158-162.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma focused CBT for children and adolescents: Treatment applications*. New York: The Guilford Press.
- Connolly, M., & Woollons, R. (2008) Childhood sexual experience and adult offending: An exploratory comparison of three criminal groups. *Child Abuse Review*, 17, 119-132.
- Crenshaw, D. A., & Hardy, K. V. (2007). The crucial role of empathy in breaking the silence of traumatized children in play therapy. *International Journal of Play Therapy*, 16(2), 160-175.
- Crenshaw, D. A., & Mordock, J. B. (2004). An ego-strengthening approach with multiply traumatized children: Special reference to the sexually abused. *Residential Treatment of Children and Youth*, 23, 1-18.
- Crossen-Tower, C. (2009). *Understanding child abuse and neglect* (8th ed.). New York: Pearson.
- Daugherty, L. (2011). *Child molestation stories: Voices of survivors of child sexual abuse (Molestation, Rape, and Incest)*. Roswell, NM: Cleanan Press.
- Davidson, G., Shannon, C., Mulholland, C., & Campbell, J. (2009). A longitudinal study of the effects of childhood trauma on symptoms and functioning of people with severe mental health problems. *Journal of Trauma and Dissociation*, 10(1), 57-68.
- Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child and Adolescent Mental Health*, 11(4), 176-184.
- Faller, K. C. (1988). *Child sexual abuse: An interdisciplinary manual for diagnosis, case management and treatment*. New York: Columbia University Press.
- Faller, K. C. (1990). *Understanding child sexual maltreatment*. Newbury Park, CA: Sage Pub.
- Faller, K. C. (1993). *Child sexual abuse: Intervention and treatment issues*. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families.
- Faller, K. C. (2007). *Interviewing children about sexual abuse: Controversies and best practice*. Oxford, UK: Oxford University Press.

- Feather, J. S., & Ronan, K. R. (2009). Trauma-focused CBT with maltreated children: A clinic-based evaluation of a new treatment manual. *Australian Psychologist, 44*(3), 174-194.
- Finkelhor, D. (2008). *Childhood victimization: Violence, crime, and abuse in the lives of young people*. Oxford, UK: Oxford University Press.
- Finkelhor, D., Hammer, H., & Sedlak, A. J. (2008). *Sexually assaulted children: National estimates and characteristics*. Bureau of Justice Statistics, US Department of Justice. Retrieved from: <http://www.ncjrs.gov/pdffiles1/ojdp/214383.pdf>
- Finkelhor, D., Mitchell, K., & Wolak, J. (2001, March). *Highlights of the youth internet safety survey*. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Retrieved from <http://www.ncjrs.gov/pdffiles1/ojdp/fs200104.pdf>
- Foster, J. M. (2011). *An analysis of trauma narratives: Perceptions of children on the experience of childhood sexual abuse* (Doctoral Dissertation). Retrieved from <http://www.worldcat.org/>
- Friedrich, W. N. (1997). *Child Sexual Behavior Inventory: Professional Manual*. Odessa, FL: Psychological Assessment Resources.
- Friedrich, W. N., Fisher, J. L., Dittner, C. A., Acton, R., Berliner, L., Butler, ... Wright, J. (2001). *Child Maltreatment, 6*(1), 37-49.
- Gil, E. (2006). *Helping abused and traumatized children: Integrating directive and non-directive approaches*. New York: Guilford Press
- Goldfinch, M. (2009). 'Putting humpty together again': Working with parents to help children who have experienced early trauma. *Australian & New Zealand Journal of Family Therapy, 30*(4), 284-299.
- Goodman, G. S., Quas, J. A., & Ogle, C. M. (2010). Child maltreatment and memory. *Annual Review of Psychology, 61*(1), 325-351.
- Goodyear-Brown, P. (Ed.) (2011). *Handbook of child sexual abuse: Identification, assessment, and treatment*. New York: John Wiley.
- Green, E. J. (2008). Re-envisioning Jungian analytical play therapy with child sexual assault survivors. *International Journal of Play Therapy, 17*(2), 102-121.
- Homma, Y., Wang, N., Saewyc, E., & Kishor, N. (2012). The relationship between sexual abuse and risky sexual behavior among adolescent boys: A meta-analysis. *Journal of Adolescent Health, 51*(1), 18-24.
- Hopton, J. L., & Huta, V. (2012). Evaluation of an intervention designed for men who were abused in childhood and are experiencing symptoms of posttraumatic stress disorder. *Psychology of Men & Masculinity*. Advance online publication. doi: 10.1037/a0029705
- Jenmorri, K. (2006). Of rainbows and tears: Exploring hope and despair in trauma therapy. *Child & Youth Care Forum, 35*(1), 41-55.
- Jones, D. J., Lewis, T., Litrownik, A., Thompson, R., Proctor, L. J., Isbell, P., . . . Runyan, D. (2013). Linking childhood sexual abuse and early adolescent risk behavior: The intervening role of internalizing and externalizing problems. *Journal of Abnormal Child Psychology, 41*, 139-150. DOI 10.1007/s10802-012-9656-1.
- Kaminer, D. (2006). Healing processes in trauma narratives: A review. *South African Journal of Psychology, 36*(3), 481-499.
- Kilpatrick, D., Saunders, B., & Smith, D. (2003). Youth victimization: Prevalence and implications. U.S. Department of Justice, National Institute of Justice report. Retrieved from <http://www.ncjrs.gov/pdffiles1/nij/194972.pdf>
- Klempner, M. (2000). Navigating life review interviews with survivors of trauma. *Oral History Review, 27*(2), 67.
- Lanktree, C., & Briere, J. (2008). *Integrative Treatment of Complex Trauma for Children (ITCT-C): A Guide for the Treatment of Multiply-Traumatized Children Aged Eight to Twelve Years*. Retrieved from <http://johnbriere.com/articles.htm>
- Leckman, J. F., & Mayes, L. C. (2007). Nurturing resilient children. *Journal of Child Psychology and Psychiatry, 48*, 221 - 223.
- Lindblom, K. M., & Gray, M. J. (2010). Relationship closeness and trauma narrative detail: A critical analysis of betrayal trauma theory. *Applied Cognitive Psychology, 24*, 1-19.
- Lobbestael, J., Arntz, A., Harkema-Schouten, P., & Bernstein, D. (2009). Development and psychometric evaluation of a new assessment method for childhood maltreatment experiences: The interview for traumatic events in childhood (ITEC). *Child Abuse and Neglect: The International Journal, 33*(8), 505-517.
- London, K., Bruck, M., Ceci, S. J., & Shuman, D. W. (2005). Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy and Law, 11*(1), 194-226. doi: 10.1037/1076-8971.11.1.194
- McGregor, K., Thomas, D. R., & Read, J. (2006). Therapy for child sexual abuse: Women talk about helpful and unhelpful therapy experiences. *Journal of Child Sexual Abuse, 15*(4), 35-59.
- McNally, R. J. (2007). Betrayal trauma theory: A critical appraisal. *Memory, 15*(3), 280-294.
- McPherson, P., Scribano, P., & Stevens, J. (2012). *Barriers to successful treatment completion in child sexual abuse survivors*. *Journal of Interpersonal Violence, 27*(1), 23-39.
- Miller, B. J., Cardona, J. R. P., & Hardin, M. (2007). The use of narrative therapy and internal family systems with survivors of child sexual abuse: Examining issues related to loss and oppression. *Journal of Feminist Family Therapy, 18*(4), 1-27.
- Mossige, S., Jensen, T. K., Gulbrandsen, W., Reichelt, S., & Tjersland, O. A. (2005). Children's narratives of sexual abuse: What characterizes them and how do they contribute to meaning-making? *Narrative Inquiry, 15*(2), 377-404.
- Murray, J. B. (2000). Psychological profile of pedophiles and child molesters. *The Journal of Psychology, 134*(2), 211-224.
- Nathan, P., & Ward, T. (2001). Females who sexually abuse children: Assessment and treatment issues. *Psychiatry, Psychology and Law, 8*, 44-45.
- Ogawa, Y. (2004). Childhood trauma and play therapy intervention for traumatized children. *Journal of Professional Counseling: Practice, Theory, & Research, 32*(1), 19-29.
- Oz, S. (2005). The "wall of fear": The bridge between the traumatic event and trauma resolution therapy for childhood sexual abuse survivors. *Journal of Child Sexual Abuse, 14*(3), 23-47.
- Pereda, N., Guilera, G., Forns, M., Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review, 29*, 328-338.
- Pipe, M. E., Lamb, M. E., Orbach, Y., & Cederborg, A. C. (Eds.) (2007). *Child sexual abuse: Disclosure, delay, and denial*. Sussex, UK: Psychology Press.
- Reyes, C. J., & Asbrand, J. P. (2005). A longitudinal study assessing trauma symptoms in sexually abused children engaged in play therapy. *International Journal of Play Therapy, 14*(2), 25-47.
- Sandoval, J., Scott, A. N., & Padilla, I. (2009). Crisis counseling: An overview. *Psychology in the Schools, 46*(3), 246-256.
- Sar, V., Akyuz, G., Kugu, N., Ozturk, E., & Ertem-Vehid, H. (2006). Axis I dissociative disorder co-morbidity in borderline personality disorder and reports of childhood trauma. *Journal of Clinical Psychiatry, 67*(10), 1583-1590.
- Saywitz, K., Mannarino, A. P., Berliner, L., & Cohen, J. A. (2000). Treatment of sexually abused children and adolescents. *American Psychologist, 55*, 1040-1049.
- Schmookler, E. L. (1996). *Trauma treatment manual*. Retrieved from http://park.org/Guests/Stream/trauma_manual.htm

- Sewell, K. W., & Williams, A. M. (2001). Construing stress: A constructivist therapeutic approach to posttraumatic stress reactions. In R. A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 293–310). Washington, DC: American Psychological Association.
- Sheinberg, M., & True, F. (2008). Treating family relational trauma: A recursive process using a decision dialogue. *Family Process, 47*(2), 173-195.
- Tomlinson, P. (2008). Assessing the needs of traumatized children to improve outcomes. *Journal of Social Work Practice, 22*(3), 359-374.
- Tremblay, C., Hebert, M., & Piche, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse and Neglect, 23*(9), 929-945.
- Tuval-Mashiach, R., Freedman, S., Bargai, N., Boker, R., Hadar, H., & Shalev, A. Y. (2004). Coping with trauma: Narrative and cognitive perspectives. *Psychiatry: Interpersonal and Biological Processes, 67*(3), 280-293.
- Ullman, S. E. (2003). Social reactions to child sexual abuse disclosures: A critical review. *Journal of Child Sexual Abuse, 12*, 89-121. doi:10.1300/J070v12n01_05
- Urman, M. L., Funk, J. B., & Elliott, R. (2001). Children's experiences of traumatic events: The negotiation of normalcy and difference. *Clinical Child Psychology and Psychiatry, 6*(3), 403-424.
- Vandiver, D. M., & Walker, J. T. (2002). Female sex offenders: An overview and analysis of 40 cases. *Criminal Justice Review, 27*, 284–300.
- Walker, D. F., Reid, H. W., O'Neill, T., & Brown, L. (2009). Changes in personal religion/spirituality during and after childhood abuse: A review and synthesis. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(2), 130-145.
- Ward, T., & Beech, A. (2005). An integrated theory of sexual offending. *Aggression and Violent Behavior: A Review Journal, 11*, 44-63.
- Webster, R. E. (2001). Symptoms and long-term outcomes for children who have been sexually assaulted. *Psychology in the schools, 38*(6), 533-549.
- Welfare, A. (2008). How qualitative research can inform clinical interventions in families recovering from sibling sexual abuse. *Australian and New Zealand Journal of Family Therapy, 29*(3), 139-147. doi:10.1375/anft.29.3.139.
- Wolf, G. K., Reinhard, M., Cozolino, L. J., Caldwell, A., & Asamen, J. K. (2009). Neuropsychiatric symptoms of complex posttraumatic stress disorder: A preliminary Minnesota Multiphasic Personality Inventory scale to identify adult survivors of childhood abuse. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 49-64.
- Wolin, S.A., & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity*. New York: Villard.
- Wright, M. O., Crawford, E., & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding and meaning-making. *Journal of Family Violence, 22*(7), 597-608.