SECTION I

IDENTIFICATION

CHAPTER 1

Child Sexual Abuse

The Scope of the Problem

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INTRODUCTION

THE PROBLEM OF child sexual abuse is one riddled with complexity. To have a sexually victimized child give a clear disclosure that is replicated in a forensic interview process, proven in a court of law, and ultimately results in both physical and felt safety for the child client is a hope held by the myriad helping professionals involved in these cases. When the victimization is of a grossly criminal nature, people are quick to term it child sexual abuse (CSA). However, many of the cases that come across the desks of those on the front lines are much more nebulous and require a nuanced view toward identification, assessment, and treatment.

The difficulty begins with definition: What constitutes child sexual abuse? What is the age of consent? What services should be offered to survivors? What consequences are administered to perpetrators? What is considered normal sexual behavior? Abnormal? Abusive? More specific questions, such as: ''How much older must the older of two sexually inappropriate children/teenagers be for a discrete sexual act to be called abuse?'' The answers to these questions and ones even more basic, including how we define the terms *perpetrator* and *victim*, are socially constructed and therefore changeable as societal norms ebb and flow (Barnett, Manly, & Cicchetti, 1993; Bradley & Lindsay, 1987).

DEFINITION

Where do we begin, as a culture, to determine when a child is being or has been sexually abused? The federal legislation that most closely addresses issues related to child sexual abuse is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974. The Keeping Children and Families Safe Act of 2003 amended and reauthorized this act. This document defines sexual abuse as:

> the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children
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> —*United States Code: Title 42-chapter 67. Report concerning voluntary reporting system/LII/Legal Information Institute*

Although every state has laws against child sexual abuse, specific definitions vary from state to state and sexual abuse is not always explicitly addressed as separate from physical abuse. For the purposes of this text, sexual abuse will be defined as any sexual activity involving a child in which the child is unable or unwilling to give consent (Berliner, 2011; Berliner & Elliott, 2002; Finkelhor, 1979). The age of consent varies in the literature and although many states put the age of consent at 18 years of age, some states define it as much younger. In Tennessee, for example, the kinds of criminal charges brought in cases of sexual abuse are determined by the age of the minor, with children under 13 most easily meeting the legal definition of child sexual abuse (Child Gateway document).

Sexual abuse extends to both contact and noncontact activities that result in the sexual gratification of an adult or a significantly older or more mature child/adolescent. Activities that fall under the umbrella of child sexual abuse include touching or fondling of genitals, oral acts involving genitalia, penetration, sexual exploitation of the child for material gain (prostitution, child pornography), voyeurism, exhibitionism, and exposure to sexually explicit talk or materials. Any act that involves coercion, force, or the threat of force can be categorized as child sexual abuse. When one child is older or developmentally more mature than the other child participating in sexual activity, the first child may coerce the younger simply by nature of his positional authority. When one child is physically bigger, even if the age discrepancy is minimal, the smaller child may feel threatened and acquiesce to inappropriate sexual activity. If an older child

controls resources to which a younger child wants access, an unspoken form of coercion may be at work. Even hierarchical differences in social standing within a peer group may arguably add to the coercive nature of a sexual encounter. The purpose of highlighting these various forms of coercion among youth is not to characterize the instigator as an ''offender'' or ''perpetrator'' by adult standards, but rather to call attention to the fact that the younger child's experience may result in a posttraumatic stress reaction or have components of the sequelae often reported by other CSA victims. In addition to these criteria, an argument can be made that any sexual behavior involving a child that results in the premature activation of that child's sexual development qualifies as abuse. When the sexual behavior of an adult or older child/teen activates a developmentally inappropriate stimulation of the sexual self of a child, the behavior can be termed *abusive*.

Taking the political and/or clinical definitions of sexual abuse and applying them to actual cases becomes significantly messier. Following are some clinical examples of cases where CSA was a potential issue.

- A school teacher goes to her principal very concerned because one of her 1st grade students has been exposing himself to classmates. School is concerned as the child has recently been reunified with his biological mother who has a reported history of substance abuse and prostitution. School is unclear who has access to the child while in mom's care.
- A mother contacts a therapist known for her expertise in child sexual abuse and says that her almost-3-year-old was recently left in the care of mother's adult nephew. Mother states that since this time, her daughter has been excessively clingy, fearful, and is not sleeping well. Mother reports that her child has stated, ''Brandon hurt bootie,'' but mother has been unable to elicit further information.
- A mother calls the Department of Children's Services in a frenzied state and tells the person on the phone that her son has been sexually abused. The mother states that upon her 9-year-old son's return from camp he has been masturbating frequently and looking at pornographic material on the Internet. She has asked that her son not ''play with himself'' in public but he continues to masturbate in the common areas of the home.
- A therapist receives a call from an anxious and angry father. The father tells the therapist that he has recently remarried and his wife has a 17-year-old son that lives with the family every other weekend. His 15-year-old daughter has started dressing ''like a slut'' and has started hanging out with a group of teenagers that have a reputation

for being sexually active. The father is concerned that something might have happened between his daughter and stepson while they were alone together in the house.

These above case excerpts highlight a range of presentations of sexual concerns. Helping professionals can often feel overwhelmed by both the nebulous nature of clients' sexual concerns and the intense anxiety that is often being experienced by one or more of the child's caregivers at the time that help is sought. The members of each professional discipline involved with CSA cases feel pressure to find definitive answers for families. Furthermore, both caregivers and helping professionals can feel overwhelmed by the number of people that can be involved in cases of child sexual abuse. See Chapter 4 for an in-depth exploration of the various roles of helping professionals involved with cases of child sexual abuse.

DISCLOSURE

Disclosure of CSA is becoming more commonly and appropriately thought of as a process versus an event (Alaggia, 2004; Goodyear-Brown, 2010; Summit, 1983). Much like other aspects of CSA, the disclosure process is not often neat, concise, and orderly. On the contrary, it is more likely to be messy, convoluted, and peppered with ambiguity. Estimated rates of disclosure are dependent on what constitutes a ''disclosure'' (telling anyone versus telling a professional involved in the investigation of the allegation). Another important consideration is the discrepancy between the incidents of CSA actually reported to authorities and the CSA that was either never disclosed or disclosed to someone but not reported to authorities at any point (Finkelhor, 1979; Finkelhor, Hotaling, Lewis, & Smith, 1990). Less than 10% of child sexual abuse is reported to authorities (Lyon & Ahern, 2011). More than one-third of suspected CSA victims fail to disclose their abuse (Lamb, Hershkowitz, Orbach, & Esplin, 2008) and some victims may choose to remain silent well into adulthood (Alaggia, 2004; Alaggia & Kirshenbaum, 2005; Finkelhor et al., 1990; Finkelhor, 1979; Summit, 1983). Delays and nondisclosure seem to be related to the level of relationship that the child has with the perpetrator, where closer relationships lead to a greater likelihood of nondisclosure (Hershkowitz, Horowitz, & Lamb, 2005; Hershkowitz, 2006; Pipe et al., 2007).

The Child Sexual Abuse Accommodation Syndrome (CSAAS), which delineates five categories: secrecy; helplessness; entrapment and accommodation; delayed; conflicted and unconvincing disclosure; and retraction, helps to illustrate the multiplicity of paths that children may take towards disclosure (Summit, 1983). Although this conceptualization of

accommodation has come under recent criticism (Bradley & Wood, 1996; London, Bruck, Ceci, & Shuman, 2005), an analysis of the research does support the phenomenon of nondisclosure and recantation.

Disclosure may be purposeful, accidental, elicited or prompted, behavioral, triggered, and purposely withheld (Alaggia, 2004). There are multiple factors that influence a victim's decision to disclose abuse and navigate the resulting fallout. Family dynamics and roles, intrafamilial communication patterns and social isolation (Alaggia & Kirshenbaum, 2005), gender (Alaggia, 2004; Finkelhor et al., 1990; Summit, 1983), developmental level (Goodman-Brown et al., 2003; Staller & Nelson-Gardell, 2005), relationship to the perpetrator (Goodman-Brown et al., 2003; Hershkowitz, Lanes, & Lamb, 2007); expected or actual support (or lack thereof) by the nonoffending caregiver (Alaggia, 2004; Hershkowitz et al., 2007; Staller & Nelson-Gardell, 2005), perceived responsibility for the abuse (Goodman-Brown et al., 2003; Staller & Nelson-Gardell, 2005) and awareness of potential negative consequences (Goodman-Brown et al., 2003; Staller & Nelson-Gardell, 2005; Summit, 1983) have all been studied as elements contributing to likelihood and timing of disclosure.

A known perpetrator, multiple incidents and severity of CSA, increased age, gender of the victim, anticipated or actual nonsupportive caregiver, potential negative consequences and additional dysfunction within the home decrease the probability of any type of disclosure, timely or not (Alaggia, 2004; Finkelhor et al., 1990; Goodman-Brown et al., 2003; Hershkowitz et al., 2007; Staller & Nelson-Gardell, 2005; Summit, 1983). An older child is more likely to have the capacity to imagine all the possible outcome scenarios that may result from the decision to disclose and therefore may be more cautious than a younger child about telling (Staller & Nelson-Gardell, 2005). Males are considered less likely to disclose CSA than females (Finkelhor, 1979; Finkelhor et al., 1990), although more research is warranted regarding the disclosure dynamics of male victims.

Recantation may be a defense attorney's realized dream and potentially a prosecutor's nightmare, but in actuality it is an anticipated part of the disclosure process. A child's recant can be the result of multiple factors and its presence is documented in various studies when there is corroboration, including physical evidence, to substantiate the initial allegation of CSA (Shapiro Gonzalez, Waterman, Kelly, McCord, & Oliveri, 1993; Hershkowitz, Lanes, & Lamb, 2007; Malloy, Lyon, & Quas, 2007). Children may be more likely to recant if they are 9 years old and older, if the alleged perpetrator is known, if more than one incident has occurred, and if the child has perceived the parent's response as anxious (Hershkowitz et al., 2007).

Finally, children risk a tremendous amount when they make a disclosure. The way in which the disclosure is met by those closest to the child can make a significant impact on the long-term adverse effects of abuse. Negative reactions appear to lead to more adverse long-term effects (Bernard-Bonnin, Hebert, Daignault, & Allard-Dansereau, 2008; Leifer, Shapiro, & Kassmen, 1993; Mannarino & Cohen, 1997), whereas support from nonoffending caregivers leads to better long-term mental health outcomes.

BEHAVIORAL INDICATORS THAT A CHILD MAY HAVE EXPERIENCED SEXUAL ABUSE

As the phenomenon of CSA has gained increasing public attention in recent years, parents, teachers, and other adults who care for children want to know what to look for; what indicators raise the red flag for potential sexual abuse. Behavior is a child's primary form of communication. When children do not have the words or ability to verbally communicate trauma they begin to ''act out,'' have psychosomatic symptoms, or show their trauma through behavioral indicators. Many of the behaviors that may indicate CSA are also exhibited in nontrauma situations, so all must be noted with caution. Professionals are trained to look for sudden emotional or behavioral changes (Hibbard & Hartman, 1992; Wells, McCann, Adams, Voris, & Dahl, 1997), clinginess or fear of being alone (Bernet, 1997; Herbert, 1987; Hibbard & Hartman, 1992; O'Keefe, 2004; Wells et al., 1997), sleep disturbances including nightmares (Bernet, 1997; Hibbard & Hartman, 1992; McClain et al., 2000; O'Keefe, 2004; Wells et al., 1997), school disturbances including learning difficulties, poor concentration and declining grades (Hibbard & Hartman, 1992; McClain et al., 2000; O'Keefe, 2004), enuresis and encopresis (Bernet, 1997; McClain et al., 2000; O'Keefe, 2004), aggression (McClain et al., 2000; O'Keefe, 2004), social withdrawal (Herbert, 1987; Wells et al., 1997), depression and suicidal ideations (Bernet, 1997; Hibbard & Hartman, 1992; McClain et al., 2000; O'Keefe, 2004; Wells et al., 1997), eating disturbances (Bernet, 1997; McClain et al., 2000; O'Keefe, 2004), anxiety (Bernet, 1997; Herbert, 1987; Hibbard & Hartman, 1992; Wells et al., 1997) and sexual behaviors (Bernet, 1997; Herbert, 1987; McClain et al., 2000; O'Keefe, 2004; Wells et al., 1997). Any of these behaviors, taken on their own, might have any number of causes. The presence of several indicators in the absence of other explanations is cause for further assessment.

PREVALENCE AND INCIDENCE

Definitions of child maltreatment, including definitions of child sexual abuse, are socially constructed and are therefore prey to the vagaries of the current sociocultural climate. This lack of definitional consensus combined

with the complexities of polyvictimization makes it difficult to gather even basic statistics such as prevalence and incidence (Cicchetti & Toth, 1995; Wynkoop, Capps, & Priest, 1995). Incidence refers to the number of new occurrences of an event within a certain time frame. Because sexual abuse is rarely reported immediately, incidence is difficult to measure (Finklehor, Hotaling, Lewis, & Smith, 1990). The Juvenile Victimization Survey (Finkelhor, Ormrod, Turner, & Hamby, 2005) was used to assess the interrelatedness of various types of victimization within a national survey. Sexual victimization was experienced by one out of every 12 survey participants (ages 2 to 17) in the study year. Prevalence measures the overall number of cases within a specific time frame. Many dynamics converge to make prevalence rates difficult to pin down. The diversity of ways in which sexual abuse is defined for research purposes contributes to this difficulty in standardization. The areas of variability include the age used to define childhood, the age difference between the perpetrator and the victim, and the specific type of sexual abuse being measured (Pereda, Guilera, Forns, & Gomez-Benito, 2009).

Data-collection tools are inadequate and have been repeatedly criticized. In 1985, Whitcomb highlighted the fact that the FBI Uniform Crime Report did not categorize sexual assault by victim age, making it impossible to discern the number of reported cases that constitute child sexual abuse. In 1995, Wynkoop, Capps, and Priest commented on the continued elusiveness of epidemiological information, highlighting the fact that, historically, most reporting instruments did not separate sexual abuse from other forms of abuse. Fifteen years later the reports of incidence and prevalence continue to vary widely across the literature. Even the National Criminal Victimization Survey (NCVS), the largest national survey of annual incidence of crime may underestimate actual incidence rates (Kilpatrick, 2004; Kilpatrick, McCauley, & Mattern, 2009). The worldwide estimate of prevalence derived from three decades of research ranges from 11% to 32% for females and 4% to 14% for males (Sapp & Vandeven, 2005). In 2008 there were 69,184 reported victims of CSA in the United States alone (U.S. Department of Health and Human Services, 2010). However, the number of reports made to child abuse authorities has decreased significantly, with some states showing as much as a 39% decline in substantiated reports between the years of 1992 and 1999 (Jones, Finkelhor, & Kopiec, 2001).

Multiple Forms of Victimization

The need for a nuanced approach to CSA stems in part from our growing understanding of the complex nature of child maltreatment. Many children with a history of sexual abuse may also have been exposed to other

forms of maltreatment and/or environmental chaos. The polyvictimization of these children, which may include physical abuse, intrafamilial violence, exposure to community violence, complicate both the identification and the treatment dynamics of work with this population (Finkelhor, Ormrod, Turner, & Hamby, 2005).

The Adverse Childhood Experiences Study (Felitti et al., 1998) looked at a person's trauma exposure and household dysfunction in childhood and the relationship of these dynamics to adult health-risk behavior and disease using data from 9,508 respondents. As the number of ACE exposures increased so did lifelong health risks. Dong, Anda, Dube, Giles, and Felitti (2003) conducted a study involving 18,175 responding adult subjects evaluating the relationship between child sexual abuse and the other nine Adverse Childhood Experiences (ACEs). Twenty-one percent of the respondents reported a history of CSA and the findings included a strong correlation between the CSA of this group and the other nine ACEs. Additionally, the respondents who reported multiple CSA experiences, more severe CSA, or multiple and intrafamilial perpetrators were also more likely to have reported multiple ACEs. CSA was most often concurrent with other negative childhood experiences such as physical abuse, physical violence against the mother, mental illness in household, neglect, household substance abuse, and so on, and not commonly identified as the only ACE. Children who are sexually victimized once are likely to be sexually victimized again, with as many as 75% of children in clinical samples experiencing multiple episodes of sexual victimization (Conte & Schuerman, 1987; Elliot & Briere, 1994; Ruggiero, McLeer, & Dixon, 2000).

Briere and Elliott (2003) surveyed a geographically diverse sample of the general population and found a 21% overlap in the number of people who had experienced both physical and sexual abuse, while other researchers have concluded that physical abuse was a noteworthy predictor of child sexual abuse across childhood (Fleming, Mullen, & Bammer, 1997). The more we understand about the overlap between various forms of maltreatment, the argument that we may indeed ''underestimate the burden of victimization that young people experience'' (Finkelhor, Ormrod, Turner, & Hamby, 2005, p. 5) is strengthened.

RISK FACTORS

Childhood sexual abuse is a pervasive problem, affecting people across lines of gender, race, culture, religion, geographic area, and socioeconomic class. The third national incidence study of child abuse and neglect (Sedlak & Broadhurst, 1996) states that from age 3, children are consistently

vulnerable to CSA. However, females are at higher risk for CSA than males (Berliner, 2011; Gault-Sherman, Silver, & Sigfusdottir, 2009). Gault-Sherman and colleagues (2009) found that females were approximately three times more likely to fall victim to CSA than males and more likely to develop depressed mood and general anxiety; 86.5% of the females with CSA identified an intrafamilial perpetrator, which was also the case for 95.9% of the males with CSA.

According to surveys from the general population, 6% to 16% of offenders were parental figures and up to one third of the cases of CSA were perpetrated by a relative. A comparatively small number of offenders (5% to 15%) were strangers (Berliner & Elliott, 2002). The remaining group is comprised of people known to the child (Berliner, 2011).

Low socioeconomic status, while an important risk factor in other forms of abuse, has not been proven to be a significant risk factor for sexual abuse (Berliner & Elliott, 2002; Finkelhor, 1993; Putnam, 2003). Race and ethnicity also appear to have little impact on a child's risk for sexual abuse, although the resulting symptom constellation may manifest differently based on these variables (Mennen, 1995; Shaw, Lewis, Loeb, Rosado, & Rodriguez, 2001).

Substance abuse is identified as another risk factor, as it can cause impairment of thought, ability, judgment, and capability to protect (Goldman, Salus, Wolcott, Kennedy, & Office on Child Abuse and Neglect [HHS], 2003). A parent's substance abuse problem can be seen as increasing the risk for various forms of maltreatment, including sexual abuse. One study found intrafamilial sexual abuse occurred more frequently when an alcoholic father was present and extrafamilial sexual abuse occurred more frequently when an alcoholic mother was present or the mother was deceased (Fleming, Mullen, & Bammer, 1997).

Family Structure

The Fourth National Incidence Study of Child Abuse and Neglect, Report to Congress (NIS-4; Sedlak et al., 2010) examined family structure as a potential risk factor for child maltreatment using data collected in 2005 and 2006. Across maltreatment groups, children living with married biological parents had the lowest maltreatment rate collectively. Children who lived with a single parent with a live-in partner had more than eight times the maltreatment rate of those living with married biological parents and were 10 times more likely to be abused. Goldman, Salus, Wolcott, Kennedy, and the Office on Child Abuse and Neglect (HHS; 2003) found that only 31% of CSA survivors lived with both biological parents, whereas 27% lived with a stepfather or mother's boyfriend.

The presence of a stepfather has long been conceptualized as a risk factor as has living without the mother, even for a short time (Friedrich, 1990). Finkelhor (1979) found that, in addition to the risk factors mentioned earlier, several risk factors were specific to maternal dynamics including: maternal distance, mom's educational achievement (lacking a high school diploma), and a punitive stance on sexuality from mom. Lack of physical paternal affection, extremely low annual household income and a lack of friendships (two or fewer friendships in childhood) were also risk factors. These risk factors were characterized as cumulative. A child's vulnerability to CSA increased by between 10% and 20% with each additional dynamic (Finkelhor, 1979).

OFFENDER DYNAMICS

Another important data set includes perpetrators of CSA and their input regarding factors that potentially put children at risk. Elliott, Browne, and Kilcoyne (1995) interviewed 91 child sex offenders regarding their selection of victims using a semi-structured questionnaire. Characteristics that the interviewed offenders identified as risk factors for children included a perception that a child had low self-esteem or a lack of self-confidence, had family problems, was overly trusting of others, had little supervision, or was isolated. The offender's subjective perception of the child as pretty and/or provocatively dressed, young and small also influenced the choice of victim. Of note, the offenders showed a 90% consistency rate regarding their answers to interview questions.

INTERGENERATIONAL TRANSMISSION OF ABUSE

Multigenerational cycles of abuse may increase risk of maltreatment, as how one was parented will likely play a significant role in his or her own future parenting style (Goldman, Salus, Wolcott, Kennedy, & the Office on Child Abuse and Neglect [HHS], 2003). This can, however, be observed at both extremes, as there are adult survivors of child maltreatment that continue this cycle with their own children and certainly those adult survivors who break this cycle. Although Oates, Tebbutt, Swanston, Lynch, and O'Toole (1998) found that children who experienced sexual abuse did not vary on measures of depression, self-esteem, and behavior regardless of whether their mothers were survivors of sexual abuse, existing studies of intergenerational issues do not separate one form of abuse from another, so there is little data specific to intergenerational patterns in CSA transmission (Putnam, 2003).

The Impact of Mass Media

If the definition of child sexual abuse holds an adult culpable for exposing a child to sexually explicit material, then there is an argument to be made for the culpability of the mass media in putting all children further at risk for CSA. The objectification of the physical body, the pervasiveness of sexually thematic material, and the frequent combination of sex and aggression in the media set the stage for unhealthy perceptions of sexuality.

According to the Nielsen's A2/M2 Three Screen Report for the second quarter of 2009, children and teenagers are watching an average of 101 hours of television per month. The sexualized messages that are prevalent in mainstream media have continued to increase in the past few years. According to Ward (1995) 11.5% of the messages coded from television involved sexually objectifying comments, the majority of which were focused at women. The sexual speech on prime-time comedies coded by Lampman and colleagues (2002) found that 23% of behavior involved leering, ogling, staring, and catcalling of female characters, and 16.5% of the sexualized speech referred to nudity or body parts.

This sexual socialization (Ward, 2003), including the focus on the attractiveness of one's physical body, has never been more highlighted than in the current group of television programs given over to beauty pageants for children. For these glitzy pageants, children as young as 2 are coached on how to capitalize on their physical attractiveness. The molding process may include fake eyelashes, fake tans, fake hair, and even fake teeth. The intention is to make the children look older than they are. Children's beauty is judged in part on how they look in a swimsuit. Children are directed to both move suggestively and dress revealingly. One young child presented on stage wearing a replica of Madonna's gold-cone corset; another dressed as Michael Jackson performed his famous crotch grab. In one memorable episode, a distressed father of a 7-year-old cringes as he compares his daughter's pageant costume to a ''dominatrix outfit.''

What is more startling still is the response from the audience when these children walk across stage in these costumes and during these performances. Positive audience and judge responses could have a direct effect on self-worth. Primarily reinforcing a child's physical attributes may contribute to susceptibility to further objectification throughout his or her development. A 2007 APA study looking at the sexualization of girls identified a link between the early emphasis on physical appearance with eating disorders, low self-esteem, and depression.

One of the most troubling double standards encouraged by the media is the characterization of sexual activity between boys with adult women and girls with adult males. Boys are more likely to be victimized by women

than their female peers, with 20% of boys and 5% of girls being motested by women perpetrators (Finkelhor & Russell, 1984) and yet many current storylines involve underage males having satisfying, even coveted, sexual encounters with adult women.

ASYMPTOMATIC CHILDREN: JUST HOW BAD IS IT?

A child who has been sexually abused is damaged goods, or so goes the assumption of many segments of our modern culture. An analysis of the research offers us a much more hopeful view, one that counters the belief that sexually abused children are tainted for life. Kendall-Tackett, Williams, and Finkelhor (1993) reviewed 45 studies and concluded that approximately one-third of the children with CSA histories showed no symptoms. Finkelhor and Berliner (1995) evaluated children who had been sexually abused and found that up to 40% of those children were asymptomatic.

Rind, Tromovitch, and Bauserman (1998) conducted a meta-analysis of almost 60 studies based on college samples and looked at the history of sexual abuse and family environment. They found that the students with a history of CSA were minimally less well-adjusted than their peers and that most of these adjustment difficulties were due to family environment. This finding is supported by our current understanding that sexual abuse survivors often come from homes that are highly chaotic or manifest dysfunction on a range of other levels.

What could account for this level of psychological resiliency? According to Kinnally and colleagues (2009), positive social support is associated with a lower risk for adverse mental health issues. A combination of familial support, a positive social support network, and inherent resiliencies can be protective factors for children who have experienced CSA and can ameliorate the possible emotional effects of childhood sexual abuse.

POSTTRAUMATIC STRESS DISORDER

The most common diagnosis given to children who have documented histories of sexual abuse is posttraumatic stress disorder (PTSD) (Berliner & Elliott, 2002; Kendall-Tackett, Williams, & Finkelhor, 1993; McLeer et al., 1998; Putnam, 2003; Ruggiero, McLeer, & Dixon, 2000). PTSD symptom clusters include avoidance and/or numbing behaviors, hyperarousal symptoms, and reexperiencing parts of the trauma. Subsets of these symptom constellations are reported by many sexually abused children (McLeer, Deblinger, Henry, & Orvaschel, 1992; McLeer et al., 1998; Wolfe,

Gentile, & Wolfe, 1989). More than 30% of children with CSA histories meet the diagnostic criteria for PTSD (Berliner & Elliott, 2002).

The proposed diagnosis of developmental trauma disorder (van der Kolk, 2005) may be a more appropriate conceptualization for post-traumatic, symptomatology in children as it more thoroughly captures the developmentally determined sequelae of symptoms in children who have experienced extensive trauma. When children experience chronic trauma, it impairs their neurobiological development and capacity to cohesively integrate sensory, emotional, and cognitive information. Developmental Trauma disorder takes into account children's ''triggered dysregulation in response to traumatic reminders, stimulus generalization, and the anticipatory organization of behavior to prevent the recurrence of the trauma effects'' (van der Kolk, 2005, p. 406).

Sexual Behavior Problems

Sexual behavior problems (SBP) appear to be a specific effect of CSA. Compared to physically abused children, clinical populations, and normative samples, children with a history of CSA more frequently engage in inappropriate or aggressive sexual behaviors (Friedrich, Beilke, & Urquiza, 1987; Friedrich et al., 1991; Gale, Thompson, Moran, & Sack, 1988; Goldston, Turnquist, & Knutson, 1989; Kolko, Moser, & Weldy, 1988). Chapter 18 provides additional information on this specific set of sequalae and current treatment approaches for SBP.

Emotional Effects

A variety of negative emotional effects have been reported by children who have experienced sexual abuse. The myriad presentations of sexually abused children make it difficult to pinpoint a ''syndrome'' or ''cluster'' of emotional symptoms specific to CSA. The emotional effects that appear to occur most frequently include depression and anxiety (Briere & Elliott, 2003; Caffo, Forresi, & Lievers, 2005; Cohen, Mannarino, & Deblinger, 2006; Kolko, Moser, & Weldy, 1988; Lev-Wiesel, 2008; Maniglio, 2009; Putnam, 2003; Sapp & Vandeven 2005; van der Kolk, 2005). Survivors of sexual abuse are five times more likely to be diagnosed with at least one anxiety disorder than their peers (Berliner & Elliot, 2002). The severity of psychological and behavioral symptoms increases with the severity of the victimization (Boney-McCoy & Finkelhor, 1996; Gidycz & Koss, 1989).

Numerous studies have shown depression and dysthymia to have a strong association with CSA (Hornor, 2010; Lanktree, Briere, & Zaidi, 1991; Putnam, 2003; Wozencraft, Wagner, & Pellegrin, 1991). Women with a

history of CSA are three to five times more likely to develop depression than the general population (Putnam, 2003). Fergusson, Lynskey, and Horwood (1996a, 1996b) report that children with noncontact CSA or CSA not involving intercourse are 4.6 times more likely to develop major depression and 8.1 times more likely if the abuse involved intercourse. Depressive disorders often occur in conjunction with PTSD (Cohen et al., 2006) and given the aforementioned rates of PTSD in this population, depression is often comorbidly diagnosed. Suicidal ideation and suicide attempts are also associated with CSA (Brodsky et al., 2008).

Depression manifests in children as anhedonia, pathological guilt, social withdrawal, complaints of fatigue, impairment in school functioning, and low self-esteem. Sexually abused youth have produced lower scores relating to low self-esteem than their physically abused or nonabused peers (Cavaiola & Schiff, 1989) with low self-esteem being related to the severity of abuse (Stern, Lynch, Oates, O'Toole, & Cooney, 1995). Of particular note is the finding that children whose abuse was incestuous in nature struggled more with self-acceptance than the other groups (Cavaiola & Schiff, 1989).

SUBSTANCE ABUSE

Much has been documented on the possible link between experienced trauma and substance abuse or addiction. CSA in girls has been linked with an increased risk of moderate to high substance abuse (Shin, Hong, & Hazen, 2010). No such association was shown for boys. Poly-substance abuse was reported at a rate of around five times that of females without a CSA history. Males who have experienced both physical and sexual abuse have a significantly increased likelihood of illicit drug use when compared to females with the same maltreatment history (Moran, Vuchinich, & Hall, 2004). A history of sexual assault puts adolescents at increased risk for substance abuse and an earlier onset of substance use for those adolescents with a victimization history as compared to their nonvictimized peers (Duncan et al., 2008; Kilpatrick et al., 2000). A PTSD diagnosis also was shown to increase substance use, specifically marijuana and hard drugs. CSA is associated with increased rates of lifetime alcohol use and lifetime diagnosis of dependency (Moran, Vuchinich, & Hall, 2004; Sartor et al., 2007).

EATING DISORDERS

Wonderlich and colleagues (2000) found that children with a CSA history were more likely than the nonabused children to display food restriction

when emotionally disturbed, have weight dissatisfaction, pursuit of what they idealized as a thin body, and increased purging behavior.

Van Gerko, Hughes, Hamill, and Waller (2005) examined associations between a CSA history and the eating attitudes and behaviors of 299 women who met the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revised (*DSM-IV-TR*; American Psychological Association, 2000) criteria for an eating disorder. Those participants with a history of CSA had significantly higher levels of purging behavior than their nonabused peers. Also reported were higher levels of shape concerns. These studies support the possibility that CSA may contribute to eating pathology, especially purging behaviors and body image disturbance, when combined with various other social, genetic, familial, and developmental factors thought to play a part in the development of eating disorders (Lock, 2009).

Ackard, Neumark-Sztainer, Hannan, French, and Story (2001) found that girls who experienced both physical and sexual abuse were four times more likely to participate in bingeing and purging than the nonabused girls, while boys were more than eight times as likely to engage in these behaviors when compared with the nonabused boys. This association was not found for girls with CSA alone. This finding gives weight to the argument that polyvictimization leads to more harmful effects. Corstorphine, Waller, Lawson, and Ganis (2007) examined the relationship between trauma and multi-impulsivity. These researchers found that of the participants who met criteria for various eating disorders, CSA was the only form of childhood trauma reliably and positively associated with multi-impulsivity.

Body dissatisfaction is associated with depression, decreased self-esteem, and eating disorders (Brannan & Petrie, 2008; Grossbard, Lee, Neighbors, & Larimer, 2009). Eating disorders are associated with risk factors of depression and low self-esteem (Mayer, Muris, Meesters, & Zimmerman van Beuningen, 2009). CSA is also associated with depression and decreased self-esteem, so the connection between body dysmorphia, CSA and eating disorders warrants further study.

When assessing the physical, emotional, and developmental damage CSA can wreak, the damage to children developing perceptions of their physical bodies should not be underestimated. Feelings of shame and helplessness paired with an actual crime against the body may predispose children to negative evaluations of their physical bodies, including Body Dysmorphic Disorder (American Psychiatric Association, 2000). The National Eating Disorders Association (2004) notes that for those with eating disorders, food and its control can be used in attempt to regulate overwhelming feelings or emotions.

ANOTHER WAY OF CONCEPTUALIZING THE EFFECTS OF CSA

Finkelhor and Browne (1985) conceptualized the emotional and cognitive ramifications of CSA by examining sexual abuse as a variety of different effects as opposed to a disorder or syndrome. They developed four traumagenic dynamics, which include traumatic sexualization, betrayal, stigmatization, and powerlessness/disempowerment. Traumatic sexualization is the process by which a child's sexuality is inappropriately or dysfunctionally shaped by the sexual abuse. Betrayal occurs with the realization that a person the child is dependent on has caused them harm. Stigmatization manifests in the negative cognitions that children believe about themselves and the world around them. It can become incorporated in the child's sense of self and beliefs about his or her self-worth. Powerlessness/disempowerment is created when the child's will, desire, and sense of efficacy are eroded throughout the abuse experience. Finkelhor and Browne (1985) argue that these four dynamics account for the main effects of trauma in child sexual abuse.

LONG-TERM EFFECTS OF CHILDHOOD SEXUAL ABUSE ON ADULT SURVIVORS

One of the prevailing methodological issues facing CSA researchers is whether the effects of CSA are causal or correlated with several confounding environmental factors. Several studies reviewed the methodological problems associated with the types of research conducted and discussed the lack of male participants in a majority of studies. Multiple studies utilized clinical samples of participants and few studies utilized a random sampling of the population (Briere & Elliott, 2003; Dilillo, 2001; Fergusson, Boden, & Horwood, 2008; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Tyler, 2002; Vogeltanz-Holm, 2004).

Another difficulty with the existing evidence base is the lack of control for outside factors such as social support, family environment, and socioeconomic status. A few multivariate studies have been conducted in recent years to control for outside effects and to show a causal relationship between the long-term effects and CSA (Boney-McCoy & Finkelhor, 1996; Dinwiddie et al., 2000; Fergusson et al., 1996; Mullen et al., 1993). As the research mounts, however, there is growing consensus about the long-term effects of CSA.

Whether the intensity of the symptoms is mild, moderate, or severe, the effects of CSA in adulthood can be understood as an extension of the short-terms effects found in children (Berliner & Elliott, 2002). It appears that a causal relationship exists between CSA and psychiatric disorders in adulthood (Beitchman et al., 1992; Berliner & Elliott, 2002;

Boney-McCoy & Finklehor, 1996; Briere & Elliott, 2003; Dinwiddie et al., 2000; Dube et al., 2005; Fergusson et al., 1996; Fergusson et al., 2008; Greenfield, 2010; Hornor, 2010; Maniglio, 2009; Mullen et al., 1993; Mullen et al., 1996; Owens & Chard, 2003; Taylor & Harvey, 2010; Tyler, 2002; Vogeltanz-Holm, 2004). Briere and Elliott (2003) looked at the prevalence of sequelae of psychological symptoms within the general population who have experienced CSA. They found that CSA is a significant risk factor for all 10 of the categories listed on the Trauma Symptom Inventory. Those categories are: anxious arousal, depression, anger/irritability, intrusive experiences, defense avoidance, dissociation, sexual concerns, dysfunctional sexual behavior, impaired self-reference, and tension-reduction behavior.

Depression, anxiety, and posttraumatic stress disorder are the predominant long-term disorders found to be associated with the occurrence of CSA. Several of the other ramifications found to result from untreated CSA are the use/misuse of substances in adulthood (Berliner & Elliott, 2002; Dinwiddie et al., 2000; Dube et al., 2005; Fergusson et al., 1996; Fergusson, Boden, & Horwood, 2008; Maniglio, 2009; Mullen et al., 1996; Vogeltanz-Holm, 2004), suicidality (Beitchman et al., 1992; Briere & Elliott, 2003; Dinwiddie et al., 2000; Dube et al., 2005; Fergusson et al., 1996; Fergusson et al., 2008; Greenfield, 2010; Hornor, 2010; Mullen et al., 1996; Tyler, 2002), potentially abusive relationships (Dilillo, 2001; Hornor, 2010), and sexual issues (Beitchman et al., 1992; Berliner & Elliott, 2002; Dilillo, 2001; Mullen et al., 1996). All of the studies reported an increase in effects when the CSA involved intercourse and/or threats and force. There are only a handful of studies that address dissociation, personality disorders, and multiple personality disorder (now termed dissociative identity disorder) and the relationship between those symptoms and CSA (Beitchman et al., 1992; Briere & Elliott, 2003; Lev-Wiesel, 2008; Maniglio, 2009; Owens & Chard, 2003; Putnam, 2003). The research shows confounding results for the relationship between CSA and personality disorders. Few studies have looked at gender differences with regard to the effects of CSA, but those that have support the idea that both male and female survivors of CSA are equally susceptible to long term mental health effects (Baynard, Williams, & Seigel, 2004; Dube et al., 2005). Certainly future research in this area is warranted.

Mullen et al. (1996) found that the women reporting CSA had more significant mental health issues than the other types of abuse survivors. These women reported a history of eating disorders, depression, substance use, attempted suicide, sexual problems, poor self-esteem, and a decline in socioeconomic status. Greenfield (2010) researched the long-term physical health effects of CSA on adults. She conducted a review of the literature based on community samples and found CSA to be a determinant of poor

physical adult health, although specific health issues were not targeted. For a more thorough treatment of this topic, read Kathleen Kendall-Tackett (Chapter 3) on the long-term health effects of CSA.

CONCLUSION

This chapter is meant to provide a synopsis of what we know and what we do not know. Child sexual abuse is a complex problem with far-reaching consequences for the individual and for society at large. Definitions, prevalence and incidence data, disclosure patterns, risk factors, the role of the mass media, the short-term psychological, behavioral and emotional effects on child survivors as well as a review of the research regarding mental health outcomes in adulthood were all presented with a view toward defining the scope of the problem of child sexual abuse. It is only then that each of us can examine how we might become a part of the solution.

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