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The Reality of Child Sexual Abuse: A Critique of the Arguments Used by Adult-Child Sex Advoates

Kacey Klein

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CLAREMONT MCKENNA COLLEGE

**THE REALITY OF CHILD SEXUAL ABUSE: A CRITIQUE OF THE
ARGUMENTS USED BY ADULT-CHILD SEX ADVOCATES**

**SUBMITTED TO
PROFESSOR KATHLEEN BROWN
AND
DEAN GREGORY HESS
BY
KACEY KLEIN**

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Introduction

“At 7, I thought that this was just what men did to little girls.” –Audrey (Cameron, 2000)

Child sexual abuse is a major concern of society because the physical and mental harm endured by children is extremely destructive. The effects can be long lasting and affect an entire family. Although it has been around for decades, perhaps even centuries, society is becoming increasingly more aware of sexual abuse and its impact on child victims. Child sexual abuse, often referred to as CSA, is not isolated to one demographic or social class. Children of many different backgrounds have been forced to engage in unwanted sexual behavior.. In 2009, it was estimated that there were 39 million survivors of child sexual abuse in America (www.darkness2light.org). Many incidents go unreported due to factors such as shame or denial, which means current statistics, which are already shocking, are still underestimated.

Victims of child sexual abuse may endure many physical and psychological problems that can contribute to a lifelong struggle. Research shows that there are many negative effects of CSA that can take away any chance of normal childhood development. Haunted by fear and anxiety, children can have a hard time coping with CSA because they are not ready for the sexual behavior that is forced upon them. Symptoms of nightmares, behavioral regression, depression, and isolation can trouble victims in childhood and continue into adulthood. Some victims even show symptoms similar to posttraumatic stress disorder because CSA is an extremely traumatic experience. The shame, guilt, or anxiety caused by CSA can put a strain on relationships and negatively influence other aspects of life such as self esteem and social interactions. There are treatment methods such as cognitive-behavioral therapy and psychoanalytical

therapy that have been proven to help victims cope and lead a healthy life after sexual abuse. Therapy for CSA victims tends to focus on shifting the blame back onto the offender to help the victim understand that he or she was not the cause of the trauma.

Society does not generally support any pedophilic behavior because people are aware of the negative outcomes for children who have experienced CSA. Unfortunately, there are advocacy groups in the United States that disagree with these societal views. These groups believe sexual relationships between adults and children are positive. Such groups are formed by self-proclaimed pedophiles. Despite all the information accessible to the public about child sexual abuse, it is always surprising that there are still people in the world who think adult-child sex is appropriate and normal behavior.

Adult-Child Sex Advocates

There have been many pedophile organizations throughout history that all had the same motivation, advocating for adult-child sex. Most organizations started in Europe and then expanded to the United States. Examples of such groups are Paedophile Information Exchange in England, The Rene Guyon Society in the U.S., and the International Amnesty for Child Sexuality (deYoung, 1989). These advocacy groups oppose age-of-consent laws and ageism, which is age-based discrimination (www.nambla.org). For example, the Rene Guyon Society advocated for the abolition of the statutory rape and child pornography laws and had the slogan, “Sex by year eight, or else it’s too late” (deYoung, 1989). Many organizations have not lasted very long because the ideas and philosophies they promote are too radical and inappropriate for society to accept them. North American Man/Boy Love Association (NAMBLA) is one of the pedophile organizations in the U.S. that advocates for adult-child sexual

relationships. NAMBLA is one of the few pedophile organizations in the world that is still active despite years of legal harassment over its behavior and philosophy (deYoung, 1989). The main goal of this organization is to end the extreme oppression of men and boys in mutually consensual relationships (www.nambla.org). Members of this organization do not believe that their relationships with young boys are considered child sexual abuse because there are two willing participants in the relationship and children are mentally mature enough to make an informed decision about engaging in sex.

NAMBLA argues that “If sex is an expression of shared love (as man/boy love is), then it is beneficial to both partners, regardless of age...Nothing is more beneficial than to feel a sense of security in the love of another...” (NAMBLA, 1985, p. 6). Pedophile organizations are constantly fighting against society to express their beliefs and ideals, but are often met with conflicting societal views. The behavior or the beliefs of these pedophile groups deviate from what the larger society considers normal (deYoung, 1989). Society generally views any sexual relationship between adults and children as harmful and abusive.

Rationalizations

When society is always insisting that pedophilic behavior is wrong, how do pedophiles justify their behaviors? These organizations rationalize their philosophy and sexual urges to try to overcome society’s condemning opinions. Mary deYoung (1989, p. 115) explains that justifications are used when “individuals or groups accept responsibility for the deviant behavior or belief, but deny the pejorative, or stigmatizing quality of it.” The justifications that most pedophile organizations use attempt to take the

attention away from their deviant behavior, shift the blame to the child, and point out the positive outcomes of adult-child relationships.

One technique is called the denial of injury, where the organization acknowledges responsibility for the abnormal behavior, but insists that it is permissible because no one is injured or harmed (deYoung, 1989). For example, NAMBLA focuses on the positive impact of adult-child sex by using personal statements from children about the advantages they have encountered from personal relationships with adult males. A frequent article in NAMBLA publications was called “The Unicorn,” which was written by an 11-year-old boy who wrote about his sexual experience with various adult lovers and the positive effects each adult had on his physical, emotional, and spiritual development (NAMBLA, 1983b, p. 10). In addition to pointing out the positive impact of adult-child sex, NAMBLA also places some of the blame back onto society for the possible harm to the child. NAMBLA attributes the reactions of society to adult-child sex as the reason children are psychologically harmed. For example, the organization says that “damage can be done by the parents of the child who had contact with a pedophile...on discovery [the parents] often react in panic...furious or outraged...” (deGroot, 1982, p. 6). NAMBLA shifts the blame onto everyone else so their actions do not appear to be the problem.

A second justification is when the victim denies any harm from the relationship. This technique puts the blame on the child for the sexual behavior. When the child is conceptualized as a willing participant, the responsibility of the adult for the behavior and the consequences that go along with the deviant behavior are diminished (deYoung 1989). NAMBLA members believe that children are willing participants and their

decisions should be respected if they choose to engage in a sexual relationship with an adult (deYoung, 1989). If members of pedophile groups believe that “there are many five year olds who understand the meaning of sex more than many 35 year olds,” their behavior seems appropriate in their view (NAMBLA, 1983a, p.4). The pedophiles in NAMBLA do not believe they are doing anything wrong because they believe children are able to make independent and mature decisions about engaging in sex. They rationalize their behavior by thinking there is no harm done to either participating party. It is not surprising that pedophiles continue their sexual behavior with children because these advocate groups encourage and reinforce the inappropriate and abnormal behavior.

Argument

These rationalizations used by NAMBLA and other pedophile organizations are all based on the denial of the truth that CSA constitutes wrong, illegal, and harmful behavior. Inappropriate sexual behavior with children is dangerous and nothing can justify the act of harming a child. After working with children, I have seen how trusting they are and experienced their innocence and enthusiasm for life so it is tragic to think of adults taking advantage of them and harming them in any way. I do not understand how people can deny the fact that CSA is bad for children and be selfish enough to put their own sexual urges above the health, innocence, and wellbeing of a child.

My thesis will convey how serious and prevalent CSA is in today’s world and summarize the very real pain child victim’s experience. I hope, by increasing awareness of this problem, my words can help in the prevention of it, for the sake of all children. NAMBLA and other pedophile organizations have mischaracterized their actions and misconstrued the deleterious impact they have on children. In the following chapters, I

will illustrate how damaging child sexual abuse is to the victims. I want to openly discuss all aspects of CSA, including the specific types of occurrences, victims, and abusers. The physical, emotional, and psychological problems caused by sexual abuse include depression, anxiety, social withdrawal, and sexual promiscuity. I want all of the problems to be clearly explained in order to show how sexual abuse shatters the lives of children, something that pedophile organizations refuse to accept. Fortunately, there are treatment methods available to children and their families to help, but it is unfair that children need to endure therapy because selfish adults took advantage of them. Based on all of the evidence, no rational person can justify sexual behavior with children.

Chapter I

The Act: Sexually Abusing a Child

“Mother had to work that weekend, so I got the rest of the family ready for our camping trip...That night, my father unzipped my sleeping bag and told me that it was time for him to take my cherry. I was not to fuss or wake the younger children.”—Nancy, 11-years-old (Cameron, 2000)

Child sexual abuse has been part of history for centuries but it has not always been an acceptable subject of public conversation. For years, it was taboo in society to discuss any disturbing intimate details of family life and public knowledge about sexual abuse was minimal. Most people, if they knew anything about child sexual abuse, thought that it only happened among the poor and ethnic minorities (Whittier, 2009). Awareness and public discourse about CSA did not occur until the late 20th century. People started to speak openly about child sexual abuse and take concerted action against it. CSA was first widely exposed in the public eye in the early 1970s when feminists led an anti-rape movement and used child sexual abuse as one example of a repressive patriarchal society (Whittier, 2009). Public figures and other non-feminists soon joined in the fight against CSA during the 1970s and 1980s (Whittier, 2009). Politicians took matters into their own hands to try and create government policy to protect children (Whittier, 2009). Part of the motivation for politicians to take action was to gain positive public attention, but political and public interest in the issue of CSA slowly decreased.

Feminist organizations were still the leaders in the movement to build awareness of CSA in the 1980s and also called for a new campaign strategy that vocalized the abuse so that victims could tell their stories and let go of the pain (Whittier, 2009). There was a growing influence from institutions and individual psychologists who argued that telling the truth about abuse as a child would help survivors heal (Hunter, 2010). The

detailed and harrowing narratives of the victims had the most impact on society and caught the attention of all types of mass media. More recently, the sexual abuse scandal in the Catholic Church, involving scores of priests across the country, also brought public attention to the topic. Newspapers, television stations, magazines and radio stations started covering many reports of childhood sexual abuse, something they had long avoided. Most people who told their stories were adults and were discussing crimes that were committed many years, even decades, before in their childhoods (Whittier, 2009). The coverage of the media about this subject made it a current public concern because the narratives illustrated that child sexual abuse was present in all aspects of society—not just among low socio-economic groups. The personal stories made sexual abuse a real concern for the public because it resonated with many people; encouraging them to get involved in creating policies to protect children. Since the 1970s, when public awareness and open discussion about child sexual abuse became more common, many organizations and advocates for CSA victims have collected data about child abuse in the United States. As more victims speak up and tell their story, people learn how personal and intimate the experience is for children and why it has such an impact on their lives. This new awareness has led to extensive research in the area and an improved knowledge base about its causes and possible treatments.

Type of Act

It is important to know the details of child sexual abuse in order to understand the intense feelings and reactions of children who experience it. For the purpose of this paper, child sexual abuse, in accordance with the approach of the American Medical Association, will be defined as "the engagement of a child in sexual activities for which

the child is developmentally unprepared and cannot give informed consent. Child sexual abuse is characterized by deception, force or coercion” (<http://www.childhelp.org/>). In other words, CSA occurs when adults use children for their own sexual gratification (LaFontaine, 1990). The act of the abuse itself can vary widely. According to Darkness to Light, a national nonprofit organization against child sexual abuse, activities that are classified as sexual abuse include (but are not limited to):

- Touching of a child's genital by an adult;
- An adult telling the child to touch the adult's or another's genitals;
- Voyeurism
- Exposure of the child's genitals, including photographing the child's genitals or the child in a sexual position;
- An adult masturbating in front of a child;
- Rubbing (masturbating) against a child;
- Oral sex performed on a child or telling a child to perform oral sex;
- Any type of penetration of a child's vagina or anus, however slight, by a penis, finger, tongue or other object;
- Exposing a child to pornography or using a child in pornography;
- Talking, commenting and or teasing a child in sexual ways.

A study by Cameron (2000) reported that 81% of 51 survivors of CSA had experienced a form of penetration (oral, vaginal, or anal) at some point during the abuse. The most common form of penetration for younger children is oral sex, or fellatio (54% of participants). Due to the small size of children, the easiest way for the abuser to gain access is through the mouth (Cameron, 2000). As children grow up, vaginal penetration

becomes the main form of abuse, which is physically distressing and clearly a progression from any previous sexual behavior forced upon the child (Cameron, 2000).

Although people have classified intercourse as a “more serious” sexual abuse and other acts (touching genitals or showing pornography) as “mild” abuse (LaFontaine, 1990), any act of sexual abuse is traumatizing to a child and should be evaluated as a serious crime. Each different type of abuse causes its own distress because there are boundaries that are invaded and distortions created (Cameron, 2000). Some clinicians suggest that sexual abuse that involves intercourse is more traumatic (LaFontaine, 1990). Children who experience any form of sexual abuse may experience the full spectrum of different forms of sexual activities, which can increase the negative impact of the abuse. In relationships that take place with a family member, it is common for sexual abuse to start at “mild” acts and progress to other, more “serious” sexual acts (LaFontaine, 1990). When a child is accessible to the abuser, there is more opportunity for the child to suffer from traumatic events. Also, some researchers have found that experiences with close relatives are more traumatizing than experiences outside the family (Finkelhor & Browne, 1988). Specifically, Jones and Morris (2007) claim CSA involving fathers or step-fathers, which is the most common experience, is the most traumatic. However, there are arguments that there is not a distinct difference between family members and non-family members; the important factor is if the perpetrator has a close relationship with the child or not (Finkelhor & Browne, 1988). If there is a close relationship, the child is putting trust into an adult who is eventually going to take advantage of him or her. Trust seems to have more of an influence on an abused child than just DNA.

There are four different forms of abuse that can take place, according to Jones and Morris (2007). First, there is familial abuse where the abuser is living with and/or is closely related to the child. This type of abuse takes place over many years and one or both parents are unaware of it. The second type is familial abuse in the context of physical and emotional abuse and neglect. This abuse usually involves sexual abuse as well, but it is less distressing or worrisome to the child than other forms of abuse. This type may also go on for years. The third type is extra-familial abuse, where a trusted, non family member (e.g., a teacher, babysitter, neighbor.) commits the act that may continue over a period of time. The last type described by Jones and Morris (2007) is one time abuse by a stranger. This type can also be categorized as rape or sexual assault. The last type of sexual abuse is the most uncommon form of child sexual abuse because, in most cases, there has to be a trusting relationship between the child and the abuser for any abuse to take place (LaFontaine, 1990).

In most cases, abusers take advantage of their relationship with the child and exploit the privilege to have the child trust them. According to a leading national non-profit organization dedicated to helping victims of child abuse and neglect, 90% of child sexual abuse victims know the perpetrator in some way and 68% are abused by family members (<http://www.childhelp.org/>). The breaking of trust between the child and his or her abuser can be just as damaging as the abuse because a sacred relationship is broken. The relationship that is supposed to be caring, safe, and important to childhood development is destroyed when the abuser exploits the child for his or her own sexual gratification. This broken trust can be detrimental to victims' relationships later in life.

How do children get into sexual abuse situations? Some, like members of NAMBLA, suggest that children are willing participants in the sexual acts and even do some of the seducing (deYoung, 1989). Hunter (2010) argues that children are simply cooperating and complying with the authority figure that they are taught to respect. The use of force used in child sexual abuse incidents varies and can be very subtle. It is difficult to explore how much force is usually needed to persuade a child to comply with the requests of the abuser. Some psychologists say that threats or coercion influence the trauma that the child suffers (Hodges & Myers, 2010). Others agree that all experiences vary and the trauma induced can be just as powerful for every child with or without the same amount of force (Hunter, 2010). According to Cameron (2000), abusers could use gentleness, roughness, violence, or even torture to pressure a child to engage in sexual activity. Her participants explain that gentle treatment was profoundly deceptive and confusing, while roughness carried a message of callousness and victims were left with a feeling of being used for sex. The violent abusers were often family members and were described in the study as caring people who changed into violent beings during the abuse. The physical force and coercion used by abusers varies, but each form has its own negative impact.

There is a subtle force that takes an intense toll on the child and his or her decisions about the sexual behavior—the authority of the abuser. Children learn at an early age that they are weak compared to adults both mentally and physically (LaFontaine, 1990). Children definitely do not compare physically to adults and so any physical capacity to stop the abuse themselves is limited. Because children learn to comply with adults and learn from their elders, it is understandable that some children

might not even know the relationship they have with the abuser is inappropriate. They will only know that they do not like the behavior or are uncomfortable with that aspect of the relationship (LaFontaine, 1990). Children will also feel like they must be loyal to the abuser because he or she is an adult. Children are expected to respect authority figures like their parents and teachers (Hunter, 2010). There are common threats told to children about what will happen if the sexual abuse is revealed to others; the consequences of death or physical abuse seeming much worse than the sexual abuse itself (LaFontaine, 1990). Children may be convinced that they will be punished for telling, which makes it seem like telling the secret is the problem, instead of the act of the abuser (LaFontaine, 1990). It is the mental control over the child that seems to force them into these inappropriate situations instead of physical force.

The amount of research on child sexual abuse is immense and very informative, but the biggest limitation is the lack of reporting of CSA crimes. According to the American Academy for Child and Adolescent Psychiatry in 2008, CSA has been reported up to 80,000 times a year, but the number of unreported instances is far greater (<http://www.aacap.org/>). Therefore, all of the information known to the public is dramatically underreported. Girls were more likely than boys to disclose the abuse. Forty-two percent of the women and thirty-three percent of the men reported never having disclosed the experience to anyone. (Finkelhor, Hotaling, Lewis, & Smith, 1990). Additionally, as reported by Darkness to Light, almost 80% initially deny abuse or are tentative in disclosing it. Of those who do disclose, approximately 75% disclose accidentally. Additionally, of those who do disclose, more than 20% eventually recant even though the abuse occurred (LaFontaine, 1990). Over 30% of victims never disclose

the experience to anyone. Even in self-reporting surveys, abuse may be underreported. Many people are afraid or ashamed to reveal victimization, have repressed memories of abuse, and refuse to participate in studies or deny that what happened was "real" abuse (National Research Council, 1993). It seems that these victims who deny the crime or internalize their problems, who have the most problems with coping after the sexual abuse.

The Victims

The demographics of child victims subjected to sexual abuse range just as much as the type of acts that take place. Child sexual abuse crosses all boundaries of age, sex, race, and socio-economic background (<http://www.childwelfare.gov>). Technically, child sexual abuse is characterized by the child being under the age of 18, but the median age for the abuse is 9 years old. More than 20% of children are sexually abused before the age of 8 years-old (Putnam, 2003). Both boys and girls are most vulnerable to abuse between the ages of 7 and 13 (Finkelhor, 1994). The National Center for Victims of Crime, in 2007, reported that girls are victimized at least 3 times more than boys, and 1 in 4 adolescent girls and 1 in 6 boys will experience CSA before reaching the age of 18 (www.ncvc.org/). Unfortunately, boys are less likely to report sexual abuse to anyone, even if they are asked (Finkelhor, 1994). Hence, the statistics about male victims of CSA could be only a portion of the true number of incidents.

The Abusers

In order to fully understand child sexual abuse, it is important to understand who the abuser is and what motivates him or her to harm children. Elliott, Browne, and Kilcoyne (1995) conducted a study of convicted child abusers to investigate the

motivations and methods of offenders to understand how to improve prevention techniques. The information collected from the study is extremely disturbing. For example, an average serial child molester may have as many as 400 victims in his lifetime!! Also, nearly 70% of child sex offenders have between one and nine victims; at least 20% have 10 to 40 victims. Of the 91 offenders, over half reported having sexual intercourse with a child and 46% claimed to have a special relationship of mutual attraction with the child. Although not all children who are sexually abused end up becoming abusers as adults (Finkelhor, 1984), two thirds of the sample in the Elliot et al. study (1995) had been sexually abused as a child.

Finkelhor (1994) found that boys are more likely than girls to be abused by strangers (40% to 21%). Of female victims, six percent were abused by their fathers or step-fathers. Most of the victims evaluated by Finkelhor et al. (1990) reported that their abuser was male (83% for boys, 98% for girls). In other research on child sexual abusers, an overwhelming majority tend to be male offenders. Although Finkelhor (1994) claims that there are more male offenders because of the socialization of men and emphasis on dominance, he also claims that the rate of female offenders could be drastically under reported. Even though there is a lot of speculation about how to know who a child sex offender could be (LaFontaine, 1990), it is very difficult to stereotype or predict who could be a sexual threat to children.

There are two main reasons for offenders to sexually abuse children. The first motivation for offenders is control. LaFontaine (1990) has explained that there can be a non-sexual aspect to the abuse and the offender could solely want to express sexual domination over anyone who seems weaker. For some offenders who lack self-esteem,

any form of power is gratifying. According to Marshall (1989) this motivation to sexually abuse children extends the patriarchal view over women and children as objects of sexual gratification. It has been theorized that those with sexual aggression against women and children had rough childhoods and they want to exhibit control over some parts of their lives now that they are adults. Marshall and Barbaree (1990) claim that poor parenting, harsh physical discipline, and lack of support can drive people to strive for control later in life in any form available to them. But, of course, many individuals have difficult childhoods and never become child abusers.

The second major motivation of child sexual abusers is sexual interest in children. These offenses are more directly related to pedophilia because there is a form of sexual arousal and sexual satisfaction instead of a struggle for control. It is very difficult to distinguish between the two different motivations; however, in a study of identified sexual offenders, the main separation was in the description of sexual fantasies (Schaefer et al. 2010). The offenders with sexual attraction to children fantasized about prepubescent children while the other group had partners from older age groups. No matter what the motivation is, the abusers gained satisfaction out of the exploitation of children and harmed them physically, emotionally, and mentally.

A comprehensive model was developed by Finkelhor in 1984 that created four preconditions that must be satisfied before a person becomes a sexual abuser. Finkelhor (1986) expressed his skepticism of some single-factor theories that explain the development of child sexual abusers. Single factor theories propose that people may become abusers based on single components such as being sexually abused as a child or being immature adults (Finkelhor, 1986). Since there is not a lot of evidence to support

single-factor theories, Finkelhor developed the four preconditions model (1984), which explain key factors that may contribute to people becoming sexual abusers. The four preconditions are:

- motivation to sexually abuse a child,
- overcoming internal inhibitions,
- overcoming external inhibitions,
- and dealing with the child's possible resistance.

The motivation to sexually abuse a child consists of emotional congruence, sexual arousal by children, and an inability to satisfy their sexual needs in other appropriate ways (Hudson & Ward, 2001). In other words, there must be a sexual attraction to children as a foundation, which is inconsistent with the findings from Scheafer et al. (2010). Preconditions two and three, overcoming internal and external inhibitors, are the next step because even though a person may be motivated to perform sexual acts with a child, he or she may not act on their emotions due to other factors. Internal inhibitors may be suppressed by alcohol, impulse disorders, severe stress, or senility (Finkelhor, 1984). External inhibitors are overcome with more conscious behavior, such as creating opportunities for the offense to take place with intricate planning (Hudson & Ward, 2001). The last precondition is overcoming potential resistance, which involves a lot of strategy. Abusers could use many different methods to gain access and build trust with the child, such as giving gifts, desensitizing the child to sex, or using threats and violence (Finkelhor, 1984). The preconditions must be satisfied in a sequential pattern because they build on each other to create a sexual abuser.

It is crucial to understand the background of child sexual abuse and the prevalence in today's society to better comprehend the effect of CSA on child-victims. It seems that no child is exempt from the threat of CSA because it reaches victims of all races and backgrounds. Adults who exploit children for their own sexual pleasure or to demonstrate power must use time and energy to accomplish the abuse. Child sexual abuse is not an accident, it clearly a deliberate and selfish act that can destroy the lives of children.

Chapter II

The Aftermath: Effects of CSA on Children and Adults

“A child whose trust has been ruptured knows, from that moment, that she is alone in a dangerous world. Distrust follows her through the years and through every relationship”—Adel, 1990 (Cameron, 2000)

Just as there is no easy formula to predict who will sexually abuse a child or which child will be abused, the effect of CSA on victims is unpredictable and difficult to categorize. There is a long list of possible symptoms and reported reactions, but every child is different. The reaction to CSA varies widely depending on the person, their upbringing and background as well as the actual circumstances of the CSA. Other factors include a person’s ability to manage negative emotions and to adapt to situations (Asher, 1988). The degree in which a child expresses his or her emotional harm depends on the child’s history of communication, the current developmental level, and the nature of the sexual abuse (Finkelhor, 1987). Groth (1978) contended that the greatest trauma occurs in sexual abuse that 1) continues for a long period of time, 2) occurs with a closely related person, 3) involves penetration, and 4) is accompanied by aggression. Canton-Cortes and Canton (2010) support that there have been some correlations between childhood coping mechanisms and adult behavior, but any claims might be oversimplifying the adjustments victims go through. Therefore, therapists and other specialists should not look for a checklist of symptoms to evaluate a CSA survivor’s experience because no one can be sure how a survivor will respond to CSA. Fortunately, through research clinicians have a better idea of what constitutes CSA symptoms in order to evaluate behaviors of CSA victims.

There are few factors that can predict the impact CSA will have on a victim in childhood or adulthood, but studies have concluded that the trauma from CSA does have

both short-term and long-term effects (Brier, 1984, Finkelhor & Browne, 1990; Fortier, DiLillo, Messman-Moore, Peugh, DeNardi, & Gaffrey, 2009). For example, people understand that abuse that is considered less serious (e.g., fondling vs. sexual intercourse) does not necessarily have less damaging effects in life (LaFontaine, 1990). Short-term effects may be more researched and better understood because children reach medical, psychiatric, or social services faster than adults voluntarily seek help (Gomez-Schwartz, Horowitz, & Cardelli, 1990). Adult survivors of CSA could also be receiving professional help for reasons other than CSA so the information could be skewed. Children are usually taken to see professionals soon after CSA incidents due to the discovery of the abuse or because they are demonstrating behavioral problems (Gomez-Schwartz et al., 1990). Every person can respond differently psychologically, emotionally, and physically no matter what interaction takes place with their abuser. Because there is no set list of standard symptoms, there is an enormous breadth of feelings, defense mechanisms, coping techniques, and psychological struggles that may occur and no simple way to treat the victim.

The emotional and psychological symptoms are sometimes hard to notice because they can be extremely subtle, but it is easier to recognize the physical signs of sexual abuse. Kempe and Kempe (1978) suggest some clues of CSA to look for are weight loss/gain, abdominal pain, vomiting, and urinary tract infections. Other signs include vaginal discharge or bleeding, rectal bleeding, vulvar irritation, bruises on or around the penis, and bowel problems (Herbert, 1987). The physical signs are usually easier to notice, but they can also be mistaken for an illness or normal ailments instead of sexual

abuse. It is important to connect the dots of many signs; behavioral, physical, and emotional, before concluding if a child has been sexual abused.

Short-Term Effects

Overall, the short term reaction that children exhibit after the abuse is a behavior called avoidant coping (Fortier et al., 2009). Avoidant coping strategies involve emotional and behavioral disengagement because facing the trauma is too difficult to experience, which is a healthy coping strategy immediately after a traumatic event, but could be detrimental if it continues for a long time (Kleber & Brown, 1992). Some children might start spending more time alone to try to avoid anything that will trigger traumatic memories and others might feel self-blame for what happened, (Fortier et al., 2009). In some instances, silence may create isolation and suffering, but it also may spare the child from additional traumatic effects of parental and community reactions to the abuse (Finkelhor & Browne, 1988). Victims of CSA experience a whirlwind of emotions immediately after the abuse, which can be carried through adulthood depending on how those feelings are expressed. The most common emotions that children feel after a CSA incident are fear and anxiety (Hunter, 2010). There is fear of the consequences of revealing the abuse and also about being punished for participating in the abuse (Walsh Fortier, & DiLillo, 2010). The anxiety is influenced by many things, such as the reactions from parents and loved ones, confusion about whether they made the right choice to reveal the secret, and involuntarily “reliving” the abuse because of the need to repeat the story to other people of authority (Putnam, 2009). Another factor that influences the child is the ruined idea of secrecy. The child, by exposing the abuse, broke a secret—a behavior that is frowned upon in society. The bond that is created by the

secret is destroyed and there is a learned association that secrets are hurtful and destructive things. A secret creates trust, confidence, closeness, loyalty, and affection between the secret holders, but all of that is ruined when the secret is sexual abuse (Cameron, 2000). Based on her study, Cameron (2000) believes that any sexual contact by a caretaker breaks the trust of a child so it does not matter how “serious” the abuse is, it will still have a significant impact. However, penetration is probably the worst offense because it can make the child feel unsafe in his or her own body. There is also a long list of emotions that have been reported by CSA survivors, but there is no determined timeline for when the survivor will experience the emotions because each survivor copes differently (Gomez-Shwartz et al., 1990). One person may feel anger toward their abuser immediately after the abuse as a child, while another person will experience the anger as an adult.

Most research separates CSA survivors into three childhood age categories: pre-school, school age, and adolescent. There are no set emotions or behaviors that occur in each age group, but researchers have found that there are different coping strategies that work better with different levels of maturity (Asher, 1988). The top three emotional symptoms that are expressed by all three childhood age groups are anxiety, withdrawal, and guilt (Gomez-Shwartz et al., 1990). Emotional expression does depend on the history of the child’s actions. If he or she was previously withdrawn and quiet, a continuation of this behavior is not a sign of sexual abuse. Other emotions that researchers believe follow CSA are betrayal, anger, sadness, hopelessness, and confusion (Gomez-Shwartz et al., 1990; Hunter, 2010; Walsh et al., 2010). There are some specific behavioral symptoms that occur in the different childhood age groups. In the pre-school

age, Goodwin (1982) found that behavioral changes include nightmares, compulsive masturbation, loss of toilet training, frequent bathing, crying without provocation, and regressive behavior like finger sucking.

As children grow older, the symptoms do not necessarily change, but others are added to the list. School age children develop additional behaviors like insomnia, school failure, truancy, and running away from home (Kempe & Kempe, 1978). Behaviors of children become increasingly socially unacceptable once they reach adolescence.

Behaviors such as petty crimes, drug use, and promiscuity are prevalent in the adolescent age group and can continue into adulthood (Asher, 1988). A very extreme behavior that might start is prostitution, but it is not as common as the others. Prostitution is an occasional outcome, especially after running away from home, because CSA victims learn to dissociate from what is happening to their bodies (Gelinis, 1983). The behaviors, although distinguished for the age groups, do not necessarily develop according to a predictable timeline. Children at all ages can exhibit the behaviors. Although this withdrawal can be a healthy strategy for kids, if there is too much, it can create a sense of numbing or detachment from reality, which can bring about psychological distress in the long run (Fortier et al., 2009). Trauma cannot be avoided forever in order for a person to heal.

Some of the symptoms that manifest during the short-term period can be categorized as Post Traumatic Stress Disorder (PTSD). Since CSA is a traumatic event for any victim, PTSD symptoms would be a logical response. PTSD is a disorder that first gained mainstream attention in connection with the soldiers returning from the Vietnam War, but now it is expanded far beyond war veterans. It is a disorder that may

begin as a result of any traumatic event (Putnam, 2010). Briere (1992) claims that survivors of sexual abuse are prone to displaying PTSD related symptoms. It makes sense for survivors to show symptoms of PTSD because sexual abuse is a highly traumatic experience. Symptoms may include anxiety, sleep disturbances, nightmares, and psychosomatic complaints (Putnam, 2009). One study (Kiser et al., 1988) concluded that nine out of ten children between the ages of two and six who were molested showed signs of PTSD. Children display PTSD symptoms differently than adults. For example, children experience more nightmares instead of the dissociative flashbacks that adult survivors often show (Koverola & Foy 1993). There are two types of nightmares that can occur after a traumatic event, as explained by Terr (1989). A type I nightmare is a graphic representation of the original trauma, which can be a single event and it normally occurs shortly after the trauma and lasts for a short period of time. The second group of nightmares, Type II, is a symbolic representation of the traumatic event and involves denial, dissociation, and numbing. Type II nightmares may occur in both the short term and long term. The type of nightmare a victim will have depends on the type of trauma experienced (Terr, 1990). There is type I trauma, which is a single event that involves sudden shock, and type II—repeated and long-lasting situations of sexual abuse (Terr, 1990).

Children, for the most part, are haunted by CSA and must find a way to escape the trauma in their minds. The most general symptoms that children display are flashbacks of the trauma, avoiding activities suggestive of the trauma, and an intensification of symptoms on exposure to events similar to the abuse (Putnam, 2009). One of two key symptoms of PTSD, dissociation, occurs more frequently in adults, but it can also be a

sign in children. Dissociation most often manifests itself in the form of forgetfulness, excessive fantasizing, sleep walking, imaginary friends, and trancelike states (Putnam, 2009). The second essential symptom of PTSD is avoidance. Children may show avoidant coping by avoiding any situation or stimuli associated with the trauma (American Psychological Association DSM-IV, 2000). Children may want to make conscious attempts to avoid anything that will remind them of the abuse. This sometimes results in children not joining activities they had previously enjoyed (Jackson & March, 1995). Other behavioral changes may take place as well, such as reenacting the traumatic play and hyper-alertness. Traumatic play, according to Jackson and March (1995), is the repetitive acting out of the specific theme of the trauma. Usually when the child reenacts the abuse, the victim becomes more empowered and is able to stop or hurt the abuser (LaFontaine, 1990). Hyper-alertness is physiological arousal and may show sleep disturbances, irritability, difficulty concentrating, and aggression (Putnam, 2009). Overall, these emotional and behavioral symptoms of PTSD can be apparent in all three stages of childhood and well into adulthood.

Not all professionals and researchers agree that victims of CSA will experience PTSD; some (e.g., Finkelhor, 1990) believe diagnosing CSA victims with PTSD is not a good way to conceptualize the events and symptoms that children face after the trauma (Putnam, 2009). Child sexual abuse is a unique experience and PTSD symptoms may be too generalized. Hudson & Ward (2001) believe that for a diagnosis of CSA, one must take into account the onset of the abuse, its development, and maintenance of the relationship. Finkelhor and Browne (1985) created a model to help break down the effects of CSA into stages. There are four stages, or traumagenic dynamics in the

Finkelhor-Browne model (1985). The first stage is “traumatic sexualization,” which is the development of the child’s sexuality in unhealthy ways. For example, a child victim is usually rewarded for engaging in the sexual act with the abuser because it is not a desired act for the child. This reward system can lead to a distorted view of all sexual activity. The stage of development that the child is in also affects how he or she perceives the sexualization. If the child is young or in the beginning stages of development, he or she will not fully understand all the sexual implications of the activities as would a child who is further along in development. Therefore, a younger child would have less traumatic sexualization than an older child.

The second experience, “betrayal,” is when the child finds out that his or her behaviors were wrong, even though they were being rewarded. Child victims had put trust in their abusers, but then discover that they were being harmed. There is more potential for betrayal when the abuser is a family member or a trusted person.

Powerlessness is the third factor, which is caused by the manipulation and coercion within the sexual abuse. Finkelhor and Browne (1985) believe many factors contribute to powerlessness such as the child’s territory and body being repeatedly invaded and the manipulation by the offender. The final feature of the model is stigmatization, which refers to all the negative associations with sexual abuse that are forced onto the child. The child starts to connect “shame, guilt, and badness” with the actions he/she engaged in, which can limit their ability to communicate. If the child feels shame over the sexual acts, the child may be reluctant to reveal any details in front of the abuser or other people. The Finkelhor-Browne model is an example of the complexity of the emotional distress a child might feel if forced to confront in person his or her alleged abuser.

Long Term Effects

CSA has many long term effects that can negatively affect victims' entire lives. Psychological impairment from CSA is very common and may reveal itself in different forms depending on the life of the survivor. Fortier et al. (2009) explain that long term difficulties include depression, anxiety disorders, personality and eating disorders, and substance use disorders. Other risks are sexual dysfunction, suicide attempts, low self esteem, dissociation, and phobic reactions (Asher, 1988). Among young adults, victims have a higher risk of dangerous sexual behavior and higher rates of college drop outs (Fortier et al., 2009). If a child withdrew from social interactions too much after CSA, there could be potentially more psychological harm as an adult because he or she did not face the reality of the trauma and still has issues to work through (Asher, 1988). One way adults may cope with CSA is to attempt to avoid the memory of the past by using all available sources as distractions. Briere (1984) found a higher incidence of alcohol and substance addiction among victims of CSA than among their non-victimized counterparts. Substance and alcohol abuse is a form of escaping reality and avoiding problems. If the reality of the abuse is too traumatizing to confront, adult survivors use more extreme measures to avoid their problems than child victims.

One way CSA affects adults is through the kind of relationships survivors have with loved ones. Some victims suffer sexually in their adult lives because of the trauma and negative connotation associated with sexual activity. Symptoms include frigidity, vaginismus (involuntary spasm of vaginal muscle that closes the vagina), inability to tolerate sexual arousal, and flashbacks (Finkelhor & Browne, 1988). It is difficult to

develop a positive perception of sex after being negatively exposed to it at a young age. Adults who impose sexual behavior on children use a gentle vocabulary to describe their criminal acts (Cameron, 2000). For example, when the abuser refers to fondling as cuddling, all positive behaviors to show affection are distorted. A key factor in changing a survivor's perception of a sexual experience is to allow them to willingly give consent to any sexual activity, which is the power of choice that was taken away from CSA victims (Haines, 1999). Sexual activity is often associated with suffering and manipulation instead of pleasure, so as an adult, one's interest in sex may be minimal, which is frustrating for the survivor and his or her partner (Haines, 1999). There is a significant decrease in trust and intimacy and dissatisfaction in marital relationships (DiLillo, 2001). There is a risk of sexual functioning problems that range from low sexual desire and arousal to an inability to tolerate touch or to experience orgasm. Also, higher levels of negative sexual affect, lower levels of perceived emotional support from partners, and feelings of betrayal, powerlessness, and stigmatization in relationships are possible problems as well (Hodges & Myers, 2010). Clearly, CSA takes a toll on one's happiness and interpersonal relationships in adulthood.

Revictimization

Revictimization is when survivors of any type of sexual abuse are victimized again by a sexual predator (www.wcsap.org). CSA victims are vulnerable to revictimization, which is the most troubling outcome associated with CSA because it can exacerbate the effects of prior abuse experience (Fortier et al., 2009). There is a vicious relationship cycle that CSA survivors tend to enter: when the victim avoids facing the reality of CSA and dealing with negative emotions, it will be difficult for him or her to

distinguish safe environments and relationships from potentially harmful or risky ones (Fortier et al., 2009). When survivors are in harmful relationships, it is difficult for them to acknowledge the problem and remove themselves from the situation. Similar to the problems of children who disengage too much and cannot function in reality, adults who use dissociation and numbing may blur their own judgment about the relationship they are in and whether it is safe or not (Fortier et al., 2009). Finkelhor and Browne (1988) believe that one's inability to recognize unhealthy relationships is one of the reasons that there are higher rates of rape among CSA survivors than non-victims. The symptoms of PTSD that some victims show are also related to the risk of revictimization. Ullman, Najdowski, and Filipas (2009) found that PTSD numbing and substance abuse contribute to an increase of sexual revictimization of adults because of the increase of vulnerability. If a survivor is no longer aware of his or her surroundings and unable to assess risky situations, there is greater risk for revictimization because he or she will not be able to realize what danger is around them. There is also a risk of symptoms getting worse or new PTSD symptoms appearing if sexual revictimization takes place (Ullman et al., 2009). Therefore, PTSD symptoms and other coping mechanisms are consequences, mediators, and causes for revictimization.

The impact of CSA on victims is complex and has lasting impacts in many parts of life. Children quickly lose their childhood innocence and struggle psychologically, whether trying to avoid the problem or coming to terms with the abuse. Child victims have their first real sexual experience in an atmosphere of broken trust, anxiety, and fear, which can traumatize them for life and make normalized sexual relations in the future highly unlikely. As children figure out what to do with all their emotions, they exhibit a

mixture of behaviors. The way children deal with CSA does affect their psychological health, behaviors, and interpersonal relationships as adults. PTSD symptoms and avoidant coping mechanisms are the most prevalent outcomes from CSA, which have negative outcomes on adults' sexual life and risk for recurring victimization.

Chapter III

The Healing Process: Treatment and Support

“As a toddler, preschooler, and most of elementary school, I was sexually abused by my grandfather. At age 11, I told my mother that “he hurt me,” and we didn’t visit him anymore. But she never asked me about it because our doctor said, “it’s best if children forget these things.” So I had no chance to work out my shame. I finally had to deal with everything in my 30s after realizing that I had married a pedophile who abused boys.”—

Paige, 1989 (Cameron, 2000)

CSA victims suffer from a number of symptoms and psychological impairments as a result of their traumatic childhood experience. In order to move past the trauma and cope with sexual abuse in a healthy manner, children need the assistance of professionals and treatment methods. Therapists, psychologists, and psychiatrists can provide treatment to relieve child victims of the maladaptive symptoms that follow CSA and thereby ensure a more normal life for them as adults. Considering the range of symptoms discussed in the previous chapter, it makes sense that a variety of treatment methods can work with different CSA survivors. There are many successful treatment interventions that are used with CSA victims in childhood and adulthood. Some methods are more successful with children and others with adults because of maturity levels and life experience, but it is important that there is a variety of resources for victims. Treatments available to victims include

- Psychoeducation
- Cognitive-Behavioral
- Group Therapy,
- Psychoanalytical approaches

The first step in therapy is to assess the patient and evaluate what abuse was experienced and how traumatic it was for the client, which is called pretreatment.

Standardized assessment techniques are helpful for professionals to learn about a victim's past and what he or she is dealing with internally so the therapist can help resolve the issues. The data collected from the initial standardized assessments create a baseline level of functioning for the patient so the healing and improvement can be recorded and compared to post-treatment assessments (Deblinger, Behl, & Glickman, 2006).

Psychologists and therapists gain an insight into the history of their clients' lives from the standardized data. Many of these assessments are parent-report or teacher-report measures because parents and teachers are often the best reporters of children's externalized symptoms (Deblinger et al., 2006). These standardized testing techniques are options for all psychologists to use, but personal statements about the sexual abuse are also valuable while evaluating CSA victims. Self-reports are better measures of internalized symptoms, such as PTSD (Deblinger et al., 2006). Therapists must remember that exhibiting certain symptoms does not automatically mean that a child is a victim of sexual abuse. A child's personal account of the abuse is what helps explain the symptoms in context.

Although there is research that supports many different therapies for CSA victims, there is not a single method that is universally practiced by all professionals. The therapy methods used with CSA victims have a common goal of helping people cope with trauma and reduce any self-blame. Courtios (1990) believes that the overall goal of trauma resolution and integration is for the patient to gradually face and make sense of the abuse trauma and to experience associated emotions at a pace that is safe, manageable, and not overwhelming. Child victims must resolve their self-blame in order to overcome many of their symptoms.

Psychoeducation

Psychoeducation is a method used by some therapists which helps victims look at the abuse objectively and learn that they should not blame themselves for the abuse. Therapists usually provide information and facts that help children and their parents put the abuse in perspective so that blame is placed on the right person (Cohen, Berliner, & Mannarino, 2003). It is also helpful for therapists to provide statistics about how many other children have experienced the same traumatic event to decrease the feeling of stigmatization (Cohen & Mannarino, 2008). If victims and their families learn to understand that the abuser had complete control over the abuse, the self-blame felt by victims should be eliminated. The victims will understand that nothing was within his or her control and that it is appropriate to be angry with their abuser for violating their bodies, trust, and emotions.

Michael Murtaugh has developed one new type of psychoeducational therapy to help switch the attribution of the abuse, which is called the Appropriate Attribution Technique (AAT). Murtaugh (2010) explains that the purpose of AAT is to eliminate the self-blame associated with CSA because it is associated with poor adjustment, life dissatisfaction, suicidal ideation, depression, anxiety, and low self-esteem. Self-blame begins with self-focused thinking, which is when the victim only thinks about his or her own participation in the abuse instead of all the actions of the perpetrator (Murtaugh, 2010). This new therapy is set up for individual and group settings and is a four-step process.

The first step is Myth Debunking, which breaks down the current attributions the client already has about the sexual abuse. There are usually three key myths that most

clients have that need to be debunked: (a) Sexual offenders commit the abuse because they themselves were victims of sexual abuse. (b) Alcohol and/or drugs caused the offender to commit the abuse. (c) If the victim experienced any physiological response of sexual arousal at any point during the abuse, then he or she must have “wanted it” on some level. These myths are excuses and rationalizations that excuse the abuser from any blame, when, in fact, the abuser is the cause of the abuse. If the victim stops believing in the myths, they will also stop providing excuses for the abuser.

The second step is for the client to learn the four preconditions to sexual offending, which are based on the widely accepted model developed by David Finkelhor (1984). As discussed in the first chapter, the preconditions are motivation, overcoming internal inhibitions, overcoming external inhibitions, and preventing child resistance. By understanding this, the client realizes that he or she is not the reason the abuse took place and the abuser had to plan out the abuse.

The third lesson in AAT therapy is learning more about cycles of sexual abuse and the special techniques offenders use to accomplish the sexual act. Examples of these cycles are the Sex Offender Cycle and Pre-Assault cycle. Clients learn more about the process of sexual abuse and many elements that lead to an offense before the victim is even present. This third step partially reiterates the second step, but it is this repetition that further prepares the victim to make the appropriate attribution of responsibility. This shows the victim’s cooperation is due to the grooming and manipulation of the offender.

The final step is Retribution. At this point the client has learned the in-depth process of sexual abuse so they can understand why the abuse happened and stop blaming themselves. The biggest challenge at this step is compartmentalizing because victims

have been trained by enduring and coping with the abuse to compartmentalize everything hurtful. Although this is the most stressful step, it can also be the most rewarding.

Cognitive-Behavioral Therapy

A common method of therapy used with child victims is cognitive-behavioral therapy. Dripchak and Marvasti (2004) describe cognitive-behavioral therapy as an approach that uses cognitive (changing how the victim thinks about the abuse) and learning (developing behaviors and skills to cope with trauma) theories to overcome the sexual abuse. Specifically, therapists use trauma-focused cognitive behavioral therapy (TF-CBT) because it is the most focused method tailored to the needs of the victim (Cohen & Mannarino, 2008). Cognitive-behavioral therapy is widely used and is regarded as highly effective in current practices (Pretorius & Pfeifer, 2010). Research by Cohen & Mannarino (1998) has determined that children who participate in cognitive-behavioral therapy experience significantly less depressive symptoms and sexual inappropriate behaviors than children who use nondirective supportive treatment. Therapists who use TF-CBT attempt to build a collection of core skills that will help establish the self-efficacy of the individual and his or her family to deal with traumatic events after the therapy is terminated (Akin-Little & Little, 2009). The skills that are taught in therapy also help victims deal with childhood traumatic grief, which is when trauma symptoms interfere with a child's ability to successfully deal with normal grieving processes (Akin-Little & Little, 2009). TF-CBT is not only a helpful treatment for sexual abuse, but it also can be used in multiple arenas of trauma, such as natural disasters or the death of a loved one.

Cognitive-behavioral therapy uses psychoeducation, cognitive exploration, and reframing with regard to causation and responsibility for the criminal activity, coping and relaxation skills, and behavioral interventions for inappropriate child behavior (Cohen et al., 2003). Psychoeducation is expanded in this approach because it goes beyond just surface-level knowledge about sexual abuse and focuses on the specific trauma as well as cognitive and behavioral issues. Therapy usually consists of individual child and/or parent sessions and joint child-parent sessions to optimize the therapy across the family. The sessions must be individualized for the parents and child to incorporate all the specific traumatic events and unique family dynamics and create a beneficial therapy (Cohen & Mannarino, 2008). Parents must be taught the correct coping skills to use in their home because they must provide stable and consistent reinforcement of the treatment that the child is receiving with the therapists. Also, parent participation in the therapy strengthens the communication skills in the parent-child relationship. Because parents do not always know the correct way to deal with their child's exposure to traumatic events, therapy is just as important for them as it is for the child. Parents can become overly protective or more permissive about maintaining routines (Cohen & Mannarino, 2008). During joint child-parent therapy sessions, child victims change from talking about the abuse with the therapist to sharing and telling their parents directly about their experiences (Cohen & Mannarino, 2008). Joint therapy sessions build the relationship and also assure the child that the parent is a reliable source of support in other traumatic situations.

TF-CBT first uses psychoeducation and cognitive adaptation before making behavioral changes with clients. As a foundation for the therapy, children and parents are

trained to use appropriate relaxation, communication, and coping skills (Cohen & Mannarino, 2008). Relaxation skills are important because they help the child gain mastery over his or her subjectively traumatic experience. Deep breathing, blowing bubbles (for younger children), yoga, listening to music, knitting, praying, and playing sports are examples of skills children learn in TF-CBT. The coping skills assist the children to identify the thoughts and emotions geared toward a particular event so their reactions can be evaluated if they are healthy or harmful responses. Also, children learn how to control their thoughts, which helps them deal with all other stressful experiences in the future.

Once the clients have control over their emotions and stress levels, the therapy changes to focus directly with the specific trauma. Children develop a trauma narrative, which is a factual and honest recollection of the trauma. A trauma narrative develops by telling the story of what happened through a book, poem, song, or story (Cohen & Mannarino, 2008). Trauma narratives are helpful for over-coming any avoidant coping of traumatic memories. Narratives also help identify cognitive distortions the child may have about the abuse through the child telling the story in his or her own words and contextualize the child's traumatic experiences into the larger framework of the child's whole life. If the abuse is put in context, the child is able to see that he or she is more than just a victim of trauma and have more to offer the world (Cohen & Mannarino, 2008). The next step is for the therapist to assist the child in cognitively processing any distortions that are contributing to negative affective states, such as self-blame, low self-esteem, or shame (Cohen & Mannarino, 2008). Some children may develop generalizations views and behaviors of the world based on their abuse. An example of

the generalizations that develop is avoiding all bathrooms if the sexual abuse took place in a bathroom. Through this therapy, children can their generalizations about the abuse which is called “in vivo mastery” of trauma reminders. Cognitive-behavioral therapy is very helpful because it builds on psychoeducation, tailors to the specific trauma and child, and develops coping skills for future traumatic events.

Group Therapy

Group counseling is a very effective method of therapy for both children and adult survivors in reducing feelings of isolation and developing behavioral changes in a safe environment. Some group therapy sessions may cover a broad range of feelings and victims, while others can have narrow focuses and deal with only specific symptoms like dissociation (Nisbet Wallis, 2002). While many approaches can be beneficial, DiNunno (2000) explains that group therapy provides the following advantages: (a) an interpersonal environment where relationship deficits can be worked on, (b) a sense of belonging to reduce the feeling of isolation, (c) group acceptance that gives victims a sense of freedom to express painful feelings, (d) a space to develop trust and encourage assertiveness and experimentation with new behaviors. Group therapy is appropriate for children because it helps to lessen the stigma and isolation that result from sexual abuse (Cohen et al., 2003). When children can share their stories with peers who can relate to their experience, children will not feel like they are alone in their difficult time. The supportive and psychoeducational factors work best for the needs of child victims (Cohen et al., 2003). Moses (1991) insists that increasing support of a sexually abused child by one person increases their chances of a normal development. Group therapy also includes family therapy, where a therapist focuses on enhancing cooperation and

mending relationships between family members (Draucker, 2000). Family therapy emphasizes understanding the maladaptive behaviors of child-victims, teaching positive communication skills, and improving problem-solving for the entire family (Cohen et al., 2003).

Adults gain different benefits from group therapy because they have been struggling with CSA symptoms for a longer period of time. In group therapy sessions, it could be the first time survivors share details of their trauma narratives with other people (Draucker, 2000). The focus of adult group therapy is to tell the story of the abuse and focus on the meaning attached to the abuse while confronting the feelings and pain that the adults have been carrying around for years (Hodges & Myers, 2010). By exchanging stories with other survivors, victims discover the central motifs surrounding sexual abuse and they will realize the similarities of secrecy and strategies used by their offenders (Draucker, 2000). Hopefully, the survivors will see that the other participants in the therapy are not responsible for the abuse, so they should be able to see the truth in their own abuse.

Psychoanalytical Approaches

Freudian approaches to therapy have also been regarded as helpful to CSA victims and other survivors of traumatic events. A Freudian approach to therapy consists of psychoanalysis and interpretive methods to help understand feelings and behaviors due to abuse. Cohen et al. (2003) explain that psychoanalysis is a way to explore and resolve psychological conflicts about an abusive experience using nondirective and interpretive sessions and projective tests that often occur over multiple months. Examples of psychoanalytical techniques are play therapy and art therapy (Cohen et al., 2003).

Play therapy is a popular method used with children in order to help children cope with sexual abuse while providing a safe and positive environment. A safe environment is developed because the therapist becomes a friend and ally by participating in the child's imaginative games (Bolkovatz & Walker, 1988). Dolls, games, and toys are included in therapy to increase the child's comfort with the therapist and also to discuss specific safety and/or prevention strategies (Cohen et al., 2003). By interpreting the imaginative play, therapists may determine if sexual abuse has taken place or what problems are present in the child's home life (Cohen et al., 2003). Role playing is another form of play therapy that therapists use to teach children lessons or help them express feelings about certain places like courtrooms or school (Marvasti & Florentine, 2004). Marvasti (1993) explains that there are two different types of post-traumatic play (PTP); positive and negative. In positive PTP, the child is able to work with the therapist to change and understand the negative components of trauma. The negative PTP may reinforce the anxiety associated with the trauma through reliving the events. Overall, using the power of play and imagination to help children can be a positive and rewarding treatment for child victims.

Freudian therapists can interpret the symbolism of the different themes of play children choose during therapy. Freudian therapists believe that play is rarely totally aimless or random, and there is symbolic value within play methods of children because they get inspiration from life experiences (Bolkovatz & Walker, 1988). Therapists may be confused by certain imaginative games chosen by the children, but there is meaning in repetitive themes or objects used (Bolkovatz & Walker, 1988). It is significant that the therapist plays with the child during each session because it is a way to gain the child's

trust and to show he or she has the capacity to develop a close relationship with an adult who will protect them (Bolkovatz & Walker, 1988). Play therapy is a good method to use because it is an indirect and pleasant way for the child to express emotions or concerns and for the therapist to build trust and help the child cope with trauma.

Art therapy is another Freudian technique that uses interpretation and open-ended methods to evaluate children. Art therapy, like play therapy, can be a way of disclosing any sexual abuse as well as a way to help cope with sexual abuse (Pretorius & Pfeifer, 2010). Art is a form of emotional release and a way of revealing internal feelings and secrets in a nonthreatening way (Marvasti & Florentine, 2004). The purpose of using art as therapy is to highlight and address cognitive and emotional issues as well as enhance developmental growth for the child victim (Carolan, 2001). If this therapy takes place immediately after a traumatic event, it is known to release tension and minimize anxiety levels of children (Pretorius & Pfeifer, 2010). There are two main goals of art therapy. The first is to introduce children to creative expressive media by providing enjoyable art experience and the second is to stimulate verbal and nonverbal expression (Marvasti & Florentine, 2004). Art therapy is best for children who are too overwhelmed or intimidated by the verbal expression of the abuse (Pretorius & Pfeifer, 2010). It is helpful to use the collection of art created throughout therapy to determine the change in the patient's healing (Marvasti & Florentine, 2004). Interpretation by the therapist is a key component in this approach because all drawings must be evaluated on a symbolic level to fully understand what the child is expressing.

Other Techniques

Other therapy techniques used by professionals also focus on the victim and eliminating self-blame and promoting social support. Crisis intervention is the supportive intervention that occurs in the immediate aftermath of any stressful event (Cohen et al., 2003). The support from anyone, but especially by a professional, offers victims the direct opportunity to express feelings about the event and obtain emotional support (Cohen et al., 2003). Other methods that emphasize action instead of emotional support include letter writing and confrontation. Letter writing allows the victim to write a letter to the abuser to express his or her feelings of anger and blame (Draucker, 2000). The letter is never sent to the abuser because the victim should be able to state his or her true feelings without having to actually connect with the abuser again and having to worry about the abuser's reaction (Draucker, 2000). If the victim does want to reconnect with the abuser, one therapeutic technique is confrontation. It is a powerful opportunity for the victim to assert his or her beliefs and perceptions of the abuse experience (Draucker, 2000). The most important component of using confrontation is that the decision must originate with the survivors themselves because it is the only way the confrontation will provide the release of feelings that they need (Draucker, 2000). If victims are not fully prepared emotionally and psychologically for a confrontation, the confrontation could reverse the progress previously made in treatment.

Summary

Overall, any type of effective therapy is very empowering for a CSA victim because it gives back the feeling of control. There are numerous methods for therapists to choose from when evaluating and treating a CSA victim. The choice of treatment

depends on the individual victim, the unique experience, and the symptoms being expressed. Therapists and psychologists also have their own methods that they believe work best so the family and therapist must work together to achieve the best outcome. Research has shown that all the different therapy approaches can be effective, but the cognitive-behavioral therapy is currently the most widely used treatment and is highly effective (Pretorius & Pfeifer, 2010). No matter what technique is used, they all have a common goal of helping CSA victims cope, live a full life, and develop skills to deal with traumatic situations later in life. It is comforting to know that society has so many resources to help children cope with trauma and return to normal cognitive and behavioral functioning.

Conclusion

“Once we perceive, question, and challenge the existence of the sexual abuse of children, we have taken the first crucial step toward the elimination of the degradation, humiliation, and corrosion of our most valuable human resource—our young.” –Florence Rush, 1980 (Wurtele & Miller-Perrin, 1992)

No rationalizations can cover up the reality of child sexual abuse. The short-term and long-term side effects of CSA are real and extremely destructive. As demonstrated in this paper, there is deep and demonstrative research to prove that child sexual abuse is harmful, notwithstanding the examples and justifications used by pedophile organizations.. No one can restore the innocence that a child loses when it is stolen by a pedophile.

The justification by such organizations that adult-child sexual relationships are a positive influence on a child’s life is simply not correct. Pedophile organizations should not make false claims when all of the evidence is against them. CSA has many negative repercussions on the lives of children. First, there are the obvious physical symptoms. Children can be subjected to vaginal and rectal bleeding, bruises, urinary tract infections, and bowel problems. If the physical harm is not enough evidence to prove the damage caused by CSA , the psychological and emotional impact on CSA victims is very convincing. Children, who are innocent victims and subjected to the unwanted sexual urges of adults, suffer from PTSD, anxiety, depression, and fear. As a result of the depression and self-blame associated with the abuse, CSA victims are at a higher risk for suicide than children who were never victims of sexual abuse. The sexual abuse is extremely traumatic and so emotionally complex that it can change the child for life. Children can lose interest or fear activities that once brought them joy in order to avoid any memory of the abuse. Victims may withdraw from social groups and friends

because they are stigmatized and feel different. As these victims grow into adulthood, these problems can follow them and affect adult relationships as well. CSA victims are more likely to be victimized as adults because of a skewed idea of intimate relations. Sexual dysfunction is also a problem in adulthood because the first sexual experience is tied to memories of pain, unhappiness, and discomfort.

The second justification offered by pedophile organizations, that the child is a willing participant, also does not warrant any support. Although pedophile organizations may claim that children are active participants in the behavior, research shows the extent of manipulation and grooming that takes place in order to place a child in the sexual situation. As discussed in the earlier chapters, researchers have concluded that children are simply cooperating with the abuser because he or she is an authority figure and have more control than them. The force behind the abuse can be direct (i.e., physical) or indirect (i.e., manipulation). Adults are overpowering physically and socially because children are socialized to respect those older than them. Some CSA victims are manipulated by threats and secrets. For example, the threat of being killed for revealing the abuse seems far worse than the abuse itself. Often, the offenders build a relationship with the child and gain his or her trust before any sexual behavior takes place so the child is manipulated into the sexual relationship. Children honor the trust and feel a sense of loyalty to the adult so revealing the abuse to anyone could feel like a betrayal, but they do not realize that they are being betrayed in a completely different and more damaging way. Children are not willing to participate in the sexual abuse as pedophile organizations would like one to believe. The innocence of children should not be stripped away by selfish pedophiles.

Since awareness of child sexual abuse has increased throughout the years, society has made some improvements to provide the necessary resources to victims. Fortunately, there are therapies that can help CSA victims and their families deal with the traumatic event and learn to cope in a healthy way. There are treatment methods that help educate victims about sexual abuse and the manipulation and effort involved in the process. Cognitive therapy helps children release any self-blame and view the abuse as a situation that they were forced into instead of allowing themselves to feel like willing participants. Play therapy is helpful with children and creates a safe environment where they feel safe to express themselves and build relationships. Play therapy, along with other psychoanalytical methods, can be used to determine if any sexual abuse has taken place. Group therapy is beneficial to adults and children because it decreases the stigma CSA victims may feel and also increases social support. Many other treatment methods, such as letter writing, confrontation, and crisis intervention have also proven to be useful when treating CSA victims. Therapy is the most important resource to have available to children because it can drastically reduce the negative psychological and emotional impact of child sexual abuse.

Clearly, there are emotional, physical, and psychological side effects from CSA that are very detrimental and depressing. There is ample scientific research that should not be ignored.. The perverse advocates for adult-child sex have a skewed perception of reality that convinces pedophiles that they are not doing anything wrong. The reality is that CSA victims are not willing to participate in sexual behavior with adults and offenders must engage in manipulative behavior to gain access to a child. The child-victims are subjected to an extremely traumatic event and then negatively affected for the

rest of their lives. The justifications used by NAMBLA and similar groups are irrational and unfair to the children subjected to this inappropriate and destructive behavior.

I gained a much better understanding of CSA through research which has definitely affected my outlook on sexual abuse and available treatment for victims. Most people are unaware of the consequences and psychological harm caused by CSA, but it is a serious problem. Children suffer from the aftermath of the abuse just as much as they suffer during the sexual abuse. It is comforting that since many treatment resources are available, children will not have to heal by themselves, but it is not fair for children to ever be exposed to such trauma. I feel that as public knowledge increases, there is hope that child sexual abuse can decrease as time continues. CSA is much less taboo today than it was years ago and the perverse acts of pedophiles are being exposed and confronted with force. Just recently, a book titled *The Pedophile's Guide to Love and Pleasure: A Child-Lover's Code of Conduct* was available on Amazon.com, but it was discontinued when Amazon was immediately faced with many angry customers. A boycott of any purchases from Amazon.com was initiated to demonstrate society's disapproval of allowing material that supported pedophile behaviors. If we continue acts like this boycott, I am confident in society's ability to fight against NAMBLA and other pedophile organizations and help reduce child sexual abuse.

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