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SYMPTOMS AND LONG-TERM OUTCOMES FOR CHILDREN WHO HAVE BEEN SEXUALLY ASSAULTED

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Violent behaviors by and toward children have become an increasing concern within the American school system, with a good deal of energy devoted to developing profiles about which children are likely to exhibit these behaviors (Goldstein & Huff, 1993). Unfortunately, much less publicity has been devoted toward children who are sexually abused, despite the fact that over 300,000 children and adolescents are sexually abused annually in this country (National Center of Child Abuse and Neglect, 1996). As such, this figure reflects about a 600% increase in actual reported cases since 1980 (Burgdoff, 1980). These data suggest that a large number of school-aged children are experiencing this kind of personal assault and professional educators are likely to encounter these children in the routine course of the educational process. This article provides a summary of the issues involved in the determination of sexual assault against a child and reviews the empirical literature describing the symptoms which may be manifested by a child who has been sexually abused. © 2001 John Wiley & Sons, Inc.

In the last 20 years the psychological and physical impact of child sexual abuse (CSA) has appropriately received a great deal of attention. In general, the impact and its sequelae appear to be highly emotionally damaging to large numbers of these survivors (Esman, 1994; McMillan, Zuravin, & Rideout, 1995).

The National Center of Child Abuse and Neglect (NCCAN, 1996) has compiled data indicating that over 300,000 children in the United States are sexually abused or assaulted annually. This figure reflects nearly a 600% increase in the frequency of documented child sexual abuse in this country since 1980 (Burgdorf, 1980), and is significantly higher than what most people would generally like to believe about how children are treated in a country that places such high regard on the value of human life. The ratio of sexual abuse is about four females for each male, with the peak time period for sexual abuse of females occurring around age 7 to 8 years up through adolescence. For males, the time period involving the sexual abuse is usually much shorter, and typically occurs prior to puberty (NCCAN, 1996). For both genders, the sexual abuse is generally a repeated series of incidents throughout this time span.

DEFINING CHILD SEXUAL ABUSE (CSA)

A number of substantial cultural, social, and empirical issues exist regarding how CSA is defined. These issues can greatly complicate both clinical practices and research in the field. For example, there tends to be more agreement among professionals that fondling and intercourse are forms of sexual abuse (SA), but less consensus about adults sleeping with a child, nudity in a child's presence, bathing an older child, or different kinds of physical touching as constituting SA (Haugaard, 2000). No widely agreed upon definition exists.

The age at which one should be identified as a child is another point of contention. Some argue that a child is younger than 18 years old (Wyatt, 1985), while others assert that being under the age of 17 (Fromuth, 1986) or even 16 (Wurr & Partridge, 1996) defines childhood.

Further, its definition may also be greatly influenced by specific cultural and/or social values. Within some cultures serious taboos exist about exposing ones' body to others or touching of any

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kind outside of marriage. In other cultures, less serious strictures may be operating that permit much greater physical contact between adults and children, regardless of their ages.

More clearly, though, is the idea that hurt or "harm" must have occurred as the result of the sexual interaction between the child and adult (Rind, Tromovitch, & Bauserman, 1998). Of course, implicit to this definition is the notion that an adult can have acceptable sexual relations with a child as long as both consent and no "harm" occurs. Yet, how does one know when harm has actually occurred? The harm may not emerge until much later in the child's lifetime when they are more emotionally mature and can comprehend the significance of the sexual acts they allegedly participated in willingly. Moreover, is a child capable of giving consent about their willingness to participate in a sexual relationship?

CSA is typically defined as involving either actual physical or nonphysical contact experiences between a child and an adult in which the child is subjected to sexually based exploitation, humiliation, or degradation. The physical contact can be either genital or nongenital in its physical focus. Nongenital sexual abuse refers to involving children in pornography, prostitution, or exhibitionism. This type of SA would refer specifically to the adult who is encouraging or coercing the child to be involved in these activities as opposed to the consumers of these activities. Power, aggression, domination, and control over the child appear as primary characteristics in these relationships. Sexual attraction or "love" as is presumed to exist in mature adult relationships, is not a prime moving impetus for the adult's treatment of the child.

FREQUENCY OF OCCURRENCE OF CSA

Estimates about the frequency at which children are sexually abused vary widely from study to study, depending upon the specific criteria used to define operationally the victim and the act. Conservative estimates suggest that only one out of five instances of child sexual abuse are ever reported to legal authorities (Everstine & Everstine, 1989). A national study by Laumann, Gagnon, Michael, and Michaels (1994) found that only 22% of those who experienced SA told anyone else about the abuse.

Retrospective studies of CSA have found widely varying levels of frequency, depending upon the specific definition used to define the CSA. Older studies found that 50 to 60% of undergraduate females experienced sexual abuse by the age of 18 (Russell, 1984; Wyatt, 1985). Finkelhor (1984) and Fritz, Stoll, and Wagner (1981) reported that somewhere between 15 and 45% of women and 3 to 9% of men have been sexually assaulted during their childhood. More recent studies have found fairly consistent frequencies ranging from 41% (Kinzl, Traweger, & Biebl, 1995) to as high as 60% (Fromuth, 1986; Haugaard & Emery, 1989).

The specific numbers of children being sexually abused serve to make these estimates more concrete. For example, in North Carolina during the 1994–1998 time period 5,979 reported cases of child sexual abuse were substantiated by County Departments of Social Services as having taken place (North Carolina Department of Health and Human Services, 1999). Nationally, 84,320 new cases of child sexual abuse were confirmed during 1997 alone (National Committee to Prevent Child Abuse, 1998). One national survey involving 2,626 adults found that 27% of women and 16% of men reported having been sexually abused during their childhoods (Finkelhor, Hotaling, Lewis, & Smith, 1990).

Many CSA victims reside in families that have a significant number of other kinds of serious problems, and it may be that the presence of these other problems makes the child vulnerable to both neglect and then later CSA. Family-wide problems often associated with CSA include the child witnessing physical or sexual violence between their parents or adults in the household, exposure to adults using alcohol and drugs, or general neglect of the child's basic living needs such as food, clothing, heat, and shelter. The degree of family-level psychopathology present

before the SA occurs may be a significant influence on how the child reacts to, and emotionally rebounds from, the abuse.

In many of these families childhood physical abuse (CPA) also frequently exists. For example, Moeller, Bachman, and Moeller (1993) surveyed 668 women and found that 35.6% reported experiencing both CSA and CPA. Surrey, Swett, Michaels, and Levin (1990) found an even higher cooccurrence of 70% for both CSA and CPA. Similarly high cooccurrence rates have been identified by Chu and Dill (1990), Kirby, Chu, and Dill (1993), and Swett and Halpert (1993), who found rates of 66, 82, and 83%, respectively, in their adult samples.

Rodriguez, Ryan, Rowan, and Foy (1991) reported that only 8% of the adults in their study experienced just CSA, and no other kinds of abuse. These data are clear in demonstrating that these children often encounter multiple trauma over a continued time period during their childhoods. Obviously, exposure to multiple traumatic experiences can compound and magnify both the short-term and longer ranging negative effects in an intricate and difficult to predict manner. What seems clear, though, is that children who have been both sexually and physically abused are at very high risk to develop emotional problems during their lifetimes (Ackerman, Newton, McPherson, Jones, & Dykman, 1998).

Abused children often reside in lower income areas (Crittendon, 1998) or, at least, these are the children who come to the attention of child protective service agencies. The rate of CSA females to males is around four to one, with the peak age for the onset of the abuse for girls occurring between 7 and 8 years, with an average duration of about 2 years (Trickett & Putnam, 1998). Data compiled by NCCAN (1996) show that male SA typically starts before puberty, and has a shorter duration time span for occurrence. For both genders the CSA is usually a repeated series of incidents.

It is important to note that descriptive statistical analyses about the age of onset and duration interval do not accurately represent the variance that exists on an individual basis. In some situations the sexual abuse can occur on a regular weekly basis and for much longer than 2 years.

IMMEDIATE AND SHORT-TERM EFFECTS ON THE CHILD

The issue regarding whether CSA generates significant negative emotional trauma within its victims is highly disputed and, as such, have been the source of a good deal of controversy within this field. Rind et al. (1998) conducted a review and meta-analysis of 59 studies involving college students who claimed to have been sexually abused as children. The results of this meta-analysis indicated that those students who were victims of CSA were only "slightly less well adjusted than controls" (Rind et al., 1998, p. 22). With this information as an interpretive perspective for the reader to consider, the remainder of this section addresses studies alternative results and conclusions.

Limited information exists at present about why some CSA victims become emotionally traumatized while others appear to adapt without significant distress (Ackerman, Newton, McPherson, Jones, & Dykman, 1998). The few studies done examining gender, ethnicity, socioeconomic status, intelligence, age at the time of the trauma, and duration of the SA as predictive of either resiliency or vulnerability to emotional harm have yielded inconsistent and inconclusive findings (Ackerman et al., 1998; Famularo, Fenton, Kinscherff, & Augustyn, 1996). Moreover, the victims of CSA come from a wide variety of personal and social-cultural backgrounds. This heterogeneity of backgrounds, personal life experiences, and family conditioning will affect how the individual child specifically reacts to the CSA. At the present time there are no specifically developed tests or assessment procedures to identify the symptoms that SA children might exhibit (American Academy of Child and Adolescent Psychiatry, 1998).

What seems to be more conclusive, though, is that the effects of CSA are highly variable, and likely to depend on how the child perceives and interprets the act, as well as a number of other

variables that will be addressed specifically later in the following section. Many of the symptoms these children can develop, either while they are actively being abused or shortly after the abuse ends, can also be seen in troubled children who are not CSA victims. Consequently, it is very difficult to establish with confidence that CSA is the main effect cause of a child's emotional or behavioral problems unless the child explicitly discloses that information. Even following disclosure, it is a complicated process to sort out and delineate the effects of preexisting conditions from the specific effects associated with the CSA on subsequent emotional and/or social adjustment problems. Simply observing a child's behaviors and social adjustment patterns will not be sufficiently reliable or valid diagnostic indicators about whether abuse is taking place or has occurred.

Moreover, clinical lore suggesting that boys are more likely to show externalizing symptoms, while girls will internalize their emotions has not received empirical support (Garnefski & Diekstra, 1997; Jumper, 1995). For example, Bauserman and Rind (1997) reviewed college and national samples, and concluded that the reactions of boys are much more neutral or positive than those for girls. Many studies have challenged these findings though (Black & DeBlassie, 1993; Mendel, 1995). Children of each gender show a high frequency of both kinds of disorders and symptoms (Boney-McCoy & Finkelhor, 1995; Flisher et al., 1997). Mendel (1995), perhaps, has summarized this situation with greatest pithy and accuracy, noting that CSA "has pronounced deleterious effects on its victims, regardless of their gender" (p. 101).

Yet, a recent meta-analysis of CSA experiences and effects on college students suggests that these men and women appear to perceive CSA differently, and that "the assumption that CSA is an equivalent experience for men and women in the population of persons who experience CSA is unsupported by these results" (Rind et al., 1998, p. 38). The contradictory findings among studies highlight the controversy and lack of clarity within this field. These findings may also reflect differences between researchers and clinician/researchers in how each approaches this topic and its effects. Research studies pool data to make quantification easier. But, this practice overlooks or obscures individuals within the sample. Effects that fail to emerge as highly statistically significant among several samples pooled together do not necessarily negate the clinical significance of the findings so that these can be dismissed as trivial or inconsequential.

The specific emotional reactions of a child who is being, or has been, sexually abused can vary widely based on genetic predisposition and temperament characteristics, socially taught patterns within the family unit and/or larger cultural group about how to express feelings, as well as the degree of emotional constriction or expressiveness shown by the child. Of course, these three general variables can also interact in complex and difficult to predict ways.

Many studies have shown that a substantial number of these child survivors may show sexualized conduct (Friedrich, Bielke, & Uriquiza, 1987), generalized anxiety disorders (Kolko, Moser, & Weldy, 1988), experience serious and periodic episodes of depression (Shapiro, Leifer, Martone, & Kassem, 1990), or have gender and identity problems (Hotte & Rafman, 1992). They may also have problems sleeping, show moderate to severe conduct problems or externalizing disorders (Wolfe, Gentile, & Wolfe, 1989), or present with multiple emotional problems. They are sometimes diagnosed as having some type of attention deficit hyperactivity disorder (Kolko, Moser, & Weldy, 1990). Guilt and shame often are apparent, which can affect the child's capacity to develop meaningful present and future relationships with peers and other adults.

Some of these children will show hypervigilance and heightened emotional reactivity to social interactions where one might see a low level of anger present, even when the behaviors shown by other people tend to be more neutral rather than aggressive in nature (Rieder & Cicchetti, 1989). They may misinterpret social interactions as negative and aggressive when, in fact, they are not (Hennessy, Rabideau, & Cicchetti, 1994). At times, they might become dispropor-

tionately emotionally upset and distressed when they see others in conflict, and can show exaggerated reactions to these situations.

Other SA children often appear to adults as being inflexible, easily distractible, or as having difficulty dealing well with changes. They may seem to be "on edge," even when they are involved in relaxed social settings. They may repeatedly visually scan their physical setting, project tension in their facial expression and physical posture, and/or interact in a guarded and cautious manner with others and especially adults.

Some SA children have been found to show a cluster of behaviors referred to as compulsive compliance (Crittendon, 1992). This cluster is characterized by the abused child being highly compliant to the demands and requests of adults; tending to modify or even falsify their feelings and the truth in the presence of adults and especially their parents to gain adult approval; being highly vigilant about what to say and how to behave based on the nonverbal cueing of their parents or significant adults in their life; and tending to be highly structured to the point of occasionally having ritualistic forms of conduct in their day-to-day living routines. These behaviors make identification of the sexually abused child a delicate and highly difficult process. It can be easy for interviewers to lead a child to respond in desired ways based on their own personal biases or presumptions during an individual clinical interview. It is equally as easy (and not uncommon) for the child to recant these allegations after leaving the interview and are reunited with their parents, even if for a brief time period.

An increasing number of studies are consistently showing that CSA survivors develop many of the symptoms associated with posttraumatic stress disorder (PTSD), although the child's symptom representation may not fully meet DSM-IV criteria (Deblinger, Steer, & Lippmann, 1999). Yet, McLeer, Deblinger, Henry, and Orvashel (1992) found that around 50% of CSA children met either partial or full criteria for PTSD. These symptoms may persist at varying levels of intensity throughout the child's lifetime (Widom, 1999). Common symptoms seen in these children may include general agitation, behavioral disorganization, repetitive play where the abuse is shown using objects and toys, vague and frightening nightmares, or actual attempts to reenact the SA with peers and/or adults.

Finally, SA children and adolescents may have a history of running away from home for no obvious precipitating causes, somatic complaints some of which are reality-based and which often involve the lower gastrointestinal or genital areas, social withdrawal, guilt and a dysphoric mood, fear of being in a bathroom or shower, sleep disturbances which begin suddenly, and generalized fearfulness and apprehension (Everstine & Everstine, 1989).

It is important to keep in mind, though, that some research also indicates about one-third of CSA victims show no immediate or identifiable emotional or behavioral adjustment difficulties (Kendall-Tackett, Williams, & Finkelhor, 1993), while some only exhibit minor symptoms such as reduced self-esteem or distress that are not clinically significant. What remains uncertain is whether these children are truly experiencing no traumatic emotional sequelae or whether they are in some kind of denial or shock phase during the initial stages of reacting to the abuse.

The hypotheses of either denial or emotional shock receive some support from recent studies showing the presence of sleeper effects for some victims. A sleeper effect refers to the situation in which the abused child shows no obviously significant or discernible emotional problems immediately subsequent to the CSA. As time passes, the child survivor slowly begins to manifest increasingly more serious emotional and/or behavioral problems of unclear etiology. Initial studies identified sleeper effects evolving about 1 year postabuse (Mannarino, Cohen, Smith, & Moore-Motily, 1991). More recent research indicates that sleeper effects can emerge much later than previously believed. In fact, symptoms can erupt during the adult years (Saunders, Kilpatrick, Hansen, Resnick, & Walker, 1999; Widom, 1999). These findings suggest that these children must

be carefully monitored for several years following the SA. It is not clear what specific variables in either the child's personality structure or life circumstances will contribute to the intensity or severity of the symptom presentation associated with sleeper effects.

Although the results of research on the immediate effects of CSA are slightly mixed in terms of research-level precision, there is a great deal of consensus across many studies using a variety of samples and definitions of CSA indicating that the psychological, social, and emotional effects of CSA are serious, intense, and very complex. Even in the absence of immediate symptoms, one cannot assume that the survivor will go on to lead a normal and reasonably well-adjusted life style.

FACTORS AFFECTING THE CHILD'S REACTION TO SA

The impact of sexual molestation on the child may be highly traumatizing, with the degree of emotional trauma apparently related to three specific variables. The first variable deals with the amount of violence or fear associated with the actual physical act of the sexual molestation (Schultz & DeSavage, 1975). In general, the greater the degree of either actual or implied physical threat and violence accompanying the SA, the greater the probability that there will be a negative emotional impact on the child. These threats or actual violence may also lead to a longer period of time that the residual emotional disturbance associated with the assault can persist. For a large number of CSA cases, the perpetrator is well known by the child. In fact, the perpetrator may actually have assumed a role of confidante, emotional support, and/or friend with the child prior to initiating the abuse.

Consequently, this personal familiarity may serve to magnify and intensify fear and emotional confusion within the child. Issues of trust, or more precisely distrust of others, and betrayal are not uncommon feelings that can emerge in these victims while they are actually being abused and that mitigate against disclosure.

The child's perceived level of personal control over their own life following the SA seems to have some influence on posttrauma adjustment (Cohen & Mannarino, 2000; Mannarino & Cohen, 1996). Child victims who perceive themselves as having greater control over what happened to them appear to react with less severity than those who do not feel they have control or can successfully defend or protect themselves. But, these findings are somewhat tentative, and further research is necessary, which examines the relationship between perceived locus of control and emotional resiliency.

A more subtle form of implied threat involves the perpetrator generating a sense of obligation and psychological dependency within the child to the abuser. The child is made to feel that they have a special and unique relationship with the abusing adult, and that others will resent the child because they are not able to have this kind of relationship with the adult. Others will become envious and jealous if they learn about their relationship and try to hurt them. To protect themselves (that is, the child) from being hurt by these other people, their interactions must be kept secret so others cannot harm them and destroy their special friendship.

A large number of sexually abusive interactions between adults and children are also characterized by the presence of more overt and explicit verbal threats. These perpetrators attempt to make the child feel that it is they who have initiated this act. The child would be punished severely for bad behavior if others learned about it. Sometimes, the perpetrator may convince the child that legal authorities will remove them from their home or imprison their parents for what they are doing. The relationship must be kept secretive for the sake of the child and their parents. Any revelation will cause both the child and their parents to be punished by legal authorities.

Finally, a smaller number of adult-to-child sexually abusive relationships actually involve outright physical assault that includes various forms of sexual torture and pain ranging from the

use of hands (digital penetration) to physical objects (sticks, bottles, or electric shock as examples) inserted into various body orifices to inflict pain on the child. Most usually, these acts are restricted to the child's genital regions. This abuse often can produce actual permanent physical damage of internal organs as well as observable scars. When these kinds of abusive behaviors exist, the perpetrator often will tell the victim that they and/or their parents will be killed if the child discloses to others about their relationship. Ackerman et al. (1998) found that coercion of the child to maintain secrecy was a significant predictive factor in the development of mood and anxiety disorders for CSA victims.

The second variable that impacts the child's reactions to sexual assault is the parents' actions when they learn about the incident (Kazdin & Weisz, 1998). In many ways, their specific emotional reactions and concrete responses to it can actually have a significant influence on the intensity and persistence of the residual trauma for the child. Parents who respond in a sensitive, loving, and protecting manner will have a more calming and reassuring effect on the child. This feedback also helps the child understand that they were not responsible for what occurred, nor are they responsible for the consequences that the perpetrator incurs following disclosure to legal authorities.

Family cohesiveness in terms of their ability to support the child through this ordeal and the ability of the parents to remain flexible to, and understanding about, the child's personal reactions as well as the stresses created by the subsequent legal investigation can become protective factors that facilitate the child's adaptation and recovery (Saywitz, Mannarino, Berliner, & Cohen, 2000). Sometimes the legal inquisition process can be equally as distressing as the actual assault.

Parents who are accusatory, angry, or aggressive, either overtly or in a more subdued manner, often can intensify the negative effects of the abuse. Many children may conclude that they are the cause of their parents' negative feelings (Finkelhor, 1984). The child may feel guilty about upsetting the parents and then eventually feel ashamed for being "bad." As they mature in age, these feelings of guilt and shame often intensify, and can become substantial influences on how the child adjusts to the teenage and adult years. These effects are discussed specifically and in greater detail in the next section of this article.

Some parents actually will not believe the child, may attempt to discredit or minimize the child's statements about the abuse, and/or become overtly hostile toward the child rather than the perpetrator of the SA. These parents usually view the child's disclosure as creating problems for themselves in the form of lost time from work, within-family conflicts, and/or social embarrassment. Such reactions will have an obviously devastating psychological effect on the child and generate much self-doubt and self-recrimination. Further, the child frequently can become alienated from the core family unit and serve as a scapegoat or pariah. This can sometimes make the child vulnerable for further sexual abuse by the same or another perpetrator.

Finally, the younger the child is when the sexual assault occurs, the greater the probability that the long-term negative psychological and social adjustment effects will continue beyond termination of the assaults (Tremblay, Herbert, & Piche, 1999). The younger child tends to be less well developed emotionally to understand the meaning of the assault, and more vulnerable because of misconceptions they may hold, or more probably have been told, about the sexual assault. Many times, the sexually molested child has been programmed by the perpetrator to believe that he/she really sought out the sexual relationship, that the child and/or others will be harmed or put in prison if they admit to the sexual relationship, or that this is the way that real friends behave with and show affection toward each other.

LONG-TERM EFFECTS OF CSA

Studies examining the long-term impact of sexual abuse on children as they mature into adolescence and adulthood are relatively few in number. Yet, several recent studies highlight the

significant and pervasive long-term negative effects of this abuse on adjustment during the adult years. Although about one-third of children survivors show no immediate negative effects from CSA, Kendall-Tackett, Williams, and Finkelhor (1993) found that many show a slow deterioration over time, and that as much as 30% of the "no effects" group develop later significant emotional and social adjustment problems (Oates, O'Toole, Lynch, Stern, & Cooney, 1994).

Several studies have shown that PTSD is one of the more common long-ranging psychological disturbances, and that it often coexists with other kinds of serious emotional disturbances (Butzel, Talbot, Duberstein, Houghtalen, Cox, & Giles, 2000; Lange, DeBeurs, Dolan, Zlachnit, Sjollema, & Hanewald, 1999; Roesler & McKenzie, 1994). Widom (1999) reported that 37.5% of a sample of 96 adult survivors of CSA met the diagnostic criteria for lifetime PTSD.

The specific symptoms associated with this late evolving PTSD typically involve flashbacks, intrusive thoughts, hyperarousal, cognitive distortions, misperception of social transactions as threatening when they are not, and avoidance of situations or stimuli that might be, in some way, reminiscent of the abuse. In fact, these data are sufficiently robust as to lead many to conclude that CSA is a high-risk factor for the later development of psychological and social adjustment problems during the adult years for both genders, and especially women (Saunders et al., 1999; Widom, 1999).

CSA involving penetration seems to be especially traumatic for these survivors, with about two-thirds of these adult survivors later experiencing varying degrees of PTSD at some point in their lifetimes (Albach & Everaerd, 1992; Williams, 1994). These survivors also frequently experience multiple traumatic events in their lives, which likely serve to exacerbate and magnify the trauma initiated by the CSA. Rodriguez et al. (1991) found that 66% of their sample of 117 adult survivors involved in outpatient treatment services described two or more significant life traumas as having occurred in addition to the CSA. These additional trauma included childhood physical abuse (62%), rape (31%), domestic violence (21%), and criminal assault (16%). Only 8% of their sample reported having been sexually abused during their childhood and not enduring any other kinds of serious personal assault or bodily harm trauma.

Women with CSA histories also report significantly greater numbers of dissociative experiences during their adulthood than nonabused matched peers (Butzel et al., 2000; Draijer & Langeland, 1999). This dissociation is usually part of a more widespread psychopathology (Lange et al., 1999). Dissociative experiences, of which there are four primary types, involve difficulties in recalling important personal information because of its stress-inducing or traumatic impact for the person or disturbances in ones' consciousness, perceptions, or personal identity.

The extent of the negative effects of CSA during adulthood appear to depend on a rather complex interaction between the victim's personal psychological vulnerability level as influenced, and possibly even determined to some extent, by the child's pre-CSA exposure to other kinds of emotionally abusive people and situations and their implicit emotional resiliency (Wind & Silvern, 1992). Many times, CSA occurs within homes that have multiple kinds of severe and extensive social and economic problems (Widom, 1999). SA can exacerbate preexisting problems in these kinds of families. Yet, it can also overwhelm an essentially healthy functioning child who resides in a reasonably well-functioning home because the SA can disrupt the primary protective factors (such as friends, caretakers, extended family, familiar neighborhood) that protected the child initially.

Finally, these women tend to have a large number of somatic complaints that have no readily identifiable physical etiology and sometimes show accompanying reduced short-term memory functioning (Bremner et al., 1995). They tend to use and abuse alcohol and drugs (Peters, 1988) and report more frequent episodes of depression and anxiety (Murphy et al., 1988) than nonabused peers. As parents, these women have been found to frequently have substantial problems with appropriate child rearing (Burkett, 1991). Tragically, they also have a higher likelihood of being raped and/or physically battered during their adulthood (Fromuth, 1986; Russell, 1986).

PHYSIOLOGICAL EFFECTS OF CSA

Several studies have found evidence suggesting that CSA of girls can produce several long-term negative physiological changes as they mature into adulthood (DeBellis, Burke, Trickett, & Putnam, 1996; DeBellis, Lefter, Trickett, & Putnam, 1994b). Specific and abnormal changes have been identified in both their hormonal and neuroendocrine systems.

Some CSA girls may show earlier development of secondary sexual characteristics than their nonabused peers. The social and emotional implications of this physical precocity can be dramatic. These girls can stand out from their peers and generate a good deal of male attention, some of which they may be ill-equipped to respond to appropriately.

DeBellis et al. (1994a) conducted comparative urinalyses on 12 sexually abused girls and 9 nonabused peers between 8 and 15 years old. The CSA girls had significantly elevated concentrations of epinephrine, norepinephrine, and dopamine. These catecholamines are typically secreted in response to perceived or real stress, and their presence suggests that the CSA girls may be functioning in a chronic state of heightened arousal and hypersensitivity to their surroundings. The practical effects of these hormones is that they can produce sleep disorders, elevated states of generalized tension, and increased anxiety. Similar findings have been noted in Viet Nam veterans diagnosed with PTSD.

Another study examined the blood levels of cortisol and adrenocorticotrophic hormone (ACTH) in 13 sexually abused girls and 13 matched nonabused peers, ages 7 to 15 years (DeBellis et al., 1994, 1996). Cortisol and ACTH are additional stress-related hormones involved in the "fight-or-flight" response. The abused girls were found to have different portions of the hypothalamic–pituitary–adrenal axis activated in an effort to reduce the production and levels of cortisol in their system. Sometimes overworking of this axis can lead to depression, at least in adults.

The research in this area continues to evolve. But, these studies are significant in that they demonstrate the impact of CSA to be intense, with its effects potentially highly destructive in a number of different areas of the survivor's life.

TREATMENT MODALITIES FREQUENTLY USED WITH CSA SURVIVORS

The overall prognosis for children who have been sexually abused is guarded. It is essential that these children become involved in an ongoing professional therapeutic program with professionals who have experience and training working with both children in general and specifically children who have been abused. A variety of therapeutic approaches have been used with these survivors and, once again, the body of research examining the efficacy of these varied approaches is evolving. Several studies have suggested that a variety of therapeutic approaches may have success, depending on the characteristics of the therapist conducting the treatment sessions. One study found that the child victims of sexual abuse saw therapy as a positive experience primarily when their therapist showed compassion, concern, sincerity, and understanding toward them about what had happened (Berliner & Conte, 1995).

Most treatment programs use some type of group process approach in which the entire family unit is involved, except for the perpetrator if that person happens to be the biological parent or a step-parent (Greenspun, 1994). Berliner and Conte (1995) conducted interviews with child abuse victims and their parents, and found that 48% of the children first reported the abuse to their mothers. Only 3% of this sample indicated that making this disclosure to their mother had been a negative experience. These findings suggest that involvement of the mother in the overall therapeutic process is quite important, provided that the mother is the nonabusing parent (Kolko, 1996).

A commonly used approach involves cognitive-behavioral therapy, which has been used with children as young as preschoolers. This therapy also successfully incorporated techniques such visual imagery, problem-solving training, and contingency management programming (Cohen & Mannarino, 1993). Some other strategies include multimodal therapy using short-term based social skills training to include relaxation and assertiveness training components, art and play therapy, individual psychotherapy where the child's feelings and belief systems associated with the abuse can be clarified and reframed in a confidential and safe manner, and family therapy (Friedrich, 1996).

Several studies have found a cognitive-behavioral (CBT) approach to be useful, especially when the focal points address both specific problematic behaviors affecting the child's present social-emotional adjustment and support the child's disclosure of how they have interpreted the SA (Kazdin & Weisz, 1998; Pithers, 1997). Deblinger, Lippman, and Steer (1996) found CBT to be useful to ameliorate many of the symptoms associated with PTSD, while Celano, Hazzard, Webb, and McCall (1996) also found it effective in encouraging parental emotional support for the child. Taking a more educationally oriented position with the child regarding sexuality, sexual relationships, and self-protection have also been shown to have some success (Lindow & Nourse, 1994).

At this time it is difficult to state which of these approaches is more useful and therapeutically effective. To a large extent, it may be that the efficacy of the specific therapeutic approach used depends on a correct match among the emotional characteristics and needs of the child victim, the reactions of the core family to the assault, the level of competency of the therapist, and the therapist's ability to be genuinely empathic while helping the child to regain an internal locus of control over their world.

Regardless of the therapeutic approach taken, it is clear that the treatment plan must be developed based on the needs of the family and the child. This may require using a multimodal approach that coordinates individual, family, and group therapies with psychotropic medications and behavior management programs in school and the home (Saywitz et al., 2000). Crisis intervention, out-patient or in-patient placement, or partial day treatment services may also be necessary for seriously troubled survivors (AACAP, 1998).

CLINICAL APPLICATIONS FOR SCHOOL PSYCHOLOGISTS

Children who have been, or are being, sexually abused, present a unique, complicated, and delicate challenge for the school psychologist. It is unusual for these children to be explicitly identified by teachers and then referred to the school psychologist for an assessment following the usual special education referral process. Most often, the child may be showing other kinds of either social adjustment problems and/or achievement difficulties that lead to a psychoeducational evaluation or consultation. The child may actually disclose the abuse, either through direct statement or by allusion, during some portion of this evaluation process. At that point the school psychologist is presented with a complex set of legal, forensic, and ethical issues. Each of these issues must be dealt with in a competent and highly accountable manner that complies with state statutes about reporting of suspected CSA. These issues cannot be easily or quickly learned by the school psychologist after a child has disclosed about the abuse. Once such a statement of allegation is made by the child, the school psychologist must proceed in a clear, concrete, and legally enlightened manner.

The psychologist's immediate reaction to the child's disclosure should be one of passive and nonjudgmental listening. Any follow-up questions asked should be presented to the child in a nondirective and nonleading format, and recorded in writing verbatim. As much as possible, all responses from the child should also be recorded verbatim and in writing. Efforts should be taken

to keep questioning minimal. One should not try to extract specific details about the abuse or challenge the veracity of the allegations. Yet, the child's allegations about the abuse must be documented clearly, precisely, and accurately.

The psychologist must know the state legally mandated requirements in advance and the subsequent protocol about whom to contact within the local child protective services (CPS) agency. Advance knowledge and clear understanding of state laws and requirements are essential. All school psychologists should be explicitly educated about each. Different legal mandates and directives often exist when the alleged perpetrator is either a caretaker (parent, or legal guardian), peer, or another adult. In short, if the psychologist gets involved, either voluntarily or inadvertently, they must know exactly what they are doing or they may jeopardize the child's present and future safety because of interviewing errors or deviations from legal protocol that compromise further protection under the aegis of legal authorities.

School psychologists can assume an active leadership role within their school district by coordinating development of school-wide policies and procedures to follow when educators are presented with this situation. Sometimes school administrators need to be educated about the primacy of state statutes and regulations over local school board policies. For example, in North Carolina, professionals who suspect that, or are informed about, a child being abused are legally required to report this information immediately to the local CPS agency. They are not required or encouraged to report the suspected abuse to their immediate supervisor, usually a principal, and gain that person's approval before making this referral. The supervisor is not placed into a position of determining whether or not a complaint should be filed with CPS. Failure to make the report to CPS officials within statute stipulated time lines places the reporter in a legally compromised position in which they can either be fined and/or lose their professional license.

At the school district level specific protocol can be established regarding documentation procedures about which information to address in the written report, where and who to report the suspected abuse to within the CPS agency, legal safeguards and support systems available for the professional reporting the alleged abuse, other persons within the school system who need to be notified, and issues about confidentiality. Direction may also be necessary about how to handle the child's allegation if the alleged perpetrator is a biological parent or legal guardian and there is a possibility of imminent physical danger before CPS officials can begin interventions. School psychologists can assume a critical and proactive role in organizing the school system in advance, as well as serve in an instructional capacity to prepare individual teachers and other school personnel about how to respond to this child.

Following initiation of the legal investigatory process, the school psychologist may wish to consider having some ongoing professional contact in the school setting strictly with the child. The purposes of these contacts would only be to offer emotional support, contact, and reassurance to the child. Yet, the decision to meet with the child following disclosure should be carefully and thoughtfully considered. Consulting with CPS professional staff is strongly advisable prior to doing so. If seen as a positive option, these contacts should not involve providing either formal or informal psychotherapy, nor should there be any discussion initiated by the psychologist about the details of the SA allegations because of the possibility of contaminating the legal investigation and criminal or civil proceedings. Written notes should be kept about each of these meetings.

The American Professional Society on the Abuse of Children (APSAC, 1998) has developed specific criteria about the training of persons who perform psychosocial evaluations of children who may have been sexually abused. Among these criteria are graduate level training in either psychology, psychiatry, nursing, social work, or child development; a minimum of 2 years applied experience working with CSA victims; specialized training in child development and CSA to include continuing education in this area; and current knowledge about the emotional and behav-

ioral effects of SA on the child or adolescent. Further, experience in conducting forensic evaluations and offering expert witness testimony are highly desirable. These guidelines emphasize the complexity of the variables involved in cases of alleged or actual CSA. No school psychologist should become involved without this basic prerequisite core of knowledge and training. Even with this training and experiences, the school psychologist would be well advised to have ready access to a clinical supervisor who also possesses these characteristics so that the probability is reduced of errors being made.

School psychologists and professional educators need to become more sensitive to, and aware of, the short-term and longer ranging effects of childhood sexual abuse. The probability is quite high that these children will be referred for special education services at some time during their educational program of studies because of either academic learning problems and/or social adjustment difficulties. Correct diagnosis of the etiology of these symptoms is essential if one is to develop and implement the proper interventions to use to protect these children from further physical and psychological harm, and help them to begin to fulfill their intellectual, emotional, and social potentials.

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