

Suggested APA style reference:

Miller, K. L., Dove, M. K., & Miller, S. M. (2007, October). *A counselor's guide to child sexual abuse: Prevention, reporting and treatment strategies*. Paper based on a program presented at the Association for Counselor Education and Supervision Conference, Columbus, OH.

## **A Counselor's Guide to Child Sexual Abuse: Prevention, Reporting and Treatment Strategies**

Paper based on a program presented at the 2007 Association for Counselor Education and Supervision Conference, October 11-14, Columbus, Ohio.

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Statistics on child sexual abuse reveal that it is a significant, yet poorly defined, problem in the United States. It is difficult to determine the actual number of children who are sexually victimized because reported prevalence rates vary across research studies and data sources. In 2002, the Rape & Sexual Abuse Center reported that there were approximately 60 million survivors of child sexual abuse living in the United States. The National Association to Prevent Sexual Abuse of Children (NAPSAC, 2008) suggested that one in five American children is a victim of such abuse. Information from the National Child Abuse and Neglect Data System (NCANDS), which contains child protective services data, showed that in 2006, 8.8% of the 905,000 children classified as victims of maltreatment were sexually abused (reported in *Child Maltreatment 2006*, U.S. Department of Health and Human Services).

Researchers generally concur that the prevalence of child sexual abuse varies by age, sex, and family economic status. Although NCANDS revealed 8.8% of all abuse victims were sexually abused, for children age 4 to 7 this percent was 8.2% and for children age 12 to 15 the percent increased to 16.5% (USDHSS, 2006). Authors of the *National Incidence Study* (NIS) concluded that children are vulnerable to sexual abuse from age 3 on, although sexual abuse of infants also occurs (Sedlak, & Broadhurst, 1996). Data from this study also revealed that girls are more likely to be sexually abused than

boys. The Rape & Sexual Abuse Center (2002) reported that the median age of sexual abuse was 9.6 years for girls and 9.9 years for boys.

Sexual minority youth (i.e., gay, lesbian, bisexual) suffer higher rates of sexual abuse than non-minority heterosexual youth (Tyler & Cauce, 2002). Extreme poverty appears to influence the incidence of child sexual abuse. NIS data from the 1993 study revealed that children from families with incomes under \$15,000 were *18 times* more likely to be sexually abused than children from families with annual incomes over \$30,000 (Sedlak & Broadhurst, 1996).

Approximately 40% of sexually abused children are victimized by family members and 40% percent by larger or older youth known to the victims (Darkness to Light, 2001-2005). The *Child Maltreatment 2006* report (NCANDS data) revealed that for children who were sexually abused, 26.2 % were abused by parents and 29.1% were abused by other relatives. These percentages are closely reflected in 1993 NIS data. Exacerbating the problem of child sexual abuse are the facts that 95% of child victims know their perpetrators (Rape & Sexual Abuse Center, 2002) and almost never tell others about this abuse. As a result, the majority of child sexual abuse cases are never reported (Darkness to Light, 2001-2005). Victims who do not report sexual abuse, or those who report and are not believed, are at greater risk for physical, emotional, and psychological problems that can persist throughout adulthood. Consequently, many adult victims describe child sexual abuse as a “life sentence” (NAPSAC, 2008).

### **Definitions and Signs/Symptoms of Child Sexual Abuse**

Definitions of child sexual abuse vary by author and organization. According to Haugaard (2000), each word connotes something different depending on the user. Two definitions from the research literature include: “any sexual exploitation of a child under the age of sixteen for the sexual pleasure or profit of an adult or much older person” (Elliot, 2001, p. 2) and “use of a child for the sexual gratification of an adult” (Crosson-Tower, 2002, p. 123). The American Academy of Pediatrics (2006, p. 1) defines child sexual abuse as “any sexual act with a child performed by an adult or an older child.”

Child sexual abuse occurs across multiple settings and contexts and includes: incest/familial abuse (by a blood relative), extrafamilial abuse (by someone outside the child's family), pressured sex (use of persuasion or enticement), or forced sex (use of force or threat of harm; Crosson-Tower, 2002). Although laws governing the definitions of and penalties for child sexual abuse differ across jurisdictions, reporting mandates are clear. Statutorily-defined mandated reporters, which include counselors in all 50 states, are legally obligated to report suspected child sexual abuse.

Several factors confound the task of identifying a sexually abused child. Some victims fail to demonstrate typical signs and symptoms associated with such abuse, while others do so in an idiosyncratic manner. The degree to which a sexually abused child exhibits typical signs and symptoms is influenced by several factors including the extent to which violence was part of the abuse, duration of the abuse, the child's age at the time of abuse, the child's relationship to the perpetrator, and responses by adult caretakers (Hopper, 2006; Newton, 2001). Compounding these difficulties is the fact that some

symptoms are associated with typical developmental tasks while others are associated with physical or mental illnesses.

Drawing from information presented by The American Academy of Pediatrics (2006), The American Academy of Child and Adolescent Psychiatry (2004), the National Center for Post Traumatic Stress Disorder (Whealin, 2006), and the Child Welfare Information Gateway (2007), which is supported by the U. S. Department of Health and Human Services, the following are signs and symptoms of child sexual abuse that are classified into four categories: physical; emotional; behavioral; and, sexual.

Physical signs of child sexual abuse are less common and include swelling or rashes in the genital area, headaches, chronic stomach pain, urinary tract infections, and sexually transmitted diseases (STDs). Emotional symptoms are more common and include inappropriate anger, anxiety, rebellion, depression, dissociative symptoms, and suicidal ideation/attempts. Behavioral signs include bed wetting, nightmares, irritability, eating problems, compulsive washing and/or masturbation, secretiveness, refusal to attend school, unwarranted fear of people and places, withdrawal, running away from home, and reenactment of abuse behaviors. Sexual symptoms include seductive behaviors, unusual interest in sexual ideas or avoidance of the same, drawing of sexual acts, and encouraging other children to perform sexual acts.

### **Short- and Long-Term Effects**

Effects of child sexual abuse can be categorized as psychological, interpersonal, and behavioral, although certain effects can be included in more than one category. Some effects manifest for short periods and resolve without intervention, while others persist through adolescence and into adulthood. Research reveals that positive outcomes are associated with early detection and treatment (American Academy of Child & Adolescent Psychiatry, 2004). Sexually abused preschool children who are not identified, diagnosed, and treated at the time of abuse frequently surface 7-10 years later in the legal system as runaways, delinquents, or prostituted children (NAPSAC, 2008). These facts dramatically highlight needs for prompt reporting of suspected sexual abuse, immediate investigation by child protection authorities, and timely referrals for treatment of sexual abuse victims.

Psychological effects of child sexual abuse include lower levels of self-esteem (Elliot, 2001), higher rates of depression, anxiety, eating disorders, substance abuse disorders, post-traumatic stress disorder (PTSD), self-mutilation, and suicide (American Academy of Child & Adolescent Psychiatry, 2004; American Academy of Pediatrics, 2006; Child Welfare Information Gateway, 2006; Elliot, 2001; Hopper, 2006). The magnitude of these effects ranges from mild to severe to life-threatening (requiring immediate counseling intervention).

Interpersonal effects are those that affect the victim's ability to form effective and meaningful relationships. They include problems with interpersonal communications and insecure/disorganized attachments in adult relationships, unstable and less satisfying intimate relationships, and increased rates of separation and divorce (Mullen & Fleming, 2006). Although these effects typically occur in adulthood, the first two may emerge during childhood and/or adolescence. Because the latency period between child sexual

abuse and emergence of interpersonal effects may be several years, many of these effects are well ingrained in personality structures and interpersonal styles. Consequently, individual, marital, or family counseling interventions are typically required for symptom remission.

Behavioral effects manifest in a wide range of contexts, but often emerge as violations of social mores or laws. Victims of child sexual abuse demonstrate higher rates of academic and conduct problems, are at greater risk for committing property offenses, domestic violence, or felony assaults, are more likely to be sexually promiscuous (including acts of prostitution), and are three times more likely to become pregnant before age 18 (Darkness to Light, 2001-2005; Rape & Sexual Abuse Center, 2002).

### **Legal/Ethical Reporting Responsibilities**

Counselors are ethically and legally mandated to report suspicions of child sexual abuse to authorities. By 1967, all 50 states had enacted laws that mandated mental health professionals, including counselors, to file reports. Failure of counseling professionals to report suspected cases of child sexual abuse places them at risk for professional and legal sanctions, including fines, license suspensions, jail sentences, and civil suits (Kalichman, 1993).

Mandated reporters are immune from liability when reports are filed in good faith, and when there is no malicious intent, regardless of whether or not abuse is substantiated by investigation (Kalichman, 1993). Reporting suspicions of sexual abuse enables child protection services and/or law enforcement to move toward early intervention. Counselors are not required to assess the probability of sexual abuse or to conduct investigations, which are the legal responsibility of child protective services and/or law enforcement. Under most state statutes, the legal mandate to report must be made by the original observer and cannot be delegated to another person (e.g., clinic director, supervisor, principal). Consequently, reasonable suspicions of child sexual abuse must be reported immediately and directly to child protective services or law enforcement.

### **Prevention and Treatment Strategies**

Supervisors and counselors in all settings can employ the following prevention strategies: (a) insure that counselors receive regular and comprehensive training in identification of child sexual abuse, reporting procedures, and legal and ethical obligations; (b) create awareness and prevention programs for clients, students, and parents; (c) require all counseling staff, parents, and others who provide services to children under the auspices of the counseling agency or school to participate in state and Federal Bureau of Investigation criminal background checks; (d) insure that at least two adults supervise children at all times (80% of child sexual abuse cases occur in single adult/single child situations; Darkness to Light, 2001-2005); (e) carefully monitor child safety in situations where older youth or adolescents supervise younger children; (f) actively support investigative efforts by federal, state, and local law enforcement agencies to combat crimes involving child sexual abuse/exploitation; and, (g) regularly review national, state, and

local laws designed to protect children from sexual crimes (e.g., Megan's Law, Adam Walsh Child Protection and Safety Act).

Counselors must be prepared to treat at least two types of child sexual abuse clients: victims and offenders (with family members comprising a third consideration). Treatment issues for victims typically include anger, trust issues, social withdrawal, self-blame, emotional dysregulation, dissociation, eating disorders, self-injury, and Post-Traumatic Stress Disorder (Budrionis & Jongsma, 2003). Cognitive-behavioral approaches have been reported to "reduce the impact" of (child) sexual abuse (Berliner & Elliot, 2002), and to be more effective than supportive therapy in promoting improvements in children's knowledge about body safety skills (Deblinger, Stauffer, & Steer, 2001). Although treatment is available, among sexually abused children with the greatest needs (i.e., elevated symptomology, poly-victimization, high levels of delinquency), relatively small percentages (less than 23% of 10-17 year olds and no more than 36% of 6-9 year olds) receive counseling services (Turner, Finkelhor & Ormrod, 2007).

Despite the heinous nature of child sexual abuse, offenders have rights to treatment in a counseling relationship characterized by dignity and respect. Common issues in offender treatment include anger, denial, guilt/shame, empathy deficits, cognitive distortions, inadequate relationship skills, legal problems, and relapse prevention (Budrionis & Jongsma, 2003). A meta-analysis by Walker, McGovern, Poey and Otis (2004) revealed cognitive-behavioral therapy to yield the highest effect sizes in the treatment of adolescent sexual offenders, although this was not confirmed by Reitzel and Carbonell's 2006 meta-analysis. Ricci, Clayton, and Shapiro (2006) reported the positive effect of eye movement desensitization reprocessing (EMDR) when used in conjunction with cognitive-behavioral therapy-relapse prevention (CBT-RP). Of common concern to counselors and law enforcement officials is the effectiveness of treatment in reducing recidivism.

### **Implications for Counselor Training**

Training in child sexual abuse is inadequate (Dove, Miller, Miller, & Vieth, 2008). Although ethical and legal mandates to report suspected abuse are typically addressed in counselor education programs, prevention and treatment issues are rarely examined. In order to prepare counselors with the knowledge and skills required to meet professional obligations, counselor educators must provide comprehensive and systematic training in the following areas: (a) signs and symptoms of child sexual abuse; (b) short- and long-term effects; (c) legal and ethical reporting responsibilities; (d) specialized training in assessment, diagnosis, and treatment for both victims and perpetrators; and (e) development of prevention and treatment programs.

Child sexual abuse is a fact of life for millions of American children. Those least able to protect themselves have the weakest voice in ending this violence. In order to stem the tides of suffering and hopelessness created by such abuse, counselors must assume their rightful roles as advocates, prevention specialists, mandated reporters, and treatment experts.

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