ACA-PBs
American Counseling Association Practice Briefs
The Center for Counseling Practice, Policy, and Research
counseling.org/practice_briefs | 703-823-9800 x324

Childhood Sexual Abuse: Treating Children

Victoria Kress and Teresa Burk, Youngstown State University

Description of Child Sexual Abuse

Definition

"There is no universal definition of child sexual abuse. However, a central characteristic of any abuse is the dominant position of an adult that allows him or her to force or coerce a child into sexual activity. Child sexual abuse [CSA] may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include noncontact abuse, such as exposure, voyeurism, and child pornography. Abuse by peers also occurs." ("Understanding Child Sexual Abuse," n.d., para. 1).

Resource: National Child Advocacy Center: http://www.nationalcac.org/

Prevalence

Reported rates of the sexual abuse of children vary widely between studies. A meta-analysis of 331 independent samples with a total of 9,911,748 participants found the global prevalence of child sexual assault to be 11.8%, yet these estimates are widely considered to be an underestimation of the scope of the problem (Stollenborgh, Van Ijzendoom, Euser, & Bakermans-Kranenburg, 2011).

Resource: Statistics on Sexual Abuse:
http://www.childwelfare.gov/can/statistics/stat_sexAbuse.cfm

IDENTIFICATION/ASSESSMENT STRATEGIES

Abuse and traumatic experiences manifest in complex ways in children (Nadar, 2011). Nadar (2011) reported that traumatic events "may disrupt a youth's brain development, developmental skills, talents, personality development, and functioning" (p.163). It is important to note that a history of childhood sexual abuse does not necessarily result in a diagnosis of Post Traumatic Stress Disorder (PTSD); in fact, prevalence rates for PTSD among CSA victims range from 37%-52% (Cummings, Berkowitz, & Scribano, 2012). PTSD symptoms are often measures of internal states, and thus they are difficult to assess especially in younger children (Nadar, 2011). Furthermore, children who experience CSA are more likely to be victims of other types of maltreatment, including verbal, physical, and mental abuse (Cummings et al., 2012). A thorough assessment of the impacts of the abuse and co-morbid issues is a starting place in determining the best course of action in counseling.

Trauma Symptom Checklist for Young Children (TSCYC; Briere et al., 2001)

The TSCYC is 90-item parent/caretaker report that is used with children age 5-12. In addition, it is one of the few norm-referenced measures for children under the age of 7. The checklist includes symptoms related to traumatic exposure with caregivers reporting on a 4-point scale to rate how often each symptom has occurred in the last month. The measure contains 8 clinical scales shown to be associated with exposure of maltreatment: Posttraumatic Stress-Intrusion, Posttraumatic Stress-Arousal, Posttraumatic Stress-Avoidance, Sexual Concerns, Anxiety, Anger/Aggression, and Dissociation. Cost: $230 for the TSCYC Introductory Kit.

Resource: http://www.johnbriere.com/tscc.htm
For Purchase: http://www4.parinc.com/Products/Product.aspx?ProductID=TSCYC

PTSD Symptoms in Preschool Children (PTSD-PAC; Levendosky, Huth-Bocks, Semel, & Shapiro, 2002)

The PTSD-PAC is a standardized measure given to the parent/caregiver and is designed to measure symptoms, based upon the DSM-IV criterion for PTSD, in children 6 years old and younger. In addition, this measure utilizes items that are specifically designed to address the unique expression of arousal symptoms in preschoolers. Cost: Free.

Resource: http://www.infantinstitute.com/MikeSPDF/PPTversion7.pdf
To obtain this instrument, contact Dr. Alytia Levendosky at levendo1@msu.edu

Trauma Symptom Checklist for Children (TSCC; Briere, 1996)

The TSCC is 54-item self-measure intended for children age 7-16. It is used to assess a wide variety of symptoms in children. The instrument consists of 2 validity scales (Under-response and Hyper-response), and 6 clinical scales (Anxiety, Depression, Posttraumatic Stress, Sexual Concerns, Disassociation, and Anger). While the results do not yield a diagnosis of PTSD per se, the measure does provide information related to symptoms of trauma, including sexual trauma. Cost: $172 for the TSCC Introductory Kit.

Resource: http://www.johnbriere.com/tscc.htm
For Purchase: http://www4.parinc.com/Products/Product.aspx?ProductID=TSCC

Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001)

This measure is designed to diagnose PTSD and to indicate the severity of the symptoms in children age 8-18 who have experienced a traumatic event (Gillihan, Aderka, Conklin, Capaldi, & Foa, in press). The CPSS is reported to be one of a small number of instruments that maps directly onto the 17 PTSD symptoms from DSM-IV-TR (Gillihan et al., in press). The instrument has 26 items, with 17 of those designed to specifically identify PTSD symptoms. Of those remaining, 2 are event items and 7 are designed to assess the degree in which the symptoms interfere with level of functioning. Cost: Free.

Resource: http://www.childtrauma.com/mezpost.html#ies8
Per the US Department of Veterans Affairs (http://www.ptsd.va.gov/professional/pages/assessments/cpss.asp), contact Dr. Edna Foa at foa@mail.med.upenn.edu to obtain a copy of the measure.

Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA; Nader, 1996)

The CAPS-CA assesses for PTSD symptoms in youth age 8-18. The measure includes 34 items that are designed to assess the frequency, intensity, and severity of 17 DSM-IV PTSD symptoms. In addition, the measure is designed to determine the effect of the symptoms on the level of coping and functioning, as well as the overall distress experienced. Items are rated on a 5-point scale of intensity and frequency (0= not a problem to 4= a big problem). Cost: $115.50 for the CAPS-CA Introductory Kit.

Resources: http://www.ptsd.va.gov/professional/pages/assessments/caps-ca.asp
To Purchase: http://portal.wpspublish.com/portal/page?_pageid=53,70504&_dad=portal&_schema=PORTAL

EVIDENCE-BASED PRACTICES

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) is currently the only established treatment for child sexual abuse that meets the criteria of being "well-established" (Silverman et al., 2008). This approach is used with children/adolescents age 3-18 and their non-offending parent/caregiver. Cognitive Behavioral Therapy, Behavioral Therapy, and Family Therapy are integrated into the TF-CBT approach. There is a substantial body of recent literature supporting the use of TF-CBT with children (Cary & McMillen, 2012). While the original TF-CBT is a branded intervention, research has indicated that non-branded versions which contain at least 4 of the 5 components of the TF-CBT are effective (Cary & McMillen, 2012). Through TF-CBT, children and caregivers: learn new skills to help them process thoughts and feelings related to traumatic life events, manage and resolve distressing feelings, thoughts, and behaviors that are related to traumatic life events,

and develop an enhanced sense of safety, personal growth, parenting skills, and improved family communication. In assessing the long-term benefits of TF-CBT, Deblinger, Mannarino, Cohen, Runyon, and Steer (2011) reported that treatment gains (i.e., reduction in depressive and anxiety-related symptoms) were maintained at 6 and 12 months post-treatment.

For children who do not have a parent/caregiver willing to participate in treatment, TF-CBT can still be used, but it is less effective when caregivers do not participate in treatment (Deblinger, 1999).

A free 10 hour certificate training program on TF-CBT can be completed through the TF-CBT web (Medical University of South Carolina, 2005). This training program provides an excellent means of deepening one's understanding of CBT treatment principles in general, and trauma-focused treatment in particular. In addition, this training is open to students who are enrolled in a counseling program.

Resources:
Medical University of South Carolina. (2005). TF-CBTWeb: A web-based learning course for Trauma-Focused Cognitive-Behavioral Therapy. Retrieved http://tfcbt.music.edu/
Review of the TF-CBT Literature: http://www.childwelfare.gov/pubs/trauma/trauma.pdf http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3083990/

Cognitive-Behavioral Therapy for Sexually Abused Pre-Schoolers (CBT-SAP)

The Cognitive-Behavioral Therapy for Sexually Abused Pre-Schoolers (CBT-SAP; Cohen et al., 2006) is a modified version of TF-CBT and is geared toward children age 3-6. Cohen and Mannarino (1996) conducted a study comparing this method to non- directive supportive therapy consisting of play therapy. The results indicated that CBT-SAP resulted in a higher degree of improvement.

School-Based Group Cognitive Behavioral Therapy

In typical mental health situations, barriers to treatment completion include: Lack of non-offending caregiver participation, cultural differences, lack of family resources to obtain mental health treatment, and the presence of multiple victims within a household; in addition, mental illness of the non-offending parent/caregiver is often an issue in compliance to treatment for the sexually-abused child (McPherson, Scribano, & Stevens, 2012). These factors, as well as the research showing that a large percentage of children needing mental health services do not receive them, have brought increased attention to the idea of school-based programs (Nadeem, Jaycox, Kataoka, Langley, & Stein, 2011). School-based programs are effective in overcoming many of the aforementioned barriers. Given the divisive racial, cultural, and socio-economic demographic present in most communities, schools serve as entry point where children/adolescents can access treatment, especially group treatment, with peers who are similar to them.

School-Based Group Cognitive Behavioral Therapy has been identified as being probably efficacious in treating posttraumatic stress symptoms, anxiety, and depression (Silverman et al., 2008). While the research is fairly new, completed studies have shown the efficacy of CBT group therapy in reducing children's anxiety, PTSD symptoms and anxiety levels resulting from traumatic events (Manassis et al., 2010).

Resource:
http://www.istss.org/AM/Template.cfm?Section=PTSDTreatmentGuidelines&Template=/CM/ContentDisplay.cfm&ContentID=2330

REFERENCES

Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) Professional Manual.* Odessa, FL: Psychological Assessment Resources.

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E.,...Ernst, V. (2001). The trauma symptom checklist for young children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect, 25*, 1001-1014. Retrieved from http://www.journals.elsevier.com/child-abuse-and-neglect/

Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review, 34*, 748-757.

Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(1), 42-50. Retrieved from ebsco.com

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York, NY: Guilford.

Cummings, M., Berkowitz, S., & Scribano, P. (2012). Treatment of childhood sexual abuse: An updated review. *Current Psychiatric Reports*, *14*(6), 599-607. http://dx.doi.org/10.1007/s11920-012-0316-5

Deblinger, E. (1999). Two-year follow up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse & Neglect*, *23*(12), 1371-1378. Retrieved from www.ebsco.com

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety*, *28*, 67-75. http://dx.doi.org/10.1002/da.20744

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The child PTSD symptom scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology*, *30*(3), 376-384. Retrieved from ebsco.com

Gillihan, S. J., Aderka, I. M., Conklin, P. H., Capaldi, S., & Foa, E. B. (in press). The child symptom scale: Psychometric properties in female adolescent sexual assault victims. *Psychological Assessment*. http://dx.doi.org/10.1037/a.29553

Levendosky, A., Huth-Bocks, A., Semel, M., & Shapiro, D. (2002). Trauma symptoms in preschool-age children exposed to violence. *Journal of Interpersonal Violence*, *17*, 150-164. http://dx.doi.org/10.1177/0886260502017002003

Manassis, K., Wilansky-Traynor, P., Farzan, N., Kleinman, V., Parker, K., & Sanford, M. (2010). The feeling club: Randomized controlled evaluation of school-based CBT for anxious or depressive symptoms. *Depression and Anxiety*, *27*, 945-952. http://dx.doi.org/10.1002/da.20724

McPherson, P., Scribano, P., & Stevens, J. (2012). Barriers to successful treatment completion in child sexual abuse survivors. *Journal of Interpersonal Violence*, *27*(1), 23-39. http://dx.doi.org/10.117/0086260511426466

Nadar, K. (2011). Trauma in children and adolescents: Issues related to age and complex traumatic reactions. *Journal of Child & Adolescent Trauma*, *4*, 161-180. http://dx.doi.org/10.1080/19361521.2011.597373

Nadeem, E., Jaycox, L., Kataoka, S. H., Langley, A. K., & Stein, B. D. (2011). Going to scale: Experiences implementing a school-based trauma intervention. *School Psychology Review*, *40*(4), 549-568. Retrieved from www.ebsco.com

Silverman, W. K., Ortiz, C. D., Wiswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence-Based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology*, *37*(1), 156-183. http://dx.doi.org/10.1080/15374410701818293

Stollenborgh, M., Van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-Analysis of prevalence around the world. *Child Maltreatment*, *16*(2), 79-101. http://dx.doi.org/10.1177/1077559511403920