VISTAS Online
ACA Knowledge Center
counseling.org/knowledge-center/vistas
703-823-9800 x281 | 800-347-6647 x281
By Drs. Garry R. Walz and Jeanne C. Bleuer of Counseling Outfitters, LLC | *Sponsored by the American Counseling Association*

Article 33

Child Sexual Abuse and Rural Areas

Courtney Evans-Thompson, Michael Brooks, and Samantha J. Green

Evans-Thompson, Courtney T., is a doctoral candidate at North Carolina A&T State University. She also works as a clinical counselor specializing in trauma. Her research interests include rural mental health, child sexual abuse, trauma, and eating disorders/behavioral addictions.

Brooks, Michael, is an associate professor at North Carolina A&T State University. He teaches primarily in the PhD program in rehabilitation counseling and rehabilitation counselor education. This program offers a unique focus in trauma and trauma informed care.

Green, Samantha J., is a graduate of North Carolina A&T State University's computational science and engineering master's program specializing in statistical methodology, SAS programming, data analysis, and quality assurance testing

Abstract

Rural populations have certain characteristics and cultural patterns requiring sensitivity and understanding. This study examined child sexual abuse in one rural community by surveying parents of children who were brought into a child advocacy center in a rural county in the mid-Atlantic region of the United States. Several factors were found that might have impacted the experience of child sexual abuse in this rural community. This research provides information to better inform professionals working with child sexual abuse in rural areas.

Keywords: children and adolescents, sexual abuse, trauma, rural, mental health

Child sexual abuse is an epidemic, affecting children of all ages, socioeconomic statuses, and cultural backgrounds; the consequences of child maltreatment can impair both physical and mental health (Modelli, Galvao, & Pratesi, 2012). Child sexual abuse definitions vary across many different resources, disciplines, and laws. For the purposes of this research, child sexual abuse will be defined as a form of child abuse that includes sexual activity with a minor (National Sexual Violence Resource Center, 2012).

Child sexual abuse (CSA) is a covert form of violence severely affecting millions of children's lives; there are as many as 150 million girls and 73 million boys below 18 years of age who experience forced sexual intercourse or other forms of sexual violence each year (World Health Organization, 2006). According to the National Center for Victims of Crime (2012), one in five girls and one in 20 boys are a victim of sexual abuse; over the course of their lifetime, 28% of U.S. youth ages 14 to 17 have been sexually victimized. The World Health Organization (2014) reported approximately one in five women and one in 13 men report having been sexually abused as a child.

Such adverse childhood experiences (i.e., CSA) can impact a child's social, cognitive, and emotional development (Prevent Child Abuse North Carolina, 2016). Many children and adolescents who suffer from CSA are under-treated or never treated at all (Hauenstein et al., 2007). Diagnosing sexual abuse in children can be a challenge due to the fact that physical signs are often not present and even when present, the interpretation of findings is highly variable (Modelli et al., 2012). Understanding risk factors for CSA is a vital part of prevention (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2001; Koss, 1988; National Council on Alcoholism & Drug Dependence, 2015).

For child survivors of CSA, mental health services exist to help with recovery. However, in rural areas, such services may be limited. Burns and colleagues (1995) shared that schools are sometimes the only "mental health system" for many children and adolescents in rural areas. In many rural communities, religion, faith groups, and clergy are the strongest social supports available (Jones, Cassidy, & Heflinger, 2012). Although beneficial, children who have experienced sexual abuse may still be in need of professional counseling services.

In fact, there are many differences between rural versus urban areas (Booth & Evans-Thompson, 2016) that could potentially impact the experiences of CSA. Studies in the past have shown differences in rural versus urban residences and how contextual factors can influence individuals' lived experiences (Smock, McWey, & Ward, 2006). Rural residents can be very different from urban residents; therefore, understanding such differences can be an important part of working with rural CSA survivors.

Factors Applicable to Rural Settings

Rural residents are a diverse group of individuals who live in less developed and populated regions (Booth & Evans-Thompson, 2016). The U.S. Census Bureau (2015) identifies rural areas as those with a population less than 2,500. According to the U.S. Department of Transportation, in 2011, almost 21% (20.78%) of the U.S. population lived in rural areas.

More updated statistics reveal that the number of U.S. residents currently residing in rural areas is at about 19% (The World Bank, 2016). There are multiple stressors unique to rural areas that may impact lived experiences (Booth & Evans-Thompson, 2016). Low employment and educational opportunities, inadequate income, poverty, social isolation, lack of transportation, low quality and lack of childcare, and lack of health care in close proximity (including mental health services) are just a few of the possible strains associated with rural living (Morris, 2006; Sano, Manoogian, & Ontai, 2012; Smalley et al., 2010).

Child Sexual Abuse in Rural Areas

Rates of sexual victimization have also been found to be higher in rural counties when compared to urban counties, with high levels of abuse by perpetrators known to the victim (Ruback & Menard, 2001). Counselors and other service providers working with rural survivors of sexual abuse have expressed concerns regarding confidentiality issues, limited resources, low levels of survivor reporting, resources available in the community (Annan, 2011), the need for additional personnel, lack of training, limited access to care facilities, and difficulties working with law enforcement (Lewis, 2005). Rural survivors of sexual abuse may be less likely to report the abuse as a result of a variety of factors, including the close-knit culture of rural communities, networks of familiarity among residents, lower population density that makes a person more easily noticed, and concern for lack of confidentiality (Lewis, 2003; Zweig, Sayer, Crockett, & Vicary, 2002). Even when a survivor does reach out for help, response times may be slow due to the small size of law enforcement agencies and expansive geographic areas (Averill, Padilla, & Clements, 2007).

Rural sexual abuse survivors have been found to face specific barriers to service utilization including fear of social stigma, self-blaming, caution regarding sharing information with outsiders, fear of gossip, long wait times for police services and mental health counseling, and shortages of professionals who help with sexual abuse in their area (Logan, Evans, Stevenson, & Jordan, 2005). Another factor may be survivor's trust in the legal system. Rosay, Wood, Rivera, Postle, and TePas (2010) showed that if it is the norm for perpetrator prosecution to occur, survivors may be more likely to report because they trust and believe the case will be referred for prosecution.

Findings such as these are important in they carry many implications regarding factors that may combat the survivors' fear of reporting. Of the research the does exist considering rural factors in relation to sexual abuse, the majority focus mainly on statistics regarding prevalence (Ruback & Menard, 2001) and the experiences of service providers (Annan, 2011; Bubar & Bundy-Fazioli, 2011; Lewis, 2005), with little research related to actual experiences of rural sexual abuse survivors.

While most of the research done on sexually abused children has been limited to urban settings, in part, due to the density disparity between the two populations, the aim of this research is to understand the experiences of child survivors of sexual abuse in one rural area in the mid-Atlantic region of the United States. A descriptive design was used for the purposes of this research. A descriptive design is a form of a non-experimental design that is used to provide systematic information and descriptions about a phenomenon (Stevens, 2009) and examine relationships among variables (Barratt & Kirwan, 2009). As a part of this design, quantitative data was used. This research examined factors that may impact rural child sexual victimization.

Methodology

For this study, a survey was used (*Child Sexual Abuse in Rural Areas*), to measure a multitude of factors that may impact child sexual victimization. This survey was designed specifically for this research. The survey assessed many variables, including: gender of survivor, age of survivor when alleged abuse took place, alleged perpetrator, type of sexual abuse, use of alcohol or drugs by the perpetrator or the survivor, who reported, any hindrance in reporting, length of time between incident and report, occurrence of a recant, if alleged perpetrator was prosecuted, obstacles in seeking professional help, if child was referred for counseling, support systems of the survivor, evidence of trauma symptomatology, and overall satisfaction with how the legal systems handled the case.

The *Child Sexual Abuse in Rural Areas* survey has not been used in previous studies, but rather, was created by the researcher in order to measure a multitude of factors that may impact rural child sexual victimization. The questions on the survey were created based upon literary constructs found after reviewing literature regarding sexual assault and literature regarding rural areas. Findings from the literature were incorporated into questions on this survey in order to measure the multitude of factors that influence CSA in rural areas.

The survey was reviewed by a panel of experts on CSA prior to administration to the sample, in order to establish content validity. Content validity addresses the match between test questions and the content or subject area they are intended to assess; experts in a given performance domain generally judge content validity (Collegeboard, 2017). The panel consisted of a forensic interviewer, child counselor, and the coordinator of a child advocacy center. The panel reviewed each item and chose whether to discard, revise, or keep the item. Alternate form reliability was used to establish reliability on the survey portion of the study. To test the reliability of the study measures, some questions asked the same thing but were worded in a different way. Overall, we found a moderately high alternate form reliability, with Pearson r scores ranging from .86 to .94, all at the $p = 0.05$ significance level, therefore, showing good evidence of alternate form reliability.

Participants

The participants in the study were parents/legal guardians who had brought their children (minors) into a child advocacy center (CAC) in a rural city in the mid-Atlantic region of the United States. The participants responded to the survey on behalf of their child/ren with information and current or past symptomatology; this was done due to their status as a minor and the possible psychological repercussions of recalling the traumatic incident/s. A purposeful sample was used in that participants were invited to participate due to certain criteria (i.e., their past experiences with the child advocacy center; Creswell, 2014).

The child advocacy center used in this research conducts approximately 45–50 forensic interviews per year. A random sample of parents/guardians of children who had come to the child advocacy center for a forensic interview in the past 5 years were asked to participate. Of a total of 226 cases that were on the CAC database, a random sample of 100 were contacted to inquire of their willingness to participate. Only two of the 100 individuals whom were contacted did not agree to participate.

Excluding criteria was based upon the child's age and, also, if they were currently using services. If the parent or legal guardian's child was, at the time of the research, 18 years or older, the parents were not eligible to participate in this study (due to the reasoning that these children could have answered for themselves; the majority of responses would be from the viewpoint of guardians, so it was thought best to keep this consistent). Of the 98 individuals who agreed to participate, 52 ($n = 52$) returned the survey completed. Participants in the study were informed that participation was strictly voluntary and informed consent was obtained from participants prior to proceeding with the survey.

Prior to beginning the research, approval from the university's institutional review board was first obtained. After receiving this approval and the final stamped and approved documents, the research began. The link to the survey was e-mailed or mailed, depending on the preference of the individual participants. In order to assure that the designated participant was completing the survey, participants were briefed on the importance of completing the survey themselves. Also, at the top of the survey, there was a disclaimer stating that only the parent or guardian of the child who came to the CAC should fill out the survey.

If the survey was to be mailed, the researchers followed a three-phase administration process to ensure a high response rate. The survey was distributed one week after the initial phone calls were made. The second phase consisted of a postcard follow up sent to all of the members of the sample, approximately 4 to 8 days after the survey was mailed out. The third mailing was sent to all non-respondents and consisted of a personalized cover letter with a handwritten signature, the questionnaire, and a pre-addressed return envelope with postage. If the survey link was e-mailed, a second e-mail follow up was sent to participants approximately 4 to 8 days after the original e-mail.

Results

Analysis revealed that the average age of the survivor when the alleged abuse took place was 8.49 years, with a mode of four years. The majority (71%) of the survivors were female, while 29% were male. Over half (57%) classified the abuse as child sexual offense, 41.18% classified the abuse as rape, and 2% classified the type of abuse as incest.

Drug and/or Alcohol Use

Fisher's exact test (FET) is a statistical significance test used in the analysis of contingency tables; the test is useful for categorical data (Stevens, 2009). It is important to note for interpretation of the results that this specific test only provides a p-value (FET has no formal test statistic and no critical value). As a part of this study, the relationship between drug and/or alcohol use and type of sexual assault was examined. Of child sexual offenses ($n = 30$), 55.17% of individuals reported that the perpetrator used alcohol at the time of the assault; of incest offenses ($n = 1$), no individuals reported that the perpetrator used alcohol at the time of the assault; and of rape offenses ($n = 21$), 19.05% reported alcohol use at the time of the assault. Of cases where the perpetrator used alcohol at the time of the assault ($n = 21$), 80% were child sexual offenses and 20% were rapes. These findings indicate that child sexual offenses are much more likely to involve the perpetrator using alcohol at the time of the assault than other offenses. Results of Fisher's exact testing indicated that the type of assault and the perpetrator's use of alcohol at the time of the alleged abuse had a statistically significant relationship ($p = 0.0126$, FET).

FET also indicated that the type of sexual assault was related to the perpetrator's use of drugs at the time of the alleged abuse ($p = 0.0064$, FET). That is, the rates of alcohol use and drug use were significantly different across the type of sexual assault. Of child sexual offenses ($n = 30$), 58.62% of participants indicated that they do not know whether or not the perpetrator used drugs at the time of the alleged offense; 31.03% of participants reported that the perpetrator was not using drugs, and 13.46% reported that the perpetrator used drugs at the time of the abuse (n = 7). Of incest cases (n = 1), all participants indicated that the abuser was not using drugs at the time of the offense. Of rape cases (n = 21), 14.29% indicated that they do not know if drug use occurred at the time of the offense, 66.67% indicated that there was no drug use at the time of the offense, and 19.05% of participants indicated that the perpetrator used drugs at the time of the offense. That is, participants who classified the assault as a child sexual offense reported not knowing whether drugs were used at a higher rate while participants who classified the abuse as rape or incest reported that drugs were not used during the assault at a higher rate.

Child's Relationship to Abuser

About two thirds (67.31%) of participants reported that the alleged abuser was a family member, 21.15% reported that the alleged abuser was a boyfriend or girlfriend of the caregiver, and 11.54% reported the alleged abuser to be a stranger or other. There was no significant relationship found between the abuser's relationship to the survivor and the type of abuse; that is, there were no differences in the percentages of perpetrator type (family member, boyfriend/girlfriend of caregiver, stranger or other) across the type of assault (child sexual offense, incest, rape). It is important to note that the categorization of "other" was created for those participants who did not describe the alleged perpetrator as a family member, boyfriend/girlfriend of caregiver, or stranger.

Reporting of abuse. A majority of the participants (76.92%) indicated that the abuse was reported by the survivor while 7.69% indicated that the abuse was accidentally discovered by an adult, and 15.38% indicated that the abuse was reported in another way. Those who responded "other" (n = 8) were asked to explain who reported the abuse, and 40% of explanations referred to the child's grandmother, 40% referred to a friend of the child, and 20% referred to a neighbor. There is a statistically significant relationship between type of perpetrator and the child's willingness to disclose the abuse ($p = 0.0009$, FET). Findings indicate that children are much less willing to disclose the abuse if the abuser is family member or boyfriend/girlfriend of caregiver than if the abuser is a stranger or other. Results also suggest that those who experienced a hindrance to reporting the abuse (n = 35) also experienced disturbances to their day-to-day functioning following the abuse ($p < 0.0001$, FET). All participants who indicated a hindrance to reporting the abuse (n = 17) also indicated disturbances to daily functioning, and a majority (63.64%) of those who experienced disturbed daily functioning (n = 21) also experienced hindered reporting of the abuse.

Recants. There was a statistically significant relationship between the type of perpetrator and whether or not the accusations of abuse were recanted after the report was made ($p < 0.0001$, FET). No participants who described the perpetrator as stranger (n = 6) or other (n = 1) indicated a recant. Of those describing the perpetrator as family member (n = 35) or a boyfriend/girlfriend of caregiver (n = 10), 72.73% indicated a recant. Of participants who recanted (n = 11), 17.27% classified the perpetrator as an acquaintance, 21.31% classified the perpetrator as a boyfriend/girlfriend of caregiver, and 51.43% indicated that the perpetrator was a family member. As such, this is strong evidence to support that recants are much more likely to occur when the perpetrator is a family member or a boyfriend/girlfriend of the caregiver to the survivor than when the perpetrator is a stranger or other.

Prosecution of Perpetrators

Of those who responded that the perpetrator is well known (n = 28), 66.67% reported feeling that this influenced both the reporting of the abuse and the legal proceedings that took place after the allegations. Of perpetrators that were not well known in the community (n = 24), 55.81% were prosecuted, while 44.19% were not prosecuted. Of perpetrators that were well known in the community, 100% were not prosecuted. Of all participants surveyed, 46.15% reported that the alleged abuser was prosecuted. Of perpetrators that were prosecuted, none were well known in the community.

Mental Health Disturbance and Counseling

Of all child sexual offense cases reported among the participants (n = 30), 55.17% of survivors experienced disturbances to their day-to-day functioning following the abuse, while 44.83% did not; additionally, 88.46% of survivors were referred for counseling and 11.54% were not. There were no significant differences in the referral rate across types of assault. Almost all survivors who were referred (n = 46) participated in counseling (94.23%), while only 5.77% did not. Of participants who did not participate in counseling, either because they weren't referred (n = 6) or they were referred and did not participate (n=8), all experienced disturbances to their day-to-day functioning. All participants who did not experience disturbances to their daily functioning (n = 16) had participated in counseling.

Additionally, there may have been a relationship between the survivor's participation in counseling and whether or not the survivor used coping strategies to help with the repercussions of the abuse ($p = 0.0602$, FET). Of those who did not participate in counseling (n = 14), none used coping strategies, while 63.27% of individuals who participated in counseling used coping strategies.

Seeking Help

When asked if they faced any barriers surrounding seeking professional help for the abuse, 71.43% of participants reported they did not experience any barriers while 28.57% reported facing barriers to seeking professional help for the abuse. Participants were also asked to indicate potential supports that they felt helped the survivor (these supports were based on findings from past literature surrounding common supports in rural areas [Pullman, VanHooser, Hoffman, & Heflinger, 2010]); participants selected an average of 2.81 supports with a minimum of one and a maximum of six. Most (80.77%) indicated close family as a support system that helped the survivor, while 53.85% indicated church, 46.15% indicated counseling, 42.31% indicated friends, 36.54% indicated religion, and 9.62% indicated sports and recreational activities as a support system that was helpful to the survivor following the abuse.

Discussion

This study reveals some factors associated with CSA in one rural community, which may have implications for other rural communities in the United States. Results show that, among the participants in this rural sample, the majority were female. This is consistent with past research that reports slightly higher rates of sexual victimization among female children as compared to male, although male children are also sexually abused at a disturbing rate (National Center for Victims of Crime, 2012; World Health Organization, 2006).

Results of this study also revealed that the type of CSA was related to perpetrator use of alcohol and/or drugs. This is in accordance with previous literature showing a relationship between alcohol and/or drug use and rape (Abbey et al., 2001; Koss, 1988; National Council on Alcoholism and Drug Dependence, 2015). With factors such as low educational attainment, concentrated poverty, unemployment, high-risk behavior, and isolation contributing to increased alcohol and drug use in rural areas (Rural Health Information, 2016), understanding victim susceptibly when exposed to alcohol and drug use is vital.

Furthermore, this research found that many survivors delay reporting the abuse. Reporting was delayed in all cases in which the perpetrator was well known in the community, which is a common occurrence in rural areas (Lewis, 2003). Previous research by Ruback and Menard (2001) also described the notion that rural areas with high levels of sexual abuse by perpetrators well known in the community had lower levels of reporting of the crime.

Additionally, the majority of participants indicated that the perpetrator was a family member or boyfriend/girlfriend of the caregiver. Previous research has also found increased risk of sexual abuse in dysfunctional families (Yen et al., 2008) with particularly high levels of sexual victimization by abusers well known to the victims in rural communities (Ruback & Menard, 2001). Also, survivors in the sample were less likely to report if the perpetrator was a family member or boyfriend/girlfriend of the caregiver (versus the perpetrator being a stranger or other), implying pressure that may be put upon rural survivors of sexual abuse when they know the perpetrator.

This research also showed a strong relationship regarding the likelihood of the child to recant (or take back the accusations) if the perpetrator was well known to the child. Alarmingly, there were a large amount of recants from children for whom the alleged perpetrator was a boyfriend/girlfriend of the caregiver or a family member (with no reported recants among children whose alleged perpetrator was a stranger or other). Past research has described that rural survivors of sexual abuse may be less likely to report as a result of knowing the perpetrator and networks of familiarity among the community (Lewis, 2003).

In addition to affecting the likelihood of recanting, the perpetrator being well known in the community may have other effects. Many participants (guardians/caregivers of the children) reported that they felt that because the perpetrator was well known in the community, they were less likely to be prosecuted. Results of the survey showed that of perpetrators that were well known in the community, 100% were not prosecuted and of perpetrators that were prosecuted, none were well known in the community. Previous research has suggested that the "know everyone" mentality associated with this rural culture could affect prosecution (Averill et al., 2007).

In relation to child mental health, it seems that many children were referred to counseling if they experienced disturbances in their daily functioning following the abuse. Children who were not referred for counseling also indicated experiencing disturbances in their daily functioning, revealing that maladaptive adjustment and trauma symptomatology is often not readily visible. This is consistent with previous research regarding the lack of physical and emotional symptoms in children who have experienced sexual abuse (Modelli et al., 2012).

Of those children who were referred to counseling, those who participated in counseling used coping strategies much more than those who did not participate in counseling. All of those who had reported no disturbances to their daily functioning also reported that they had participated in counseling, highlighting the potential benefits of mental health care. Additionally, all children who used coping strategies to deal with their abuse had also participated in counseling. This highlights the important benefits counseling can bring for children who have experienced such abuse.

Contextual factors (i.e., rural residence) that could affect help-seeking behaviors were also considered. Being the sample resided in a rural area, it was hypothesized there would be common barriers surrounding seeking professional help for the sexual abuse (Morris, 2006; Sano et al., 2012; Smalley et al., 2010). On the contrary, a small amount of participants reported facing barriers to seeking such professional help, but multiple supports among this rural sample were endorsed.

Conclusions

Several factors were found that may have impacted the experiences of CSA in this rural community. First, this research supports previous statistics showing gender differences in rates of CSA (National Center for Victims of Crime, 2012). However, the high rates of CSA, both male and female, are still a concern in both rural and urban areas.

This study found that type of sexual abuse was related to the perpetrators use of alcohol and/or drugs at the time of the alleged abuse. Also standing out, the majority of participants reported that the alleged abuser was known to the survivor. Children in this sample were much less likely to disclose the abuse if the abuser was well known to them versus being a stranger. As for prosecution of perpetrators, slightly under half of alleged perpetrators were prosecuted (it is important to note that some of these cases were still awaiting trial, due to the overcrowding of court cases in this rural county). The majority of participants in this study reported that they felt that the alleged perpetrator being well known in the community affected the prosecution.

This research also vividly reveals the positive effects counseling can make on rural CSA survivors, with just about all child survivors who participated in counseling reportedly using coping strategies to help deal with the aftermath of the abuse. Consistent with hypotheses and previous research were the types of supports most frequently endorsed (Jones et al., 2012). These results shed light on supports that are influential in the lives of rural residents (i.e., close family, church, counseling, friends, religion, and/or recreational activities). Mental health professionals working with this clientele should consider rural specific supports to enhance survivors' recovery.

Implications for Counseling

The findings show the importance of understanding risks regarding the exposure of children to adults under the influence and also how alcohol and/or drugs may exacerbate such risks. With high rates of alcohol use and a drug epidemic occurring in rural areas (Rural Health Information, 2016), this information is important in highlighting the risks associated with exposing children to adults under the influence of alcohol or drug use. For counselors working with children exposed to adults under such influence, safety protocols on behalf of the child (e.g., safety planning) are imperative.

Other variables emerged in this study that carry additional implications. Understanding survivors' reluctance to report is vital in order to reduce sexual abuse among children. Reasons for recants dependent upon relationships are suspected to be due to pressure from family members, feelings of guilt, etc. In rural areas, pressure of "knowing everyone" and networks of familiarity among survivors and perpetrators (Ruback & Menard, 2001) may decrease willingness to come forward. The power of the survivor's voice can be his or her ultimate "weapon" of defense against further abuse. Counselors working with child survivors of sexual abuse in rural areas should consider such enmeshed relationships and how such variables may ultimately impact the "voice" of the child survivor. Also, in working with children who have come forward under such circumstances, the counselor should commend the child, thus instilling encouragement for a valiant act.

This study revealed several other relationships of importance to counselors serving this population. This research has important implications regarding participants' perceptions of justice in rural areas. As mentioned in previous literature, if it is the norm for perpetrator prosecution to occur, survivors may be more likely to report (Rosay et al., 2010). This is especially important in rural areas, with rural survivors of sexual abuse being less likely to report as a result of knowing the perpetrator and networks of familiarity among the community (Lewis, 2003). Counselors working with child survivors of sexual abuse should advocate for the client (e.g., proving information about legal aid, etc.) in order to encourage the survivor's resilience in the face of obstacles.

Following the reporting of CSA, a mental health assessment should ensue to identify any post-trauma symptoms and stressors and to also provide psycho-education about CSA and safety planning (Medical University of South Carolina, 2005). Although rural areas oftentimes face a shortage of mental health providers (Burns et al., 1995), mental health care is vital for children experiencing CSA. These findings suggest that participating in counseling plays a crucial role in determining whether or not the survivor's daily functioning will be impaired following sexual abuse. This shows the vitality of mental health care for children in learning to cope with, and thus recover from, the abuse.

Although many supports were endorsed by participants for helping the child recover and cope after the incident, it is also important to understand that these findings were from the viewpoint of guardians and not the children themselves. These results seemingly carry positive implications regarding the infrastructure and ability of this rural area to adequately handle such cases. However, professionals working with this population should always use an individualized approach to treatment. Although indicated as a support, not all choices may truly be perceived as supportive by the child survivor of sexual abuse, but rather, perceived this way by the caregiver participating.

Treatment and professional help should ensue, utilizing an individualized approach to care. Overall, by understanding the rural culture, including their support systems, the stress and/or trauma associated with sexual abuse can be tackled more efficaciously through recommendation of the use of already intact support systems for coping resources.

Strengths and Limitations

Strengths of this research include that it is one of the only known to the researcher that investigates CSA specific to rural areas. While previous research has considered sexual abuse in rural areas, the main focus is on statistics regarding prevalence (Ruback & Menard, 2001) and interviewing mental health professionals/service providers (Annan, 2011; Lewis, 2005). This research went beyond prevalence reporting and interviewing mental health professsionals. Instead, the guardians of the child survivors of sexual abuse were provided the chance to respond to the situations surrounding the abuse. Although this research did include statistics regarding prevalence rates, it went further by describing relationships between certain variables, which are implicative for future action.

One limitation of this research is that the sample was from one small rural county in the United States. More research is needed so the research is inclusive of other rural areas. Future research should also use qualitative research to examine the lived experiences of survivors (for more detailed, narrative descriptions of lived experiences).

Also, the survey that was used in this study was created by the researcher and has not been used in the past. Overall, there was a moderately high alternate form reliability, with Pearson r scores ranging from .86 to .94, all at the $p = 0.05$ significance level, therefore showing good evidence of alternate form reliability. More research regarding the validity and reliability of this survey could be done to further develop this into an instrument.

Lastly, this study is limited in that the answers were from the viewpoint of the survivor's guardians. It should be taken into account that these results are from a secondary source, not the survivors themselves. Although a limitation, such precautions were take due to the victims' status as minors and the possible psychological repercussions.

Future Research

While virtually all sexual assault research has focused almost exclusively on urban areas, by further understanding rural child sexual victimization, counselors and mental health professionals can better understand what specific characteristics exist that may influence sexual assault in rural areas and work more efficaciously with this vulnerable population. Counselor educators can provide effective multicultural education regarding the specificities of rural culture deserving clinical attention. Future research should use qualitative research to obtain more narrative data of the participants. Also, research should focus on ways to efficaciously improve services rendered to rural populations, considering their vulnerabilities.

References

Abbey, A., Zawacki, T., Buck, P., Clinton, M., & McAuslan, P. (2001). Alcohol and sexual abuse. *Alcohol Research & Health*, *25*(4), 43–51.

Annan, S. L. (2011). “It’s not just a job. This is where we live. This is our backyard.”: The experiences of expert legal and advocate providers with sexually abused women in rural areas. *Journal of the American Psychiatric Nurses Association*, *17*(2), 139–147. doi:10.1177/1078390311401024

Averill, J. B., Padilla, A. O., & Clements, P. T. (2007). Frightened in isolation: Unique considerations of sexual assault and interpersonal violence in rural areas. *Journal of Forensic Nursing, 3*(1), 42-46. doi: 10.1111/j.1939-3938.2007.tb00091.x

Barratt, H., & Kirwan, M. (2009). *The design, applications, strengths, and weaknesses of descriptive studies and ecological studies.* Retrieved from http://www.healthknowledge.org.uk/public-health-textbook/research-methods/1a-epidemiology/descriptive-studies-ecological-studies

Booth, C. S., & Evans-Thompson, C. (2016). Rural families. In J. Carlson & S. Dermer (Eds.). *The SAGE encyclopedia of marriage, family, and couples counseling*. 1430-1432. New York, NY: Sage.

Bubar, R., & Bundy-Fazioli, K. (2011). Unpacking race, culture, and class in rural Alaka: Native and non-native multidisciplinary professionals’ perceptions of child sexual abuse. *Journal of Ethnic and Cultural Diversity in Social Work*, *20*, 1–19. doi:10.1080/15313204.2011.545941

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., & Erkanli, A. (1995). Children’s mental health service use across service sectors. *Health Affairs*, *14*, 147–159.

Collegeboard. (2017). *Validity evidence.* Retrieved from https://research.collegeboard.org/services/aces/validity/handbook/evidence

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed design approaches.* Thousand Oaks, CA: Sage Publications.

Hauenstein, E., Petterson, S., Rovnyak, V., Merwin, E., Heise, B., & Wagner, D. (2007). Rurality and mental health. *Administration and Policy in Mental Health and Menal Health Services*, *34*(3), 255–267.

Jones, D. L., Cassidy, L., & Heflinger, C. A. (2012). “You can talk to them. You can pray.” Rural clergy responses to adolescents with mental health concerns. *Rural Mental Health*, *36*, 24–33.

Koss, M. P. (1988). Stranger and acquaintance rape: Are there differences in the victim’s experience? *Psychology of Women Quarterly*, *12*(1), 1–24.

Lewis, S. (2003). *Sexual abuse in rural communities.* Harrisburg, PA: VAWnet, A Project of the National Resource Center on Domestic Violence/ Pennsylvania Coalition Against Domestic Violence. Retrieved from http://vawnet.org/sites/default/files/materials/files/2016-09/AR_RuralSA.pdf

Lewis, S. (2005). *Unspoken crimes: Sexual abuse in rural America.* Enola, PA: National Sexual Violence Resource Center. Retrieved from http://www.nsvrc.org/publications/nsvrc-publications/unspoken-crimes-sexual-assault-rural-america

Logan, T. K., Evans, L., Stevenson, E., & Jordan, C. E. (2005). Barriers to services for rural and urban survivors of rape. *Journal of Interpersonal Violence*, *20*, 591–616.

Medical University of South Carolina. (2005). *Trauma-focused cognitive behavioral therapy.* Retrieved from https://tfcbt.musc.edu/

Modelli, M. E., Galvao, M. F., & Pratesi, R. (2012). Child sexual abuse. *Forensic Science International*, *217*, 1–4.

Morris, J. (2006). Rural marriage and family therapist: a pilot study. *Contemporary Family Therapy*, *28*(1), 53–60. doi:10.1007/s10591-006-9694-3

National Center for Victims of Crime. (2012). *Child sexual abuse statistics.* Retrieved from https://www.victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics

National Council on Alcoholism and Drug Dependence. (2015). *Alcohol, drugs, & crimes.* Retrieved from https://www.ncadd.org/about-addiction/alcohol-drugs-and-crime

National Sexual Violence Resource Center. (2012, August). *Understanding child sexual abuse definitions and rates.* Retrieved from http://www.nsvrc.org/sites/default/files/NSVRC_Publications_TalkingPoints_Understanding-Child-Sexual-Abuse-definitions-rates.pdf

Prevent Child Abuse North Carolina. (2016). *ACE study statistics.* Retrieved from https://www.preventchildabusenc.org/about-child-abuse/ace-study

Pullman, M. D., VanHooser S., Hoffman, C., & Heflinger, C. A. (2010). Barriers to and supports of family participation in a rural system of care for children with serious emotional problems. *Community Mental Health Journal*, *46*, 211–220. doi:10.1007/s10597-009-9208-5

Rosay, A. B., Wood, D., Rivera, M., Postle, G., & TePas, K. (2010). Investigation and prosecution of sexual assault, domestic violence, and stalking. *United States Department of Justice.* Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/236429.pdf

Ruback, R. B., & Menard, K. S. (2001). Rural-urban differences in sexual victimization and reporting: Analysis using UCR & crisis center data. *Criminal Justice and Behavior*, *28*, 131–155.

Rural Health Information. (2016). *Substance abuse in rural areas.* Retrieved from https://www.ruralhealthinfo.org/topics/substance-abuse

Sano, Y., Manoogian, M. M., & Ontai, L. L. (2012). "The kids still come first": Creating family stability during partnership instability in rural, low-income families. *Journal of Family Issues*, *33*(7), 942–965. doi:10.1177/0192513x11430820

Smalley, K. B., Yancey, C. T., Warren, J. C., Naufel, K., Ryan, R., & Pugh, G. L. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology*, *66*, 479–489. doi:10.1002/jclp.20688

Smock, S. A., McWey, L. M., & Ward, D. B. (2006). Rural versus urban clinical needs: Are there differences? *Journal of Family Psychotherapy*, *17*(2), 37–49. doi:10.1300/J085v17n02_03

Stevens, J. P. (2009). *Applied multivariate statistics for the social sciences.* New York, NY: Routledge.

U.S. Census Bureau. (2015). *Urban and rural classification.* Retrieved from https://www.census.gov/geo/reference/urban-rural.html

U.S. Department of Transportation. (2011). *Census issues: U.S. populations living in urban vs. rural areas.* Retrieved from http://www.fhwa.dot.gov/planning/census_issues/archives/metropolitan_planning/cps2k.cfm

The World Bank. (2016). *Rural population data.* Retrieved from http://data.worldbank.org/indicator/SP.RUR.TOTL.

World Health Organization. (2006). *Global estimates of health consequences due to violence against children.* Geneva, Switzerland: Author.

World Health Organization. (2014). *Child maltreatment*. Retrieved from http://www.who.int/mediacentre/factsheets/fs150/en/

Yen, C. F., Yang, M. S., Yang, M. J., Su, Y. C., Wang, M. H., & Lan, C. M. (2008). Childhood physical and sexual abuse: Prevalence and correlates among adolescents living in rural Taiwan. *Child Abuse and Neglect*, *32*, 429–438.

Zweig, J. M., Sayer, A., Crockett, L. J., & Vicary, J. R. (2002). Adolescent risk factors for sexual victimization: A longitudinal analysis of rural women. *Journal of Adolescent Research*, *17*, 586–203.

Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://www.counseling.org/knowledge-center/vistas