Child Adolesc Psychiatr Clin N Am. Author manuscript; available in PMC 2015 Apr 29.
Published in final edited form as:
Child Adolesc Psychiatr Clin N Am. 2014 Apr; 23(2): 321–337.
doi: 10.1016/j.chc.2014.01.003

PMCID: PMC4413451
NIHMSID: NIHMS666885
PMID: 24656583

Child Sexual Abuse

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Keywords: Child sexual abuse, Prevalence, Treatment

Sexual abuse toward children and adolescents is a stark reality worldwide. A common misperception about child sexual abuse (CSA) is that it is a rare event perpetrated against girls by male strangers in poor, inner-city areas. To the contrary, CSA is a much too common occurrence that results in harm to millions of children, boys and girls alike, in large and small communities, and across a range of cultures and socioeconomic backgrounds. These acts are perpetrated by many types of offenders, including men and women, strangers, trusted friends or family, and people of all sexual orientations, socioeconomic classes, and cultural backgrounds.[1]

PHENOMENOLOGY AND DEFINITIONS

CSA encompasses many types of sexually abusive acts toward children, including sexual assault, rape, incest, and the commercial sexual exploitation of children. Although there are some differences among these, the unifying term of “child sexual abuse” is used throughout this article to describe commonalities across these experiences. There are many definitions of CSA in use, each of which may have subtle differences in coverage or terminology that influence surveillance and reporting efforts, and potentially lead to different policy, service, or legal implications. According to the US Centers for Disease Control and Prevention (CDC), child sexual abuse is “any completed or attempted (noncompleted) **sexual act, sexual contact** with, or exploitation (ie, **noncontact** sexual interaction) of a child by a caregiver.”[2] The CDC provides specific definitions for each of the boldface terms, distinguishing sexual acts as those involving penetration, abusive sexual contact as intentional touching with no penetration, and noncontact sexual abuse such as exposing a child to sexual activity, taking sexual photographs or videos of a child, sexual harassment, prostitution, or trafficking.[2] The World Health Organization (WHO) defines CSA as:

The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials.[3]

Of note, these definitions include as CSA acts that both do and do not involve physical touching or physical force, including completed sex acts, attempted sex acts, abusive sexual touching, and noncontact assaults such as harassment, threats, forced exposure to pornography, and taking unwanted sexual images, such as filming or photography. In some instances, the recipient may not be aware of their own victimization, or that violence has been perpetrated against them. This breadth of scope reflects the recognition that imposing sexual intent of any sort on someone against his or her will is an inherently violent act, regardless of the use of physical force or resulting contact or injury. These definitions also raise the important consideration of consent, and identify categories of people who are unable to consent or resist because of age, disability, state of consciousness or intoxication, or fear of harm to self or others.

Because a legal age of majority is required for consent, all sexual acts between an adult and underage child (even with child assent) are, by definition, CSA. The United Nations Children's Fund (UNICEF) endorses the Council of Europe's definition of child sex abuse, which includes activities involving a child under the legal age as provided by national law, as well as sexual activities with children that involve coercion, abuse of a position of trust or influence, or exploitation of a vulnerable or dependent child.[4] Additional acts of CSA toward children involve the sexual exploitation of children through prostitution or abusive images; profiting from or any role in the facilitation, observation, or exploitation of a child's involvement in sexual performances; causing a child to witness sex abuse or sex acts; and child solicitation.[4]

EPIDEMIOLOGY

Accurate measurement of the prevalence of childhood CSA is made difficult by several methodological issues. Definitions of CSA typically vary across studies, such as in terms of the age used to define childhood, whether an age difference is specified, or if peer abuse is included, as well as the types of acts considered as sexual abuse (eg, both contact and noncontact). Decisions of sample selection (eg, convenience or probability sampling), survey methods (face-to-face interviews or self-administered questionnaires), and number and detail of screening questions also all influence the resulting prevalence estimates.[5]

Most prevalence surveys rely on adult retrospective reporting and may be subject to recall bias, while objective informant observations are likely to underreport because of the large proportion of CSA that goes unseen. The WHO 2002 *World Report on Violence and Health* suggests that cases reported to authorities may reflect a more physically violent subset with injuries requiring treatment, as these cases are less easily hidden. It likens the magnitude of CSA or sexual violence to an iceberg, in which only the smallest portion is reported to authorities, a larger yet still incomplete portion is reported on surveys, and an unquantifiable amount remains unreported because of shame, fear, or other factors.[6]

Feelings of guilt and shame, such as perceptions of responsibility for the abuse, lack of honor, and loss of self-worth, influence disclosure.[7–9] Other studies have also found inverse associations between disclosure and the severity of abuse, with children more likely to disclose noncontact abuse than contact abuse.[10]

With these considerations in mind, several studies have been undertaken to document the prevalence of CSA in countries around the world. The 2006 *World Report on Violence against Children*[11–14] provided estimates that in 2002 approximately 150 million girls and 73 million boys were subject to contact CSA worldwide, including 1.2 million trafficked children and 1.8 million exploited through prostitution or pornography.

In the United States, a population-based sample of face-to-face interviews with more than 34,000 adults found that 10% of respondents reported experiencing contact CSA before age 18 years, 25% of whom were men.[15] A nationally representative study using telephone-based interviews with 4549 children and their caregivers reported that 6.1% of children had been victims of CSA (contact and noncontact) in the past year and 9.8% in their lifetime; when looking only at adolescents aged 14 to 17 years, these numbers escalated to 16.3% and 27.3%, respectively.[16]

Two recent meta-analyses of global prevalence studies produced strikingly similar estimates. The first analysis included 65 articles involving 37 male and 63 female samples across 22 countries, totaling more than 10,000 individuals. Definitions of CSA in the studies varied, with an upper age limit ranging from 12 to 17 years and approximately two-thirds of the studies including noncontact CSA. The investigators reported a combined mean prevalence of CSA in 7.9% of males and 19.7% of females, with the highest rates occurring in Africa and the lowest in Europe.[17]

The second analysis included data from 331 studies representing nearly 10 million individuals.[18] In this analysis, the total combined prevalence was 11.8%, with 7.6% of males and 18% of females reporting experiences of CSA. In this analysis, Asia reported the lowest combined prevalence for both boys and girls, while Africa had the highest prevalence for boys and Australia the highest prevalence for girls. This analysis also compared informant with self-report studies, and found that informant studies produced a much more conservative estimate of 0.4%, compared with 12.7% when assessed via self-report.

RISK FACTORS

Childhood sexual abuse often occurs alongside other forms of abuse or neglect, and in family environments in which there may be low family support and/or high stress, such as high poverty, low parental education, absent or single parenting, parental substance abuse, domestic violence, or low caregiver warmth.[15,19] Children who are impulsive, emotionally needy, and who have learning or physical disabilities, mental health problems, or substance use may be at increased risk.[19,20] The risk of CSA also appears to increase in adolescence.[16,20]

Out-of-home youth may be particularly at risk for CSA, initially as a condition that leads to their out-of-home status and later as a consequence of situations such as violent street life.[21–23] These youth may be exploited and forced to trade sex for survival needs such as food, shelter, money, or drugs.[24] In many countries, children in conflict with the law may be at risk of abuse by authorities both on the street and in detention; when detained, they may also be inappropriately housed with adults and made vulnerable to CSA and exploitation.[25]

Children living in conflict and postconflict environments are also at increased risk for CSA, attributable to the breakdown of normal protective structures or the use of CSA as an act of war.[26–28] Some of the children at particular risk in these settings are un-accompanied children who have been separated from their families and may lack adequate protection; children in detention; child soldiers; adolescents; children with disabilities; working children; adolescent mothers, who may lack support or resources; and children born of rape, who may be cast aside by their communities.[29]

FACTORS INFLUENCING DISCLOSURE

Experiences of childhood CSA often go undisclosed and unrecognized. A review of the literature[10] reveals the many factors that inhibit disclosure. In addition to being developmentally vulnerable, children are often manipulated to feel guilty or responsible for the abuse. These children may fear the disclosure will not be believed, or that it will negatively affect their own well-being and that of their families. Moreover, they may be concerned about consequences for the perpetrator, as often the perpetrators are familiar figures who develop complex, confusing, and ambivalent relationships with the child.

A study by Kogan[30] involving a subset of 263 adolescent girls from a nationally representative sample in the United States showed that younger children were not likely to disclose CSA immediately, whereas children aged 7 to 13 years were most likely to tell an adult within a month, and older adolescents were more likely to tell their peers. Kogan hypothesized that adolescents may be more aware of the potential negative reactions of family members; this may be a particular concern when the perpetrator is known to the family, as a close or familial relationship with the perpetrator decreased the likelihood of disclosure. In this sample, girls who feared for their lives or experienced penetration were more likely to tell an adult, suggesting that seeking protection or requiring medical treatment likely influences disclosure.

Priebea and Svedinb[31] sought to explore variables influencing disclosure in a population-based sample of 4339 high school seniors of both sexes in Sweden. In the total sample, 65% of the girls and 23% of the boys reported experiencing CSA. The investigators suggested that the high prevalence may be due to better recall of youth in comparison with adults, as well as a definition that included peer abuse. Of those who had experienced CSA, most youth (81% of girls and 69% of boys) reported disclosing the abuse to someone; however, approximately 40% of the youth talked about their experience only to a same-aged peer, whereas only 8.3% had spoken to a professional, and even fewer (6.8%) said their experience had been reported to social services or police. Contrary to the previous findings, in this study youth who had experienced greater severity of abuse were more likely to feel they could not talk to anyone about the abuse, and they were less likely to talk to a parent or family member. Factors associated with lower disclosure for girls included experiencing contact versus noncontact abuse, single versus multiple instances of abuse, a known abuser rather than a stranger, and perceiving their parents as noncaring. For boys, lower disclosure was associated with attending a vocational program rather than a traditional high school, living with both parents, and perceptions of parents as over-protective or not caring.

Other factors, such as culture and gender, may also influence willingness to report experiences of CSA. Fontes and Plummer[32] presented a thoughtful analysis of the many ways that decisions to disclose CSA are influenced by the social and cultural context, noting that although no one value is exclusive to a particular culture, issues and values may weigh differently in different cultures and influence the ability to disclose. The investigators provided several examples of potential barriers to disclosure, including of the roles of modesty; taboos and shame; sexual scripts that normalize CSA (eg, it is

normal for men to want sex, so abuse is a girl's fault for tempting a man); the emphasis on virginity and honor; girls' reports of CSA being discounted as fabricated because of their lower status within a community; fear that disclosure would lead to obligations to avenge lost honor through further violence; respect for elders and filial piety; the influence of religious beliefs and teachings; and structural factors such as language barriers and immigration status.

With respect to gender, Romano and De Luca[33] summarized research suggesting several reasons why boys may be less likely than girls to report these experiences. These investigators described how female sexual abuse is more widely recognized and screened for, leading to higher reporting; along this same line of thought, boys may be more reluctant to seek support owing to gender norms reinforcing self-reliance, which in turn leads to a continued underestimation of the problem of male CSA. Boys may also experience more confusion about the abuse; they may mistakenly believe that admitting CSA by male perpetrators would mean that they are homosexual; and they may be confused as to whether sexual acts with an older person are abusive because of their visible physiologic responses, emotional grooming by the abuser, and some societal views that sexual exploration with someone not much older than them is a neutral or even a positive experience, rather than potentially traumatic experience.

COURSE AND OUTCOMES

The heterogeneity of definitions of child sexual abuse is also reflected in the widely varied reactions, ranging from severe psychological impact to no evidence of negative psychological sequelae.[34] For those who are affected, the mental health effects of childhood sexual abuse are varied.[35] Child survivors of sexual abuse are at increased risk for anxiety, inappropriate sexual behavior and preoccupations, anger, guilt, shame, depression, posttraumatic stress disorder (PTSD), and other emotional and behavioral problems throughout their life span.[36–40] Research shows that survivors of child sexual abuse are more likely to experience social and/or health problems in adulthood, such as alcohol problems, use of illicit drugs, suicide attempts, and marriage/family problems.[41] Numerous studies show that CSA survivors are vulnerable to later sexual revictimization in both adolescence and adulthood.[42,43] Finally, CSA has a clear correlation with high-risk sexual behaviors (eg, multiple sexual partners) and may have a connection with later abuse on others.[44–46] The effects of CSA are often compounded by other types of co-occurring abuse and dysfunction, producing a cumulative effect on risk factors for negative health outcomes, including adult diseases such as heart, lung, and liver disease, and cancer.[47] Although much of this literature focuses on the outcomes for girls, a meta-analysis of the impact of childhood CSA on boys shows similar outcomes.[46] Although the design limitations in CSA research often preclude causal inference, twin studies have demonstrated that the association between CSA and such adverse health outcomes is independent of other risk factors in the home environment.[48]

Although survivors of CSA are at risk of poor health outcomes, these outcomes are not fixed. Factors supporting healthier outcomes include self-esteem and social support from family and peers, as well as family expressiveness and cohesion, whereas family conflict negatively affects resilience. In fact, some literature suggests that social support and family characteristics may be more influential than particular risk factors or characteristics of the experienced abuse in determining resilience.[49–51]

SYSTEMS INVOLVEMENT

There are numerous systems involved after a child experiences sexual abuse, which may include Child Protective Services (CPS), police, legal teams, medical teams, other child protection agencies, foster care and child welfare agencies, and/or residential treatment facilities. CPS is generally responsible for

the investigation of and intervention in cases of suspected sexual abuse whereby the offender is in a caretaking role for the child. Law enforcement agencies are usually responsible for the investigation of cases involving offenders in non-caretaking roles. However, CPS are often involved in situations where the perpetrator is not the caregiver, but the child's caretaker fails to protect the child. On receiving a report, CPS conduct an investigation, within a specified time frame (typically within 24 or 48 hours or up to 5 days) to determine whether abuse has occurred. The child usually participates in an interview conducted either by CPS alone or CPS in conjunction with law enforcement. The length and number of interview sessions may vary depending on the case, age of the child, and who is interviewing (eg, the skill and years of experience of the interviewer). A child who has been sexually abused also usually receives a medical examination, ideally by a professional who specializes in CSA evaluations.[52] In the case of recent abuse or concern of injury, it is important that this examination be conducted as soon as possible, and in accordance with established forensic practice. Caregivers and family members are also interviewed. These results are provided to CPS, law enforcement, and often a legal team. There are 2 or 3 courts that are potentially involved in a sexual abuse case: the Juvenile Court, responsible for child protection; the Criminal Court, responsible for offender prosecution; and/or the Family Court.

CPS ultimately determine whether the abuse is likely to recur in the future and whether the child's safety can be ensured in the home (the first choice). If CPS determine that the child is not safe within his or her own home, they may suggest removal of the child and placement with a relative or a foster family, or in some cases a residential treatment facility if there is more severe symptomatology. Efforts may also include removing the offender from the home.

Many of these agencies are involved in specific tasks, many of which are short term. However, sexual abuse is usually not a short-term problem, and requires different interventions at different times. Thus, the coordination of multiple services is important to ensure the long-term protection and healing of the child. Some communities have set up multidisciplinary teams and links between agencies[53,54] that serve to coordinate care. In other communities, services are poorly integrated. How child protection systems and legal institutions need to respond is discussed in the WHO World Violence Report,[6] with key recommendations highlighting the need for better assessment and monitoring, better response systems, policy development, better data, documentation of effective responses, and improved training and education for professionals. There are additional guidelines for best practices in investigating allegations of CSA that highlight agencies and processes commonly used, such as medical providers, forensic interviewing, and psychosocial evaluations.[55] Online resources and research publications discuss the challenges of responding to and evaluating CSA cases, such as nondisclosure of abuse by family members or the child, difficult decisions of whether to remove a child from a home, and again the complicated process of coordinating the multiple agencies involved.

THERAPEUTIC STRATEGIES

Treatment of a child and familial system after sexual abuse is multifaceted and generally requires a biopsychosocial approach. Depending on the presence and extent of physical injury, medical professionals may be involved in ongoing treatment. Children and their caretakers (family or foster caretakers) are usually assigned a case manager. The role of a case manager is to link the child and family to necessary services, and continue to assess need. Case managers often help the family connect with medical and mental health services, as well as any legal or court appointments. This article focuses on the mental and behavioral health of the family and child after sexual abuse.

There is a growing evidence base of effective psychotherapeutic treatments for sexually abused children and their families. Unfortunately, it is common for sexually abused children to have other types of traumatic experiences; for example, being removed from their home, witnessing domestic violence, and experiencing multiple instances of sexual abuse, physical abuse, and/or neglect.[37,47,56] Most of the treatment studies conducted have included populations with multiple traumatic experiences and/or a particular diagnosis common after trauma (eg, PTSD).[37] A recent Cochrane review examined the effectiveness of psychological therapies in treating children and adolescents who have been diagnosed with PTSD.[57] Fourteen randomized controlled trials (RCTs) were included, totaling 758 participants who had experienced sexual abuse, civil violence, natural disaster, domestic violence, and motor vehicle accidents. The therapies used in these 14 studies were: (1) cognitive-behavioral therapy (CBT); (2) exposure-based; (3) psychodynamic; (4) narrative; (5) supportive counseling; and (6) eye-movement desensitization and reprocessing (EMDR). Most compared a psychological therapy group with a control group, showing significant improvement across symptoms of PTSD, depression, and anxiety. Of therapies assessed, CBT was shown to have the greatest efficacy, with significant improvement and lower PTSD symptoms documented for up to a year following treatment. Depression scores were also lower with CBT treatment, and no adverse effects were identified. For narrative therapy and EMDR, this review reported no statistically significant difference in PTSD or depression symptom scores in comparison with controls. A review by Silverman and colleagues[58] also evaluated RCTs of psychosocial treatments for children exposed to traumatic events.[59,60] Results showed that trauma-focused cognitive-behavioral therapy (TF-CBT) was the only treatment that met criteria for a "well-established treatment, based on Chambless and colleagues'[60] categories of evidence." School-based group CBT[61,62] was determined to be "probably efficacious," and 7 other treatments (resilient peer treatment, family therapy, client-centered therapy, cognitive-processing therapy, child-parent psychotherapy, CBT for PTSD, and EMDR) were classified as "possibly efficacious."

TF-CBT is one of the most rigorously evaluated treatments for CSA.[63] TF-CBT is a hybrid model that integrates elements of exposure-based, cognitive-behavioral, affective, humanistic, attachment, family, and empowerment therapies into a treatment designed to address the unique needs of children with problems related to traumatic life experiences such as sexual abuse. This treatment was developed to ideally include both the child (aged 3–18 years) and a supportive caregiver, in weekly parallel sessions. Eight components are delivered and practiced over a period of approximately 12 to 16 weeks. The components of TF-CBT include: (1) psychoeducation; (2) relaxation; (3) affective modulation; (4) cognitive processing; (5) trauma narrative (gradual exposure) and cognitive restructuring of the trauma; (6) in vivo desensitization; (7) conjoint parent/child session; and (8) enhancing safety skills. Although the treatment is designed with specific components, each with a set of goals, TF-CBT is highly flexible in meeting the individual presentation of symptoms and the needs of different children and families.

Multiple RCTs have demonstrated TF-CBT to be a highly effective treatment for the sequelae of child trauma exposure, including depression, anxiety, and PTSD symptoms.[64,65] Many of these RCTs had clear inclusion criteria of a sexual abuse experience,[64,66–71] although many of the children had experienced multiple traumas. Follow-up studies demonstrated sustained benefit at 6 months, 1 year, and 2 years after treatment.[68,72,73] Recent RCTs, quasi-experimental trials, and open trials included children exposed to multiple traumatic events.[74–76] There is also a growing body of literature on the implementation of TF-CBT for youth with ongoing traumas.[77–79] TF-CBT has been adapted and used effectively with a variety of populations including Latino youth,[80] Native American youth,[81] and orphans and vulnerable children in Zambia.[82,83] Research suggests broad applicability and acceptability among ethnically diverse therapists, children, and parents.[84,85]

Dissemination and Implementation

Research shows that despite high rates of CSA and known negative sequelae, many children who have experienced sexual abuse either do not receive treatment or receive treatment that has not proved to be effective.[86,87] The wide-scale dissemination and implementation (D&I) of evidence-based treatments (EBT) is an area of high interest, and is also wrought with many challenges.[88] For example, effective D&I usually requires ongoing, multilevel strategies across numerous partnerships (eg, trainers, providers, organizations, policy-makers) that can be expensive and time-consuming. Some studies have sought to identify specific barriers to D&I of EBT to guide the use of specific strategies. Barriers may include clinician attitudes toward EBT, contextual or institutional factors (eg, organizational culture and climate, leadership), client attitudes, and population characteristics.[89] Another barrier to D&I of EBT is the cost of training and ongoing supervision, especially with attrition. Research has begun to lay out various strategies that can be helpful with D&I.[90] For example, training accompanied by regular supervision and/or consultation has been found to be effective with community mental health professionals trained in manualized treatments.[91–93]

Although the D&I of effective treatments for CSA is a challenge, some notable progress has been made. For example, the National Child Traumatic Stress Network[94] was established by the US Congress in 2000 with the mission of raising the standard of care and increasing access to effective treatment for children who have experienced traumas such as CSA. More recently, increasing numbers of state-wide initiatives to implement treatments for sexual abuse, such as TF-CBT, are showing positive results and are overcoming some common D&I challenges.[95–97]

These initiatives demonstrate different strategies used for D&I, and discuss important successes and lessons to help in future endeavors. One reoccurring challenge is gaining buy-in from therapists to complete the entire training process. Strategies used to aid in this include more careful identification of practitioners most likely to complete and use an EBT, offering additional consultation call and advanced training opportunities for clinicians, and varying call times to help with difficult schedules. Most groups found it important to match the national certification in TF-CBT with state requirements as another incentive. Strategies used to disseminate and effectively implement EBT have included a combination of assessing organizational readiness, live training sessions, and ongoing consultations. Another key strategy that has seen success across many states is the use of learning collaboratives, an approach using groups within an organization to study and adapt implementation practices to capitalize on shared learning and collaboration. It is clear that different strategies and approaches are needed for varying contexts and settings, and ideally EBT should be provided during graduate school to truly produce a readily trained workforce of mental health professionals proficient in evidence-based trauma treatments.

Intrafamilial Sexual Abuse

CSA committed by someone within the family is often cited as a particular challenge. In these cases, it is usually more common that a child needs to be removed from the home for some time, along with any siblings. These family systems often undergo stress during investigations. There is some research suggesting that children abused by someone within the family represent a distinctly different group from those abused outside the family. Distinct features may include an increased guilt about and/or reluctance to disclose abuse[98,99] and a higher likelihood of recantation.[100] There may be coercion from caregivers to recant and/or change a disclosure, and often there is significant financial stress

introduced into family systems when the breadwinner is forced out. There is also some evidence to suggest that children who have experienced intra-familial abuse show less improvement following therapy[101] and may be more subject to the cumulative impact of polyvictimization,[37] owing to exposure to both sexual and emotional abuse. However, most treatment studies do not distinguish between those abused within the family or by someone outside the family, creating challenges in truly teasing out the differences.

Cultural Considerations in CSA Populations

Some publications discuss concern about the cross-cultural sensitivity and applicability of EBT.[102,103] Culturally competent treatment has been emphasized in several published guidelines.[104–106] Some challenges to better understanding the cross-cultural effectiveness include low minority recruitment in clinical trials, uncommon examination of culture as a moderator of treatment, limited descriptions of culturally modified changes to treatment, and cultural validity of treatment outcome measures. Nevertheless, a recent review found that some trauma-focused treatments were probably efficacious for ethnic minorities.[84] The three treatments include: (1) TF-CBT; (2) the Fostering Individualized Assistance Program (FIAM),[107] which is an individualized case management intervention; and (3) cognitive-behavioral intervention for trauma in school (CBITS).[62] Although challenges remain and more studies are needed, Huey and Polo[84] recommended using an existing EBT for ethnic minorities rather than unstudied treatments.

Fewer evaluations of child and adolescent EBT for sexually abused populations have been conducted globally. A recent, small-scale RCT assessed group-based TF-CBT with war-affected, sexually exploited girls in the Democratic Republic of Congo.[108] Compared with a wait-list control condition, TF-CBT participants had significantly greater reductions in traumatic stress symptoms and other psychosocial difficulties. Researchers noted a mean decrease of 22.5 symptoms from pretest to posttest in the treatment group, compared with a mean increase of 2.6 symptoms in the control group ($P<.001$). An open trial of TF-CBT in Zambia demonstrated the feasibility of integrating TF-CBT into existing human immunodeficiency virus (HIV) care systems (eg, hospices, HIV-centered clinics), with promising clinical outcomes.[82] Of particular interest may be the specific modifications across cultures made to TFCBT, which were conceptualized as alterations in technique rather than changes in core components or goals of the treatment.[83] There is also growing evidence from research in global mental health as a whole that with careful adaptation to local context, EBTs developed in high-income settings can be feasibly, acceptably, and effectively delivered in low-resource settings with different cultural backgrounds.[109]

SUMMARY

CSA is truly a global problem, often defying myths and stereotypes, and it does not appear to be decreasing over time. There are many different definitions of CSA, adding to the challenges of measurement, assessment, and treatment. Globalization and modern technology may increase the risk of abuse and exploitation, but may also offer opportunities to strengthen our responses, particularly in areas of lower resources. It is clear that CSA is associated with the risk of negative psychosocial and health outcomes, but processes of resilience have also identified several protective factors (eg, family support, parent-child relationships, social support) that could be strengthened through prevention and early intervention efforts.

Several therapies have been shown to be efficacious in treating the psychological sequelae of CSA.[58] The results of treatment studies are encouraging, as many include youth from high-stress homes and foster care systems, and those who have experienced polyvictimization. Results suggest that a wide range of symptoms are decreased, including individual symptoms of PTSD, depression, anxiety, and behavioral problems, as well as family and relationship problems. At present, there is a shift from developing new treatments toward moving effective treatments from the laboratory to real practice settings with wider-scale D&I. This agenda raises its own set of challenges regarding flexibility and fidelity: the delicate balance of staying true to an evidence-based model and assuring that it meets the needs of diverse populations and settings.[110] Future research must examine the barriers and facilitators within D&I efforts, and evaluate various strategies to improve reach and uptake.

KEY POINTS

- Child sexual abuse (CSA) is truly a global problem, often defying myths and stereotypes, and does not appear to be decreasing over time.
- There are many different definitions of CSA, adding to the challenges of measurement, assessment, and treatment.
- Globalization and modern technology may increase the risk of abuse and exploitation, but may also offer opportunities to strengthen our responses, particularly in areas with lower resources.
- Several therapies have been shown to be efficacious in treating the psychological sequelae of CSA.
- The results of treatment studies are encouraging, as many include youth from high-stress homes and foster care systems, and those who have experienced polyvictimization.
- Results suggest that a wide range of symptoms are decreased, including individual symptoms of posttraumatic stress disorder, depression, anxiety, and behavioral problems, as well as family and relationship problems.
- At present, there is a shift from developing new treatments toward moving effective treatments from the laboratory to real practice settings with wider-scale dissemination and implementation.
- Future research must examine the barriers and facilitators within efforts at dissemination and implementation, and evaluate various strategies to improve reach and uptake.

Acronyms

CBITS	Cognitive-Behavioral Intervention for Trauma in School
CBT	Congnitive behavioral therapy
CDC	Centers for Disease Control and Prevention
CPS	Child Protective Services
CSA	Child sexual abuse D&I Dissemination and Implementation
EBT	Evidence-based treatments
EMDR	Eye movement desensitization and reprocessing
FIAM	Fostering Individualized Assistance Program
RCTs	Randomized controlled trials
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Footnotes

The authors have no conflict of interest.

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