2011

An Analysis Of Trauma Narratives Perceptions Of Children On The Experience Of Sexual Abuse

Jennifer Marie Foster
University of Central Florida

AN ANALYSIS OF TRAUMA NARRATIVES: PERCEPTIONS OF CHILDREN ON THE EXPERIENCE OF SEXUAL ABUSE

by

JENNIFER MARIE FOSTER
B.A. Cedarville University, 2002
M.S. Palm Beach Atlantic University, 2007

A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the College of Education
at the University of Central Florida
Orlando, Florida

Spring Term
2011

Major Professors: W. Bryce Hagedorn
Monifa G. Beverly

ABSTRACT

Child sexual abuse (CSA) is estimated to affect 1 in 4 girls and 1 in 6 boys before the age of 18 (Centers for Disease Control and Prevention, 2005). Despite the prevalence of sexual abuse and frequent negative outcomes for child victims as well as adult survivors, little is known about CSA from the perspective of the child. To date, the vast majority of research has targeted adults. Studies conducted on children are mostly quantitative and have explored the effectiveness of various treatment interventions. To address the gap in the research literature, the present study investigated the perspectives of children on sexual abuse through thematic analysis of trauma narratives, which were written by children as a therapeutic intervention and described life prior to, during, and following sexual abuse.

Analysis of 21 trauma narratives selected through purposive sampling revealed one meta-theme, which was titled Fear and Safety. Children's descriptions of past and current fears as well as concerns about their safety and the safety of others were evident throughout all sections of the narratives. Three themes also emerged from the analysis: (1) Memories of the Abuse, (2) The Disclosure and Subsequent Events, and (3) The Healing Journey. The first theme, Memories of the Abuse, included three subthemes: descriptions of the sexual abuse, details about the perpetrators, and children's thoughts and feelings about the abuse. The second theme, The Disclosure and Subsequent Events, included three subthemes: perceptions of the abuse disclosure, experiences during the investigation, and experiences with the justice system. The third theme, The Healing Journey, also resulted in three subthemes: experiences in counseling, how life had changed, and future hopes and dreams. The themes are discussed, and ramifications for prevention efforts, treatment of child victims of sexual abuse, and counselor preparation are

explored. Additionally, implications of the present study for counselors and community members are delineated. Finally, recommendations are made for future research with child victims of sexual abuse.

This dissertation is dedicated to my mom. You are the most courageous, beautiful person that I know. I cannot thank you enough for the many ways that you have shown your love and support for me. I love you.

ACKNOWLEDGMENTS

First and foremost I give glory to God for giving me the strength and perseverance to complete this research. Without Him, my life would lack purpose, meaning, and direction. He has given me a passion to be a voice for child victims of trauma. It is my desire to live out the words of Isaiah 1:17: “Learn to do right! Seek justice, relieve the oppressed, and correct the oppressor. Defend the fatherless; plead for the widow” (Amplified Bible). It is my prayer that the present study would not only inform the field of counseling but lead to the protection of children and the healing of victims of sexual abuse.

I want to express my gratitude to my chairpersons, Dr. W. Bryce Hagedorn and Dr. Monifa Beverly. Dr. Hagedorn, I appreciate you guidance, feedback, and encouragement. Your edits have helped improve my writing and my study. I also appreciate your example as a Christian in higher education. You have been an incredible role model for me. Dr. Beverly, your wealth of knowledge of qualitative research methods helped me conceptualize my research questions and study design. From the very start you saw the value of this research and encouraged me throughout the process. You are also a role model for me and have given me an excellent example to follow as someone who is balancing the roles of wife, mother, and professor. To my other committee members, Dr. David Carson and Dr. E.H. “Mike” Robinson, your support has made such a difference. Dr. Carson, you were the first person who encouraged me to consider continuing my education beyond the master's degree and expressed your belief in my abilities. Dr. Robinson, I am grateful for the opportunity to work with you as a research assistant. I have learned so much from you. Throughout this process, I was able to rely on all of

my committee members' wealth of experience and research expertise, which helped me design a research study that I can be proud of.

Ryan, my wonderful husband, thank-you for believing in me and for all the sacrifices you have made to make my dream of earning a doctorate degree possible. I am so blessed to have you in my life. I look forward to our future together. I love you.

To my sweet baby Savannah Grace, thank-you. You too have been an important part of this journey. You inspire me and give me the passion to conduct research that will lead to the protection of children. It is hard for me to put into words just how much I love you.

I also wish to express my gratitude to my sisters, Sarah and Emily, and to my parents. You have been my cheerleaders (I can still hear you saying "Go Jenny!"). Every day I realize I am so blessed to have you in my life. You have believed in me and my dream. Your phone calls, visits, and unwavering support have kept me moving forward.

My good friends and cohort members are also deserving of recognition. You each have made my life better. You brought me joy and support. My life would not be the same without each of you in it. I am glad we have had this time together.

I must also thank my faithful cat Ginger who sat next to me, on my lap, on top of my books, and at times draped over my arm while I typed. You kept me company and helped relieve my stress. I miss you.

Lastly, I wish to thank the partnering agency for your assistance with this research project. I am grateful for the time and effort each of you put into this study. Most of all, this research would not have been possible without the children who found the courage to share their story. This dissertation is for you and for those whose stories remain untold.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE: THE PROBLEM AND ITS UNDERLYING FRAMEWORK

Overview

Current statistics estimate that 1 out of 4 girls and 1 out of 6 boys will be sexually abused before the age of 18 (Centers for Disease Control and Prevention, 2005). According to the National Child Abuse and Neglect Data System (U.S. Department of Health & Human Services [DHHS], 2009), a total of 65,964 children were reported as sexual abuse victims in the United States in 2009; 26 of the reported cases of sexual abuse ended in the child's death. Child sexual abuse (CSA) is a pervasive societal problem (Nkongho, 2006) that frequently results in negative outcomes for child victims and the potential for continued challenges in adulthood (Briere, 2002; Wolf, Reinhard, Cozolino, Caldwell, & Asamen, 2009). As a result of trauma, many children experience social, cognitive, academic, physical, spiritual, and emotional difficulties (Goldfinch, 2009; Tomlinson, 2008). Additionally, the abusive experience often hinders children's growth and development (Cicchetti & Toth, 2006; Goodman, Quas, & Ogle, 2010) and increases the risk for mental health disorders (Briere & Lanktree, 2008). Research has estimated that approximately half of children who experience sexual abuse develop severe psychiatric symptoms and disorders such as Posttraumatic Stress Disorder (PTSD) (Adler-Nevo & Manassis, 2005). Additional mental health challenges facing child victims of abuse include: depression, anxiety, eating disorders, personality disorders, dissociation, and substance abuse (Briere & Lanktree, 2008). According to Briere and Lanktree (2008), victims may also have difficulty regulating emotions and may exhibit aggressive behavior. The authors also noted that distorted

cognitions, self-injurious behaviors, relational problems, and participation in unsafe sexual activities are common problems faced by child sexual abuse victims.

The devastating effects of CSA are not limited to childhood; its impact can be long reaching, often continuing into adulthood. Unresolved sexual trauma in adults frequently leads to intrapersonal and interpersonal difficulties that negatively impact general health and wellbeing (Parker, Fourt, Langmuir, Dalton, & Classen, 2007). The experience of sexual trauma in childhood can result in adult psychosis and poor functioning in various domains (e.g., psychological, social, and occupational) (Cohen, Mannarino, & Knudsen, 2005; Lataster et al., 2006). A meta-analysis conducted on adult survivors of childhood victimization found an increased risk of anxiety disorders, depression, Posttraumatic Stress Disorder (PTSD), suicide, substance abuse, and personality disorders (including anti-social personality disorder and borderline personality disorder) (Chapman, Dube, & Anda, 2007). CSA survivors were also at risk for eating disorders, sexual disorders, dissociative disorders, and self-mutilation, (Cole, Sarlund-Heinrich, & Brown, 2007). Bradley and Davino (2002) concluded that three out of four incarcerated women with a CSA history experienced further physical and/or sexual victimization in adulthood. Additionally, research has indicated that unresolved child sexual trauma can increase the likelihood of engaging in prostitution (Parillo, Freeman, Collier, & Young, 2001; Vaddiparti et al., 2006), which increases the risk of sexually transmitted diseases such as HIV (Greenberg, 2001). Prostitution and substance abuse often result in legal consequences for sexual abuse victims; therefore, it is not surprising that a high number (59%) of incarcerated women have a CSA history (Browne, Miller, & Maguin, 1999). Clearly the consequences of unresolved trauma are great for adult survivors of CSA.

Statement of the Problem

The literature as cited above has documented the potential for both immediate negative consequences for child victims and long term poor outcomes for adult survivors of CSA. The cost to individuals, families, and communities is great. Data gathered from multiple sources indicates that the direct (e.g., hospitalization, mental health care system, child welfare services, and law enforcement) and indirect (e.g., special education, juvenile delinquency, mental health and health care, adult criminal justice system, and lost productivity to society) costs of child maltreatment is estimated to be $103.8 billion dollars annually (Wang & Holton, 2007). Despite the considerable economic costs, they pale in comparison to the immediate and long term negative outcomes experienced by victims of sexual abuse.

In order to address the problem of sexual abuse, one must understand the experience through the eyes of the child victim. Currently, the experience of the child victim is almost completely missing from research in the field of counseling. The literature lacks insight into how children's experiences are similar or dissimilar to adult victims of CSA (Nkongho, 2006). Basing our knowledge of children's experiences on adults' memories is problematic. To start, adults are removed from the event in terms of time, which is likely to impact their memory of the experience as well as their emotional response. Another limitation to applying what is known about adults' experiences to child victims is that adults possess a higher level of cognitive functioning which effects how they view and interpret events. A child and adult may view the same situation very differently due to their cognitive development. The differences between children and adults are vast. The only way to understand the experience of the child is to view the abuse through their eyes.

Despite these significant differences between children and adults, nearly all studies on the topic of CSA consider only the adult victims' perspective. There is a dearth of research on how children perceive their abuse experiences (McGregor, Thomas, & Read, 2006; Nkongho, 2006; Sar, Akyuz, Kugu, Ozturk, & Ertem-Vehid, 2006; Urman, Funk, & Elliot, 2001; Walker, Reid, O'Neill, & Brown, 2009). In fact, an extensive review of the literature did not locate any studies that had analyzed children's written descriptions of their abuse in the form of trauma narratives in order to uncover their perceptions of the abuse experience. Child victims' thoughts, feelings, and beliefs about their abusive experiences, themselves as victims, their perpetrators, and others involved such as family members or counselors are largely unknown.

The lack of research with children may be due to obstacles that prevent or limit research on traumatized children. Such challenges include children's reluctance to discuss their abuse with researchers, the difficulty of attaining consent to conduct interviews with child victims, and strict research guidelines (Chu, DePrince, Weinzierl, 2008; Walker et al., 2009). The lack of research results in an extremely limited ability to understand how children perceive life before, during, and after sexual abuse. Despite the challenges, it is necessary to understand how children perceive their traumatic experiences.

The current inability to comprehend child victims' experiences may hinder CSA prevention efforts; whereas, an increased understanding of children's experiences with their perpetrators will likely aide prevention programs and decrease the number of sexual crimes against children. For the children who have already experienced abuse, effective and developmentally appropriate interventions are needed to address current symptoms and decrease the potential for adverse outcomes in adulthood (Adler-Nevo & Manassis, 2005). Many of the

current therapeutic interventions rely solely on research that has been conducted with adult clients reflecting on their CSA experiences. In order to create developmentally sound interventions, the perspective of the child victim must be considered.

Along with the need to improve intervention programs and treatment is the need to train current and future counselors to address the needs of CSA victims. Many professionals state that they feel unprepared to meet the needs of child sexual abuse victims (Winkelspecht & Singg, 1998). Not only do those in the counseling field need to be informed about CSA, community members also need to understand the experience of victims in order to put prevention and intervention efforts into place to reduce the incidence of child sexual abuse and to assist victims. In order for these changes to take place, researchers, counselors, students, and community members must understand CSA from the perspective of the child victim.

Purpose of the Study

The purpose of the study was to explore children's (ages 6-17) descriptions and perceptions of childhood sexual abuse (CSA) through a qualitative analysis of trauma narratives. One of the more widely used therapeutic interventions with victims of CSA, trauma narratives are written descriptions of the abuse that are completed during the counseling process (Cohen & Mannarino, 2008). Utilized within the framework of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidenced-based treatment (Cohen & Mannarino, 1996, 1997; Cohen et al., 2005; Silverman et al., 2008) approved by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2008), trauma narratives are designed to uncover children’s perspectives of their CSA, including life prior to, during, and after the abuse experience. The

study specifically examined the content of these narratives in order to identify themes from the perspective of the child victim, rather than from the perspective of adult victims, which has been the former standard (Walker et al., 2009). Understanding child victims' experiences will assist in child sexual abuse prevention efforts and the creation of treatment and prevention protocols that are based on children's developmental understanding of their trauma. The information attained will also be beneficial in educating practicing counselors, supervisors, and counselors-in-training. The perspectives of children on their abuse experiences will lead to a new understanding that will potentially permeate the field of counseling as well as communities locally and nationally.

Rationale for the Research Approach

This study addressed the gap in the research by investigating children's perspectives of CSA. This was achieved through an analysis of trauma narratives received from a local community agency serving child victims of sexual abuse and their nonoffending parents or caregivers. The narratives serve as a method to access the world of the child that may otherwise be prevented due to stringent research protocols with children (as noted above). The narratives were de-identified by the agency to protect the confidentiality of all participants. Only demographic information was collected including: (a) age at time of treatment, (b) age at time of the abuse, (c) gender, (d) ethnicity, (e) reported family income, (f) relationship to the perpetrator, and (g) diagnosis.

A qualitative approach was utilized in this study to investigate child sexual abuse from the perspective of child victims. Narratives allowed the researcher to gather data that described

the lived experiences of participants (Creswell & Miller, 2009). The underlying principle for this research was the presupposition that individuals are shaped by their life experiences, which results in a unique worldview. Children who have experienced CSA have been altered by the abusive events in their lives. Although each child victim possesses a different experience, it was hypothesized that commonalities would emerge as a result of the data analysis. The goal was to uncover themes of CSA through the collection of multiple narratives.

Research Questions

The following research questions guided the study:

1. How do children express their thoughts, feelings, and beliefs about their life prior to, during, and after sexual abuse in the form of trauma narratives?
2. What themes emerge from childhood accounts of CSA from a trauma narrative intervention that can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members?

Significance of the Study

There is a dearth of research in the area of sexual abuse from child victims' perspectives (McGregor et al., 2006; Nkongho, 2006; Sar et al., 2006; Urman et al., 2001; Walker et al., 2009). Specifically, information about sexual abuse from child victims close to the time of the trauma is almost nonexistent in the counseling literature and would be valuable to know (Walker et al., 2009). Understanding sexual abuse from the perspective of the child using existing data in the form of trauma narratives has numerous implications for CSA prevention efforts, treatment

of child victims, preparation of clinicians and counseling students, the counseling field, and communities both locally and nationally. These implications are discussed briefly in this chapter, followed by a more in-depth discussion in Chapters Two and Five.

First, the information gathered from the analysis of trauma narratives can inform child sexual abuse prevention programs. Understanding children's experiences before, during, and after the abuse is an important step in decreasing the prevalence of child sexual abuse. The children's narratives may include descriptions of perpetrator's grooming behaviors, children's signs and symptoms of abuse, and the challenges of disclosure, which would be significant components to include in comprehensive educational programs. Such programs may decrease the occurrence of CSA, increase children's disclosure of abuse, and assist parents or caregivers in responding in a healthy and productive manner to disclosure (Wurtele, 2009).

Another implication of this study is that the themes uncovered from the trauma narratives may lay the ground work for developmentally appropriate treatment methods. According to Adler-Nevo and Manasis (2005), developmentally sensitive counseling interventions are needed for children who have experienced trauma. Trauma often hinders children's ability to complete developmental tasks, which negatively impacts their current mental health and may hinder future adult functioning (Chapman et al., 2007). Furthermore, reactions to CSA vary depending on children's developmental stages and impact their response to treatment (Feather & Ronan, 2009). Therefore, children's perspectives of the abuse experiences must be understood in order to provide interventions that account for children's developmental levels. The creation of developmentally based treatment approaches may help counselors intervene with CSA victims.

Timely, age-appropriate methods will likely improve children's mental health and potentially decrease problems frequently experienced by abuse survivors in adulthood.

An additional implication of this study is its usefulness in training current and future counselors to work with children and adults who have experienced childhood sexual abuse. Given the prevalence of CSA (Centers for Disease Control and Prevention, 2005) and high rates of adult survivors seeking mental health treatment (Read, Goodman, Morrison, Ross, & Aderhold, 2004), proper training is necessary for counselor competence in the provision of services to victims of CSA. Specifically, counselor educators and supervisors could utilize the information to help students empathize with the experience of the child, understand the numerous ways in which CSA can impact normal growth and development (Chapman et al., 2007; Goodman et al., 2010; Reyes & Asbrand, 2005), and learn how unresolved trauma may negatively impact adults (Bradley & Davino, 2002; Browne et al., 1999; Chapman et al., 2007; Cohen et al., 2005; Cole et al., 2007; Greenberg, 2001; Lataster et al., 2006; Parillo et al., 2001; Parker et al., 2007; Vaddiparti et al., 2006).

Furthermore, the current study can further the field of counseling as it is the first known research study to examine the perceptions of children as recorded in trauma narratives about sexual abuse that are written during the counseling process. As mentioned previously, research is especially difficult to conduct due to research restrictions with children, who are a protected population because of their vulnerability and risk for retraumatization (Walker et al., 2009). Through the use of existing data in the form of trauma narratives, this study utilized a noninvasive method of accessing children's perspectives on trauma, which eliminated the risk of harm that could occur in other forms of research such as extensive interviews. Trauma narratives

allow those in the field of counseling to begin to understand how children experience and perceive their sexual abuse.

Lastly, the information derived from the study can be communicated to community members at a local and national level to partner in efforts to decrease the prevalence of CSA and improve services for victims. In sum, the study is significant for numerous reasons, including implications for prevention of CSA, treatment of child victims, preparation of current and future counselors, and education in the counseling field as well as communities both locally and nationally.

Definition of Terms

The following terms are defined as they apply to the current study.

Child sexual abuse is defined by federal legislation in the Child Abuse Prevention and Treatment Act (CAPTA), which was amended and titled the Keeping Children and Families Safe Act of 2003 [42 U.S.C.A. §5106g(4)] as:

> (a) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or (b) the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Grooming is defined as methods used by perpetrators to earn trust and keep children involved in sexual acts; common strategies for such manipulation include giving the victim gifts or special privileges, which is often a confusing experience for the child victim (Lanktree & Briere, 2008).

Trauma is defined as "the realization of one's worst fears, the experiences that every human being would never want to have" (Klempner, 2000, p. 77).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a treatment strategy designed for children who have experienced trauma, including child sexual abuse. It is based on principles from cognitive behavioral therapy and includes a family therapy component. TF-CBT targets trauma symptoms, dysfunctional thoughts, and the child victim's fears (Cohen, Mannarino, Berliner, & Deblinger, 2000).

Trauma Narratives are written descriptions of the sexual abuse that are completed in counseling. The trauma narrative format utilized by the partnering community agency is organized into eight chapters: (a) Life Before the Abuse, (b) The First Time the Abuse Occurred, (c) My Worst Memories, (d) The Disclosure, (e) The Investigation and Court, (f) How My Life has Changed, (g) My Counseling Experience, and (h) My Hopes and Dreams. For a complete description of trauma narratives and TF-CBT, please see the manual created by the Child Sexual Abuse Task Force and Research and Practice Core, National Child Traumatic Stress Network (NCTSN, 2004). A more in depth discussion of TF-CBT and the trauma narrative process is provided in Chapter Two.

Organization of the Study

Chapter One discussed the problem of sexual abuse and the current lack of understanding of the perspectives of child victims. The purpose of this study, which was to uncover how children perceive life before, during, and after sexual abuse, was explained. The rationale for the analysis of narratives was provided, and research questions were presented. The significance of the results of the research on CSA prevention efforts, treatment protocols, counselor training, adding to existing knowledge in the field of counseling, and community education was discussed. Finally, definitions of key terms in the study were provided.

In Chapter Two, the results of a review of the literature on CSA are discussed, including relevant information about child sexual abuse and its impact on both adult survivors and children. An overview of theoretical models for the treatment of CSA is presented with special attention given to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and the trauma narrative intervention. Lastly, a review of the existing research with child victims of sexual abuse is provided along with the rationale for further qualitative research with children.

In Chapter Three, the research methodology for investigating children's descriptions of life before, during, and after sexual abuse is presented, including a discussion of ethical considerations for research with children. The research questions and a description of the study's design are provided along with a description of the partnering agency and sample. Research protocols, including detailed descriptions of data collection, analysis, and verification procedures are discussed. Chapter three concludes with the rationale for the study. In Chapter Four, the results of the study are presented. Lastly, in Chapter Five, there is a discussion of the results followed by conclusions and recommendations for further research.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

This project presents an innovative approach to the study of child sexual abuse through thematic analysis of trauma narratives. There is a dearth of research from the views of children on trauma, specifically child sexual abuse (McGregor et al., 2006; Sar et al., 2006; Urman et al., 2001; Walker et al., 2009). The vast majority of research in the field relies on adults' memories of childhood sexual victimization (Goodman et al., 2010; Lindblom & Gray, 2010). Through a thorough review of the professional literature (as noted below), it appears that this is the first study to examine children's written descriptions of abuse through a qualitative analysis of trauma narratives, which were completed during Trauma-Focused Cognitive Behavioral Therapy. It was the intent of this study to provide information that will be invaluable to the counseling field and the local and national communities as it can lead to an increased understanding of child sexual abuse.

The review of the literature for the present study consisted of searching the following databases: Academic Search Primer, Dissertations and Theses Full Text, Education Full Text, ERIC, JSTOR, Medline, Psychology: A SAGE Full Text Collection, PsycARTICLES, PsycINFO, Social Sciences Full Text, Sociological Abstracts, and WorldCat. The subjects entered into the search included: sexual abuse, trauma, narrative, narrative therapy, story, storytelling, children, and adolescents. The keywords were used in various combinations to search peer reviewed journals, books, book chapters, and dissertations. A cut-off date was not utilized in the criteria due to a dearth of information published on children's perspectives of child sexual abuse experiences.

The articles and books yielded by the search were further analyzed to determine if they provided additional information about CSA, specifically as it relates to children's perceptions of their experiences and would therefore further inform the study. To ensure that all relevant published work on the topic was included, the reference lists of the articles were utilized for further review of the literature. Additionally, Web of Science © (Thomson Reuters, 2010) allowed the researcher to locate scholarly works with similar reference list citations to the initial articles found. Web of Science also provided the ability to identify recent theoretical documents and research studies that cited the articles that met the search criteria.

The review of the literature revealed only one research study that examined sexual abuse accounts told by children during counseling sessions (Mossige, Jensen, Gulbrandsen, Reichelt, & Tjersland, 2005). Several studies explored aspects of children's experience, such as the sexual abuse disclosure (Jensen, Gulbrandsen, Mossige, Reichelt, & Tjersland, 2005), religious coping (Nkongho, 2006), and counseling for CSA (Nelson-Gardell, 2001). The vast majority of studies conducted with children focused on symptom reduction and treatment outcomes (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen et al., 2005; Deblinger, Stauffer, & Steer, 2001; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004; King et al., 2000; Trowell et al., 2002).

The scarcity of research on child victims of sexual abuse may be due in part to stringent research restrictions with children (Chu, et al., 2008; Walker et al., 2009). As a protected population, children are difficult to study, especially children who have been victims of trauma. Researchers who study child abuse victims run the risk of retraumatization (Chu et al., 2008). Retraumatization could occur through the use of common research strategies such as extensive

interviews and the administration of a battery of assessments about the trauma. Adults are an easier population to gain access to, which has led to numerous studies and publications on adult survivors of child sexual abuse (e.g., Briere, Kaltman, & Green, 2008; Cole et al., 2007; Parker et al., 2007). Nonetheless, the gap in the research literature remains, resulting in limited knowledge about child sexual abuse from the perspective of the child.

The following sections of the literature review provide the reader with an overview of child sexual abuse, including a discussion of child sexual abuse within interpersonal relationships, perpetrators of CSA, and disclosure of abuse. This is followed by a description of the effects of CSA on adult survivors including issues of depression, grief, and loss, Posttraumatic Stress Disorder, memory, spiritual and religious beliefs, challenges in intimate relationships, and the risk of future victimization. The potential for posttraumatic growth and resiliency is also discussed. The review provides a description of the effects of CSA on children, including its impact on growth and development, functioning across various domains, symptoms similar to those experienced by adults, the cycle of abuse, alternative reactions to trauma, and the potential for resiliency.

After a discussion of the effects of CSA on adults and children, an overview of trauma counseling with children is provided, including a description of the theoretical models (expressive writing, narrative therapy, and cognitive therapy) that are the foundation for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). A description of TF-CBT is presented along with an overview of its tenets, goals, and values. Details regarding training in TF-CBT and use in group settings are also included. A discussion of empirical support for TF-CBT is provided as well as a description of how to implement TF-CBT with CSA victims. Trauma narratives, which

are a central component to TF-CBT, are described. The neurological basis for narratives, the counselor's role, organization of the narrative, use of the narrative to process the trauma, family sessions with narratives, and termination are explained. Additionally, information on navigating challenges in trauma work is provided. The final sections include an overview of the current research which has been conducted with child victims of sexual abuse and the rationale for further research with children.

At the conclusion of the literature review, the reader will have a basic understanding of child sexual abuse, its effects on adults and children, and theoretical models for treatment including TF-CBT. The reader will be exposed to the rationale for utilizing the trauma narrative in counseling and its use with child sexual abuse victims. Finally, the reader will be provided with a review of the limited empirical studies on child victims of sexual abuse and will be made aware of the gap that exists in the literature on children's perceptions of CSA.

Child Sexual Abuse

Child maltreatment in the United States is a pervasive problem that often results in immediate negative effects on children, followed by the potential for numerous problems throughout the lifespan (Briere, 2002; Wolf et al., 2009). Child maltreatment is often organized into four categories: (a) physical abuse, (b) sexual abuse, (c) emotional abuse, and (d) neglect (Green, 2008). The risk of experiencing any of the four types of maltreatment is greater for younger children (Green, 2008). Research has documented that abuse and neglect hinder proper growth and development (Cicchetti & Toth, 2006; Goodman et al., 2010) and place children at risk for a host of mental health disorders including: "anxiety, depression, anger, cognitive

distortions, posttraumatic stress, dissociation, identity disturbance, affect dysregulation, interpersonal problems, substance abuse, self-mutilation, bulimia, unsafe or dysfunctional sexual behavior, somatization, aggression, suicidality, and personality disorder"(Briere & Lanktree, 2008, p. 8).

The focus of the present study was on children's perceptions of their sexual abuse (CSA). Child sexual abuse, which was defined in Chapter One, is a pervasive problem in the United States today (Nkongho, 2006). Jones and Morris (2007) asserted that sexual abuse tends to fall into one of four categories: (a) abuse by a family member, often occurring for an extended length of time, in which one or both parents/caregivers do not possess knowledge of the abuse, (b) abuse within the family that occurs along with other forms of abuse and neglect, in which the parents or caregivers are aware as one or both are the perpetrators of the abuse, (c) abuse by a trusted individual outside of the family that has access to the child such as a coach or caregiver, and lastly (d) abuse by a stranger. Finkelhor, Hammer, and Sedlak (2008) found that almost half (49%) of children under the age of six were sexually abused by a family member, compared to 42% of children ages 6-11 and 24% of children ages 12-17. These authors noted that stranger-initiated sexual abuse is much less common, effecting 3% of children 6 and under, 5% of children 6-12, and 10% of children 12-17. Moreover, children between the ages of 7 and 13 are at the highest risk of sexual abuse (Finkelhor, 1994).

According to the Centers for Disease Control and Prevention (2005), approximately 1 out of 4 girls and 1 out of 6 boys are sexually abused before the age of 18. Other sources indicate the rate is much higher; for example, a meta-analysis estimated that approximately 40% of female youth experience some form of sexual abuse (Bolen & Scannapieco, 1999). Internet crimes that

target against children are also cause for concern. It is estimated that 1 in 5 children are solicited sexually while using the Internet (Finkelhor, Mitchell, & Wolak, 2001).

There are several challenges involved with attaining accurate CSA prevalence statistics (Davidson et al., 2009). The above estimates of CSA prevalence may be lower than the actual number of victims as they represent only reported cases. Many acts of CSA go unreported, which result in an underrepresentation of the phenomenon. For example, in one national study, 87% of adolescents who had been sexually abused or assaulted never reported their trauma to anyone (Kilpatrick, Saunders, & Smith, 2003). Another study indicated that for female victims of CSA, the amount of survivors that never disclose is around 30% (Ullman, 2003). In a review of numerous retrospective studies with adult survivors, the majority of studies found about two-thirds (66%) of CSA victims did not disclose their abuse (London, Bruck, Ceci, & Shuman, 2005).Given this research, national figures of CSA are most likely significantly lower than the actual rates (Green, 2008).

An additional challenge in the process of attaining accurate prevalence figures is the variety of sexual abuse definitions found across the fifty states (U.S. Department of Health & Human Services [DHHS], 2009). What may qualify as sexual abuse in one state may not in qualify as such in another. The lack of a single, universal definition of CSA hinders accurate collection of national statistics (Green, 2008). Additional confusion exists in the mental health field when the terms *sexual abuse* and *sexual assault* are used interchangeably as well as to represent different types of victimization. Other terms used by mental health professionals for CSA include *molestation, incest, sexual exploitation* or *sexual victimization* (Whetsell-Mitchell,

1995, p.3 as cited in Gardner, 2008). Therefore a clear definition of CSA that is utilized amongst professionals is still needed (Mannon, & Leitschuh, 2002).

CSA is widely recognized as a societal problem experienced by many children in the United States (Nkongho, 2006). Although CSA has received increased attention in the media and among professionals, this level of awareness and open discussion of the problem was not always the case. At one time, professionals in the helping professions, as well as members of society in general, dismissed or minimized the gravity of survivors' experiences of CSA (Miller et al., 2007). A slow shift in understanding the ramifications of CSA, as well as the need to address it clinically, began when the National Center on Child Maltreatment was launched by the federal government in the 1970s (Silverman et al., 2008). The organization increased awareness through education, which resulted in increased attention to the problems of child sexual abuse. More recently, the National Child Traumatic Stress Network, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and authorized by Congress in 2000, has invigorated research efforts in the area of child trauma (SAMHSA, 2008). These efforts have led to a greater understanding among professionals of the best practices for addressing the needs of CSA victims (Silverman et al., 2008). Although best practices for treatment are an important starting point, there is still a gap in the counseling field's understanding of CSA from the perspective of the child victim.

Along with greater awareness of CSA issues amongst mental health professionals, increased media coverage of CSA has resulted in heightened public awareness. Much of the recent media attention has been on school teachers, religious leaders, and Internet perpetrators (Green, 2008) and less attention given to the sexual abuse that occurs within the context of the

family. Increased public awareness of CSA has produced positive changes, including new legislation aimed to help victims receive justice (Gaines, 2006; Levenson, D'Amora, & Hern, 2007). Further, heightened awareness of CSA among both clinicians and the community has led to improved prevention initiatives and services for children and families (Silverman et al., 2008).

Despite these positive changes in professional and public awareness, the need to understand child sexual abuse from the perspective of the child victim remains. The current study addressed this gap in the research literature. The following sections provide a brief overview of current CSA information and research in the following areas: (a) child sexual abuse within interpersonal relationships, (b) perpetrators of child sexual abuse, and (c) disclosure of child sexual abuse.

Child Sexual Abuse within Interpersonal Relationships

Early childhood family experiences shape the way in which children view the world (Goldfinch, 2009). In healthy families, children feel safe and secure as a result of the predictable patterns established by their parents or caregivers. When sexual abuse occurs in the context of the immediate family, the child does not receive basic protection from their parents or caregivers, which results in an environment that is unsafe and unpredictable (Goldfinch, 2009).

Child sexual abuse (CSA) has been referred to as a "special case of trauma in that it usually comprises a series of traumatic events that occur within the context of interpersonal relationships" (Oz, 2005, p. 24). Research indicates that between 70 and 90% of sexually abused children were victimized by someone that they knew personally (e.g., friends, baby-sitters, individuals in positions of authority, immediate family members, and relatives) and abuse by a

stranger is much less likely (Finkelhor, 1994; Finkelhor et al., 2008) The likelihood that the child victim knew the perpetrator of the abuse is an important aspect to understanding CSA from the perspective of the child victim.

Familial abuse is generally thought of as involving a parent or caregiver as the offender and the child as the victim, but this is not always the case (Welfare, 2008). Sexual abuse can also occur between siblings. According to Welfare (2008), there is a dearth of research on sibling sexual abuse, despite the fact that it may be the most frequent type of sexual abuse within families. Sibling sexual abuse often involves aggressive behavior and use of force to make the victim comply with the abusive act, which frequently involves penetration (Tremblay, Hebert, & Piche, 1999). According to studies on sibling sexual abuse, child victims are less apt to disclose sibling abuse than other forms of familial abuse (Carlson, Maciol, & Schneider, 2006).

Due to the child victim often knowing the perpetrator prior to the abuse beginning, counseling often must address the relationships in which the abuse occurred (Gold, 2000). When sexual abuse occurs in the context of the family, the counselor works with the child to explore the effects of the abuse on relationships with other family members. In CSA cases, children may be removed from their homes and placed in foster homes or group homes to protect them from abusive parents or caregivers (Gold, 2000). Whereas the safety of the removed child is ensured in such situations, the removal process itself may further traumatize the child (Feather & Ronan, 2009). As a counselor, it is necessary to discuss changes in family structure in counseling, such as the removal from one's home. According to Sheinberg and True (2008), "providing children space to describe their perception of family dynamics increases the counselor's as well as the family's understanding of what needs to be addressed" (p. 181). The counselor's consideration of

the impact of the child's relationship with the perpetrator and changes in the relationship as a result of the disclosure are necessary to address in CSA counseling.

Frequently, children abused by an immediate family member or relative do not tell anyone about their abuse (Carlson et al., 2006; Lundqvist, Hansson, & Svedin, 2004). In some families, the nonoffending members are unaware of the abuse. In other families, those who do know about the abuse turn a blind eye to it (Oz, 2005). The failure of family members to admit and acknowledge the abuse leaves the child feeling alone and without protection. In both of these scenarios, the abuse continues until it is discovered by someone who acts to protect the child or until the child discloses the secret to a family member or individual outside of the family who takes action to stop the abuse (Oz, 2005). Understanding the challenges children face when CSA occurs within the context of the family is an important part of understanding CSA from the perspective of the child victim.

Although the end of the abuse in the context of interpersonal relationships is positive for the safety and wellbeing of the child, it may not seem that way from the child's perspective. The victim's family frequently experiences its own set of crises immediately following the disclosure or discovery of the abuse (Oz, 2005). For example, family members must choose whether to believe the child or the perpetrator, resulting in ruptures in immediate and extended family relationships. Disbelief and denial are common responses in an attempt to maintain the false reality of a healthy, functioning family. When family members respond to the disclosure with denial, the child is often in danger of further abuse. When considering the perspective of the child, the failure of adults, especially family members, to respond in a protective manner can be extremely confusing, frightening, or upsetting to the child (Oz, 2005).

The child's perspective of CSA in the context of the family is taken into account in Betrayal Trauma Theory (Freyd, 1996; Gobin & Freyd, 2009). This theory asserts that certain traumas, such as sexual abuse by a trusted individual, involve betrayal and therefore should be conceptualized as different from sexual abuse that is committed by an unknown individual. The victim of a betrayal trauma experiences a complete loss of trust in a close relationship that should be safe and protective. Often, the victim was in a position of dependence on the abuser for essential physiological, security, and social needs (Klempner, 2000; Lanktree & Briere, 2008). Linblom and Gray (2010) asserted that some victims of betrayal trauma are unable to recall the traumatic events. According to the authors, other victims exhibit strategic avoidance of the memory, in which the victim recalls the abuse but denies that it occurred. Whereas these responses may be functional survival tools for the time of abuse, they pose significant threats to one's future health and wellbeing (Lindblom & Gray, 2010).

Common characteristics of those who have experienced betrayal trauma include their being overly trusting, unable to trust, or incorrectly identifying or responding to untrustworthy behaviors in others (Gobin & Freyd, 2009). These characteristics can increase the likelihood of challenges in interpersonal relationships throughout adolescence and adulthood (Briere & Lanktree, 2008; Whisman, 2006). Research has also shown that the above characteristics lead to an increased susceptibility to future traumas including a heightened risk of revictimization through such things as sexual assault, domestic violence, or some other form of crime (Gobin & Freyd, 2009).

Individuals who have experienced sexual abuse within interpersonal relationships frequently exhibit difficulties in one or more areas of functioning (e.g., physical, emotional,

social/relational, cognitive/academic, and spiritual) resulting in various trauma related symptoms (Goldfinch, 2009; Lanktree & Briere, 2008; Tomlinson, 2008) As one might imagine, these challenges in the various domains of functioning often result in problems at home and school, which are observed in children's inability to form or maintain friendships, poor academic performance, limited ability to regulate emotions, and behavioral problems. Early intervention with children who experience CSA in the context of interpersonal relationships is especially important in order to decrease future risk factors. The goal of the current study was to understand CSA from the child victim's perspective, which informs prevention initiatives and early intervention programs with children and families.

This section provided an overview of understanding CSA when it occurs in the context of interpersonal relationships. Examining the current theoretical literature on the experience of the child sexual abuse victim lays the groundwork for this study which analyzed children's written perspectives of their CSA in the form of trauma narratives. Narratives frequently include descriptions of the perpetrator of the abuse in the context of describing the sexual abuse. The following section provides information from the literature on perpetrators of CSA, which is necessary to understanding CSA from the perspective of the child.

Perpetrators of Child Sexual Abuse

Understanding perpetrators of child sexual abuse is pertinent to understanding the experience of sexually abused children because the perpetrator is central to the occurrence of their abuse. According to Jones (1999), “Child molestation represents the most socially unacceptable of behaviors. People who rape and molest children are viewed with contempt by

society" (Introduction section, para. 3). Many people hold inaccurate mental images of perpetrators, also referred to as child molesters and pedophiles, when in fact they represent various ages, genders, ethnicities, socioeconomic levels, sexual orientations (heterosexual, homosexual or bisexual), relationship statuses (single, married, or divorced), and experiences with children (e.g., those with or without their own children) (Finkelhor, 1994; Murray, 2000). Adults account for approximately 77% of sexual offenses and crimes with the other 23% perpetrated by juvenile offenders (Finkelhor et al., 2008). Moreover, perpetration of child abuse is thought to frequently begin in one's late teens (Murray, 2000).

Men account for 96% of reported cases of CSA (Finkelhor et al., 2008) and one study found that male perpetrators of CSA are significantly more likely to have a childhood sexual abuse history (45%) than nonsexual criminal offenders (28%) (Connolly & Woollons, 2008). According to experts in the field, CSA by females is likely to be underreported and is only beginning to be identified as a problem in the United States (Synder, 2000). Female offenders are most likely to offend a child below the age of six (Finkelhor et al., 2008). Similar to male offenders, female sexual abuse perpetrators tend to know their victims, work in positions with access to children, and have a history of childhood abuse or neglect themselves (Nathan & Ward, 2001; Vandiver & Walker, 2002). Some research indicates that both male and female perpetrators may choose victims that mirror their own abuse experience (e.g., selecting a victim to reflect their gender and age at the time of abuse) (Murray, 2000).

In addition to studying demographics of perpetrators, including age and gender, research has also focused on rates of perpetration and the nature of the crime. Studies indicate that approximately 70% of CSA perpetrators abuse between 1 and 9 children during their active

abusing history, 20% abuse between 10 and 40 child victims, and serial abusers victimize as high as 400 children over their lifespan (Elliott, Browne, & Kilcoyne, 1995). It is estimated that prior to initiating the abuse, between 70% and 90% of perpetrators knew their victims (Finelhor, 1994). Most sexual abuse that is committed by a male offender with a female victim occurs within the victim's home; whereas male victims are more likely to experience abuse by an unknown perpetrator at a location other than the child's home (Murray, 2000). Use of a weapon with a child victim between the ages of 12-17 was found to be rare (firearms used in 1% of cases and other weapons in 4% of reported crimes) (Finkelhor et al., 2008). These statistics are useful in understanding the nature of the sexual crimes that are committed against children.

Along with investigating the frequency and nature of sexual abuse victimization, researchers have studied the personal characteristics of those who are sexually abusive. Studies have identified four common characteristics (in which one or more tend to be present) among those who perpetrate CSA (Ward & Beech, 2005). These include the inability to properly regulate emotion, a deficit in social skills, abnormal sexual arousal patterns, and cognitive distortions (e.g., an inability to empathize with the victim's suffering). Children who have experienced sexual abuse may observe some of these characteristics and report them as they describe their perpetrators in their trauma narratives.

It is not uncommon for children to discuss the process through which their perpetrator gained their trust during counseling and in their trauma narratives. Experts in the field have studied the processes whereby perpetrators establish trust with their victims over a period of time, a phenomenon known as grooming. Grooming, which was defined in Chapter One, includes tactics used by perpetrators to keep children involved in the sexual activity. According

to Lanktree and Briere (2008), grooming may include special treatment or presents, which is frequently confusing for the victim. According to the authors, abusers frequently gain access to child victims and attain their trust through the giving of special attention and time as well as the granting of certain privileges. The authors further assert that many perpetrators invest a great deal of time and energy into methods designed to deceive the child and ensure that the abuse is kept secret.

Perpetrators of CSA also tend to create specific rituals with their child victims. For example, some perpetrators utilize cues that signal to the child when the abuse will begin as well as end (Oz, 2005). Cues to initiate the abuse may include a gesture, a game or activity, or by taking the child to a designated location. At the conclusion of the abuse, an exit ritual may be used to signal the end of the abuse. This may include a word or phrase that is repeated at the end of the abuse (e.g., a perpetrator may tell the child to go clean up). Some perpetrators give the child money or a gift to signal the end of the abuse. According to Oz (2005), the use of cues creates predictability which may increase victims' compliance. The trauma narratives collected for this study provide additional insight into children's experiences with perpetrators.

Whereas some perpetrators utilize “loving” and playful methods to ensure compliance, others use violence and threats to control the child and increase the secrecy of the abuse (Murray, 2000; Oz, 2005). It is not uncommon for children to be threatened with serious harm or death, or to have the child's family members or pets threatened with such harm. Due to children’s' developmental levels and limited abilities to reason, many children believe that the perpetrator has the capacity to carry out such acts of violence and therefore are more compliant and secretive with the abuse (Oz, 2005).

In addition to violence and threats, perpetrators may also attempt to convince the child that he or she is at fault for the abuse (Oz, 2005). Statements of blame, which evoke feelings of guilt and shame, may be utilized to ensure that the abuse will be kept secret. Perpetrators often tell their victims that no one will believe them if they disclose the abuse. For children, the concerns that others will blame them or not believe them are significant fears that often hold them captive in silence (Oz, 2005). Trauma narratives allow children to break their silence in a safe environment and hold valuable information for counselors, counselors-in-training, counselor educators, and community members. The information from the narratives in this study provided a research-based understanding of children's experiences as they relate to their perpetrators.

Disclosure of Child Sexual Abuse

Besides describing experiences with perpetrators, children write about their disclosure of the abuse in their trauma narrative. Understanding the disclosure process is valuable to understanding the CSA experience from their perspective. The current literature on CSA and disclosure indicates that parents or caregivers may be hesitant to acknowledge abuse symptoms in their children which may be a result of denial of the abuse (Lanktree & Briere, 2008). Additionally, parents or caregivers may "minimize the trauma or deny the emotional impact" or continue to associate with the alleged perpetrator in order to maintain the relationship and to prevent disruption (Lanktree & Briere, 2008, p. 23).

According to Dyregrov and Yule (2006), children are significantly impacted by their parents' or caregivers' responses to the disclosure. Failure of adults to believe the child solidifies the child's worst fear that the abuser has power not only over him or her but also over others in

the child's world. The lack of an appropriate response to disclosure often results in further suffering for the child (Lanktree & Briere, 2008), leaving the child feeling completely alone and helpless in this situation, which decreases the likelihood of disclosing a second or third time (or beyond).

Some victims of CSA never disclose their experiences. Numerous studies with both child and adult survivors of sexual abuse indicate that between 30% and 87% did not disclose their abuse (Kilpatrick et al., 2003; London et al., 2005; Ullman, 2003). Failure to disclose can occur for a variety of reasons. Children may be dependent on the abuser for their basic needs (Klempner, 2000; Lanktree & Briere, 2008). Others understand the potential consequences of disclosure, such as the perpetrator being arrested and possibly convicted. Knowledge of these consequences results in a hesitance to tell anyone about the abuse, especially if the child cares for the offender. Others are hindered from disclosing the abuse due to feelings of fear, guilt, shame, or anger (Klempner, 2000; Lanktree & Briere, 2008). The children who risk disclosure may find that it results in them being silenced and left unprotected (Lanktree & Briere, 2008).

According to the literature, children who tell someone about their abuse often experience feelings of agony, grief, and sorrow following their disclosure (Crenshaw & Mordock, 2004). In fact, it is not uncommon for children to regret disclosing their abuse (Jones & Morris, 2007; Oz, 2005). This may be confusing to adults as it would appear that the end of the abuse would be a positive thing for the child. Yet, to the child, there is the potential for a host of new traumas and consequences as a result of the disclosure (which are discussed below).

As noted, there are several potential consequences associated with CSA disclosure. For example, breaking the silence of familial CSA often results in the loss of that relationship (e.g.,

incarceration of the perpetrator or the child's removal from the abuser's care) (Lanktree & Briere, 2008). In some cases, the child may "forget" or deny the trauma experience in order to keep the family intact and protect the perpetrator from legal consequences (McNally, 2007). The individual accused of the abuse may face consequences if convicted, which results in further separation between the victim and perpetrator.

In situations of sibling sexual abuse, victims may minimize their trauma in an attempt to decrease their parents'/caregivers' suffering. In this type of abuse disclosure, parents or caregivers experience the difficult task of securing help for both the victim and offender. Both the child victim and child offender need their parents' or caregivers' emotional support and love, which is difficult for many parents and caregivers due to their own reaction to the abuse (Welfare, 2008). Welfare further asserts that there is both a need for accountability for the child perpetrator and ultimately reunification of the family when all members are ready for this to occur.

In addition to the possibility of a lost relationship, another risk children face during disclosure is that the threats made by the perpetrator may be carried out (Oz, 2005). As discussed previously, perpetrators may threaten to kill the victim, the victim's family members, or household pets. When perpetrators use fear as a primary way to ensure that the abuse continues, many children come to believe that their perpetrator is capable of carrying out his/her threats, which makes disclosure extremely difficult and potentially dangerous. An analysis of trauma narratives will help inform the field on the child's experience with disclosure of their abuse, which is important knowledge for current and future counselors.

The previous sections provided an overview of current information and research on child sexual abuse (CSA). The nature of CSA in the context of interpersonal relationships, understanding perpetrators, and exploring the process of disclosure are important to understand prior to conducting research with child victims. This study examined the experience of child victims, through uncovering themes in children's narratives about their abuse. A thorough understanding of this basic information on this topic is necessary as it provides a foundation for examining the perspectives of child victims. The next section details the experiences of adult victims of CSA, which has been studied extensively throughout professional research literature. Although adults were not the focus of this study, according to Boote and Beile (2005), it is necessary to broaden the literature review on subjects in which there is a dearth of literature. Since very few studies have been conducted on children, the literature review on adult survivors serves as a guide to understanding to long term of effects of CSA. The current study closed the gap between what is known about adult survivors and what is unknown about child victims.

The Effects of Child Sexual Abuse on Adult Survivors

The long term mental health impact of sexual abuse as well as other forms of child maltreatment has been widely recognized in the adult population (Parker et al., 2007). Exposure to multiple types and incidents of trauma is likely to result in the presentation of various symptoms in victims (Briere et al., 2008). Specifically, CSA has the potential to foster harmful effects on adult functioning (Cole et al., 2007). Symptoms documented in adults are both intrapersonal and interpersonal in nature (Parker et al., 2007) and negatively impact survivors' general health and wellbeing. Interestingly, not all adult sexual abuse survivors exhibit poor

functioning or diminished mental health; instead, some individuals display characteristics of resiliency and posttraumatic growth, which are explored in this section. It is important to discuss these issues here as it provides an understanding of the long term effects of CSA and reiterate the need for early intervention with child victims.

Overview of Adult Outcomes

In terms of negative outcomes, the long term effects of sexual abuse can be observed in the high numbers of adults with a CSA history receiving mental health treatment. On college campuses, roughly one-third of students seeking counseling services report a CSA history (Stinson & Hendrick, 1992). Studies on adults receiving psychiatric services also report a high incidence of CSA. A meta-analysis of 40 studies found that females seeking psychiatric services through inpatient and outpatient settings had a rate of CSA histories, ranging from 22% to 85% with an average of 50% (Read et al., 2004). An analysis of 25 studies on men receiving mental health treatment conducted by Read and colleagues revealed a prevalence of CSA that ranged from 0% to 47% with a weighted average of 28%. An additional study indicated that 58% of formerly homeless women receiving mental health treatment had a sexual abuse history (Goodman, Dutton, & Harris, 1995). According to some experts, sexual trauma in childhood may actually *result* in adult psychosis (Lataster et al., 2006). The psychiatric problems experienced by those who were abused are at times pervasive and long term, resulting in poor functioning across the spectrum (Cohen et al., 2005). Overall, it is not uncommon for individuals diagnosed with mental health disorders to report a history of childhood abuse (Bendall, Jackson, Hulbert, & McGorry, 2008).

In a meta-analysis on the adverse effects of childhood victimization, Chapman and colleagues (2007) found research pointing to an increased risk of anxiety disorders, depression, Posttraumatic Stress Disorder (PTSD), suicide, substance abuse, and personality disorders (including Anti-Social Personality Disorder and Borderline Personality Disorder) among adults who had been abused in childhood. Cole and colleagues (2007) listed the same mental health problems as cited above (Chapman et al., 2007) with the addition of eating disorders, sexual disorders, dissociative disorders, self-mutilation, and risk of suicide in CSA survivors.

In a study conducted by Aspelmeier, Elliott, and Smith (2007), women were asked to share problems that they had experienced as adults related to their CSA history. These women reported intrusive memories of the abuse, avoidant and dissociative coping strategies, unhealthy sexual and relational behaviors, self-harm, negative image of self and their sexuality, feelings of anger, irritability, depression, and anxiety, and low levels of attachment security to adults, parents, and peers. Additionally, several other studies indicated an increased risk of adult survivors of CSA to engage in prostitution or sex trading (Parillo, Freeman, Collier, & Young, 2001; Vaddiparti et al., 2006). A history of CSA, which may increase participation in risky sexual behaviors, has also been correlated with a heightened risk of HIV or AIDS (Greenberg, 2001). Involvement in activities such as prostitution and illegal drug use often result in legal consequences. Studies on incarcerated women have indicated that many (59%) had experienced sexual abuse as children (Browne, Miller, & Maguin, 1999) and further physical and/or sexual victimization in adulthood (75%) (Bradley & Davino, 2002). The numerous studies cited here point to the potential for long term negative consequences of CSA for adult survivors.

Although there are many challenges faced by adult survivors of CSA, there are several that deserve a more in depth discussion due to their prevalence as reported in the literature. The following sections detail some of the most common challenges for such adults, with a focus on: (a) depression, grief, and loss, (b) Posttraumatic Stress Disorder, (c) memory, (d) changes in spiritual and religious beliefs, (e) problems with intimate relationships, and (f) risks for future victimization. Each of these areas is explored to understand the experience of the adult survivor. A discussion of recent research as it applies to the negative outcomes of CSA is included. Finally, the potential for posttraumatic growth and resiliency are discussed as it relates to adult survivors of child sexual abuse.

Depression, Grief, and Loss

Depressive symptoms are common in victims of CSA (Arata, 2002). Depression is often related to significant feelings of grief and loss as a result of their traumatic experience(s) (Miller et al., 2007). Victims often grieve over their loss of innocence as a result of sexual abuse and/or may grieve the loss of the relationship with the perpetrator, especially in situations where the individual was a close friend or family member. Other losses include the loss of personal identity, the ability to trust, and their view of the world as a safe or trustworthy place (Janoff-Bulman & Frantz, 1997 as cited in Wright, Crawford, & Sebastian, 2007). The loss of the belief of the goodness in the world can lead to the loss of one's sense of purpose in life, which has potential impacts on many other domains (e.g., suicidal ideations, religious/spiritual beliefs, and interpersonal problems.).

Posttraumatic Stress Disorder

In addition to experiencing depression, grief, and loss, many adults with a history of CSA are diagnosed with Posttraumatic Stress Disorder (PTSD) (Levin & Nielsen, 2007). For a detailed description of PTSD and diagnosis criteria, see the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). CSA victims with PTSD frequently remember their abuse experience through flashbacks or nightmares (Levin & Nielsen, 2007). This unpredictable recall of abuse memories is often upsetting and potentially frightening (Briere, 2002). Many CSA victims cope with traumatic reminders by numbing their feelings through substances or dissociation (Briere, 2002). In addition, CSA victims may display avoidant behavior by dismissing memories of the abuse (Briere, 2002). Victims of CSA may avoid specific people and locations related to their abuse in an attempt to avoid triggers that can provoke flashbacks. Although the avoidant behaviors in individuals with PTSD serve a purpose, they impede healthy functioning (Briere, 2002). PTSD hinders survivors from the ability to move forward due to frequent unwanted reminders of their abuse.

Memory

Just as PTSD is common in adult survivors of CSA, challenges with memory have also been documented in the research literature (Goodman et al., 2010; Lindblom & Gray, 2010). Some survivors report very detailed memories of their abuse; whereas, others state they are unable to remember parts or all of their experience. Research has pointed to a connection between PTSD and those who have detailed memories, indicating that enhanced memory of

maltreatment increases the risk of developing trauma related disorders such as PTSD (Goodman et al., 2010). According to Goodman and colleagues (2010), current scientific knowledge and understanding of the topic of memory as it relates to childhood trauma is in the beginning stages and is highly debated.

Goodman and colleagues (2010) provided an overview of the current published studies on memory as it relates to child maltreatment, which includes CSA. The vast majority of studies on adults cited by Goodman et al. indicated that survivors do remember their traumatic childhood experiences. At the same time, other studies indicate that some adults with a documented history of abuse either fail to report their abuse memories or demonstrate an inability to recall their abuse when interviewed about traumatic childhood events (Lindblom & Gray, 2010). Overall, the studies indicate that there are several common factors that increase survivors' memories of the abuse. These include: experiencing the abuse at an older age, surviving chronic or severe abuse, and possessing little-to-no dissociative symptoms. Adult survivors with a documented history of CSA vary in terms of memory. While some possess clear memories, others possess generalized, limited, or nonexistent memories of the trauma. The present study analyzed child sexual abuse from the accounts of children closely following their abuse experiences. The study of children's trauma narratives resulted in detailed descriptions that overall were not subject to memory problems experienced by some adults.

Spiritual and Religious Beliefs

In the same way trauma can impact the mental health and functioning of a survivor of CSA, trauma also frequently changes one's worldview, which includes personally held religious

or spiritual beliefs (Walker et al., 2009). Walker and colleagues reviewed 34 child abuse studies which explored the impact of the trauma on victims' experience of religiosity and/or spirituality. The meta-analysis indicated that whereas some abuse victims turn *towards* religion as a means to cope, others turn *away* from their former belief system. A large number of victims found themselves caught between the two extremes with mixed feelings about religion and spirituality. Those in this group may hold onto their beliefs and yet struggle to understand their experiences in light of their view of the world. Some victims of child abuse wrestle with difficult questions related to their beliefs and abuse experience, such as questioning where God (or their Higher Power) was during the abuse or even blaming God for their pain. For the vast majority of adult survivors, their childhood experiences altered their way of looking at their world and their chosen ways of believing (Walker et al., 2009). The current study searched for themes related to children's beliefs and how those may have changed as a result of their experiences.

Challenges in Intimate Relationships

In addition to the aforementioned intrapersonal problems and changes in one's belief systems, adult survivors of CSA often experience challenges in interpersonal functioning (Arata, 2002; Laumann, Paik, & Rosen, 1999; Maltz, 2002; Whisman, 2006). One common difficulty discussed in the literature is in the area of intimate relationships. The experience of sexual abuse often leads to persistent difficulties with sexual intercourse and intimacy (Maltz, 2002). A national study found that females with a CSA history experienced a high rate of arousal disorders; whereas, men were three times more likely to possess erectile dysfunction, were two times more likely to experience premature ejaculation, and experienced lower sexual desires

when compared to peers without a history of sexual trauma (Laumann et al., 1999). It was theorized that these problematic reactions were as a response to a trauma memory trigger (e.g., a flashback of the abuse) or in an effort to avoid traumatic memories during intercourse (Maltz, 2002). Those who have experienced CSA also report statistically lower levels of marital satisfaction (Whisman, 2006). It is possible that sexual difficulties, such as those discussed above, play a role in the relationship challenges experienced by victims of CSA (Arata, 2002).

Risk of Future Victimization

Another potential interpersonal risk factor for adult survivors of CSA cited in the literature is an increased likelihood of experiencing intimate partner violence (Whitfield, Anda, Dube, & Felitti, 2003) or other forms of future victimization (Bradley & Davino, 2002). Research has shown that women with a history of CSA are two to three times more likely than their non-sexually abused peers to experience various types of victimization in adulthood (Arata, 2002). Types of revictimization include physical abuse/assault, sexual abuse/assault, kidnapping, and stalking (Widom, Button, Czaja, & DuMont, 2005). Further, level of dissociation, trauma symptoms, and experiencing CSA that involved betrayal by a family member increase the likelihood of future victimization (Gobin & Freyd, 2009) Furthermore, women with a CSA history face heightened risk of experiencing revictimization in more than one relationship (Alexander, 2009). Multiple traumas increase the likelihood of mental health problems and poor functioning. The current study explored children's CSA experiences with the intention of utilizing the information to enhance prevention programs and improve early intervention efforts for child victims, which may decrease the occurrence of mental health problems in adulthood.

Posttraumatic Growth and Resiliency in Adults

It is important to note that the literature indicates that positive adjustment for adult survivors of CSA is possible (Wright et al., 2007). Several studies warrant a closer examination in order to identify factors that impact growth and resiliency. In a study on recovery from CSA, Anderson and Hiersteiner (2008) conducted group interviews with adult survivors. Themes that were identified from the interviews included: the experience of telling others about the abuse, finding meaning, and attaining support. The disclosure was important for many of the participants, because it allowed them to break their silence, which they viewed as an empowering experience. Many child victims were not believed when they disclosed, which led to their parents or caregivers continuing family life as if nothing had happened. For these clients, having a counselor who believed them, did not try to change the topic, and did not minimize the experience was an important part of their recovery. In addition to having the support of a counselor, many cited their group counseling experience as significant to their recovery and posttraumatic growth.

Tedeschi and Calhoun (2004) also studied the growth that can occur as a result of treatment for CSA. In this study, survivors shared that they perceived themselves as having better coping skills, an increased ability to relate well to others, improved inner strength, and amplified feelings of gratefulness for their life and the opportunities that they have. Survivors from another study described their ability to utilize the adverse experience as a catalyst for personal growth and finding meaning in life (Wright et al., 2007). Himelein and McElrath (1996) reported on victims who stated they have an increased ability to protect themselves, stand up to peer pressure, and distinguish between healthy and unhealthy relationships. The CSA victims

also experienced a strengthened belief system. The survivors in the studies viewed their experience as leading to posttraumatic growth, indicating that they developed resiliency despite their trauma history.

According to recent research, factors that increase CSA victims' resiliency are the following: (a) social support, (b) religious or spiritual beliefs, and (c) possessing an optimistic outlook, which is related to clients' willingness to address their trauma (Tarakeshwar, Hansen, Kochman, Fox, & Sikkema, 2006). These authors suggested several techniques that can be used to cultivate clients' resiliency, such as exploring existing social support and increasing such support systems, which may incorporate faith-based resources. Resiliency can also be promoted through assisting clients to find personal meaning in their traumatic experience. The authors concluded that posttraumatic growth and resiliency are characteristics of many sexual abuse survivors and this is an area that warrants additional research.

This section provided an overview of the challenges adult survivors of CSA may experience along with the potential for posttraumatic growth. The literature has documented numerous intrapersonal and interpersonal problems that may manifest in adults, especially those who did not receive treatment as children. Several common experiences were discussed in depth, including: (a) depression, grief, and loss, (b) Posttraumatic Stress Disorder, (c) memory, (d) changes in spiritual and religious beliefs, (e) problems with intimate relationships, and (f) risks for future victimization. Although, many adults experience mental health problems related to CSA histories, some survivors possess qualities of resilience and posttraumatic growth. In addition to the exploration of the effects of CSA on adults, it is especially relevant to this study to consider the impact of CSA on children that has been documented in the literature. This

information serves as a basis for understanding the experience of children, which is the purpose of the present study.

The Effects of Child Sexual Abuse on Children

Whereas numerous studies exist on the effects of CSA on adult survivors, the research is limited on the direct effects of CSA on children (McGregor et al., 2006; Sar et al., 2006; Urman et al., 2001; Walker et al., 2009). Many experts in the field assert that the experience of CSA, along with other severe traumas, can leave children with "wounds [that] penetrate deeply to the core of their spirit" (Crenshaw & Hardy, 2007, p. 162). Child victims of sexual abuse may experience a myriad of symptoms as a result of their trauma. According to Lanktree and Briere (2008), symptoms of trauma are likely to be heightened if the child (a) had a close relationship with the perpetrator, (b) experienced trauma that included violence or was intensive or invasive in nature, (c) experienced a loss as a result of the trauma (e.g., one of their parents was incarcerated), (d) was injured during the trauma, (e) believed he or she was to blame for what happened, (f) had a history of prior trauma, (g) had poor functioning (e.g., academic or social skills) or had a developmental delay prior to the experience, (h) had poor attachment to his or her caregiver, (i) experienced the trauma at a young age, and/or (j) lived in poverty or an unsafe home/neighborhood.

There is a broad range of effects of CSA (Adler-Nevo & Manassis, 2005). At one end of the continuum, about one third of children do not experience any symptoms immediately following the abuse; whereas, at the opposite end of the spectrum, about half of the children develop severe psychiatric symptoms that lead to diagnoses such as Posttraumatic Stress

Disorder. Pre-existing factors such as age at the time of abuse, the child's disposition, family structure, and social skills may influence mental health outcomes (Webster, 2001). Additionally, factors related to the abuse may impact recovery (e.g., relationship to the perpetrator, severity and frequency, use of violence, and reactions of others to the disclosure) (Welfare, 2008).

Children who present for clinical treatment for CSA are frequently diagnosed with one or more mental health disorders. The most common and widespread problems effecting children and adolescents who have experienced trauma, including child sexual abuse include: "(a) anxiety, (b) depression, (c) anger, (d) cognitive distortions, (e) posttraumatic stress, (f) dissociation, (g) identity disturbance, (h) affect dysregulation, (i) interpersonal problems, (j) substance abuse, (k) self-mutilation, (l) bulimia, (m) unsafe or dysfunctional sexual behavior, (n) somatization, (o) aggression, (p) suicidality, and (q) personality disorders" (Briere & Lanktree, 2008, p. 8). Despite the many immediate and potential future negative consequences of the trauma, early intervention is often successful in treating the child's presenting symptoms (Green, 2008). This research study investigated children's CSA experiences, which leads to a better understanding of CSA that can enhance both prevention and early intervention efforts.

The following sections explore various aspects of the impact of sexual abuse on children and the similarities and differences that have been identified between adults and children. The first section focuses on the ways in which trauma, specifically CSA, can negatively affect a child's growth and development. Second, the impact of CSA is discussed as it relates to the five domains of the child's life (emotional, social/relational, physical, academic/cognitive, and spiritual). The third section highlights symptoms that are often observed in adult survivors of CSA that can manifest in children. The fourth section includes a discussion of alternative

reactions to abuse. Finally, as previously discussed with regards to adults, resiliency in children is explored. Understanding the impact in each of these identified areas lays the foundation for this study which examines children's written descriptions of CSA in trauma narratives.

Growth and Development

Children's satisfactory completion of developmental tasks directly impacts their future adult functioning and wellbeing (Chapman et al., 2007). In recent years, practitioners and researchers have acknowledged the impact of trauma on child development (Feather & Ronan, 2009; Goodman et al., 2010; Keiley, Howe, Dodge, Bates, & Petit, 2001; Reyes & Asbrand, 2005; Sandoval, Scott, & Padilla, 2009). The experience of CSA frequently obstructs children's ability to complete developmental tasks (e.g., development of motor skills, cognitive ability, and social skills), which negatively affects their overall well-being, both at the time of the abuse and throughout the lifespan (Reyes & Asbrand, 2005).

Many children who have experienced trauma exhibit a lower developmental stage than what would be considered normal for their chronological age (Keiley et al., 2001). According to Keiley et al. (2001), traumas occurring at early ages have the potential to negatively impact the child's psychological well-being. Additionally, the experience of repeated traumas may result in alterations in the functioning of the brain, especially in areas that moderate stress. The risk of such problems is heightened during times of accelerated growth and development (Goodman et al., 2010).

Sexual abuse is likely to be viewed as a crisis for children of any age, but the way in which it is experienced may vary greatly. The response to the trauma and ability to cope can

differ significantly depending on the developmental stage of the child (Feather & Ronan, 2009). According to the authors, responses to treatment (positive or negative) have also been found to correlate with the child's age/developmental stage more so even than other factors such as the severity of the abuse. One reason treatment responses vary by developmental level is that coping skills take longer to develop in young children than in adolescents. Additionally, older children are also better able to process dysfunctional cognitions about abuse (such as "I am to blame for what happened") (Feather & Ronan, 2009). In order to provide developmentally appropriate services, age at the time of CSA and the child's developmental level are factors that must be considered (Sandoval et al., 2009; Tomlinson, 2008).

Difficulties often observed in younger children include aggressive or destructive behaviors as well as repetitious behaviors in their play and drawings (Dyregrov & Yule, 2006). As children develop, their understanding of the abuse experience improves, generally when they reach the ages of 8-10. Children at this stage and older often present with symptomatology that is reflective of what is observed in adults. For example, children may display signs and symptoms of anxiety, depression, and Posttraumatic Stress Disorder, which are common diagnoses in adult survivors of sexual abuse and are discussed in more detail below.

Children who are entering pre-adolescence or adolescence are likely to exhibit poor coping through substance abuse, unsafe sexual practices, or violent behaviors (Briere & Lanktree, 2008). Research has indicated that substance abuse and sexual promiscuity (which may include prostitution) places adolescents at an increased risk of future victimization as well as sexually transmitted diseases. Many adolescents also engage in behaviors as a means of distraction and self soothing to reduce stress (e.g., self-mutilation, disordered eating, and other

compulsive behaviors) (Briere & Lanktree, 2008). Adolescents also differ from their younger peers in their ability to perceive the long-term effects of the abuse and its social impact (Dyregrov & Yule, 2006).

Although some studies have investigated the ways in which child victims of sexual abuse differ from adults with a CSA history, more research is needed to study the developmental differences. Specifically, research is needed in order to create developmentally appropriate treatments, which will increase satisfactory outcomes for child victims. In order to understand the experience of the child, it is beneficial to examine the effects of CSA with regards to the five domains of a child's life.

The Impact of Child Sexual Abuse Across Five Domains

According to Goodman and colleagues (2010), ". . . children who have suffered maltreatment are at risk for problems across several domains of functioning, not only in childhood, but throughout life" (p. 327). Evidence from research indicates that the experience of CSA can negatively impact children in one or more domains: (a) emotional, (b) social/relational, (c) physical, (d) academic/cognitive, and (e) spiritual (Tomlinson, 2008). These impacts can be observed in one or more settings, including the home, school, and/or counseling office. Awareness of potential challenges in each domain is essential to timely and developmentally appropriate interventions. This research study looked for evidence of each of these domains through analysis of children's writing about their abuse in the form of trauma narratives. Current research in each domain lays the foundation for the findings in this study.

In the emotional domain, children who have experienced maltreatment, including CSA, may exhibit a limited ability to express and regulate their emotions (Goodman et al., 2010). According to the authors, children who have experienced maltreatment may cry easily or become angry, fearful, or moody very quickly and for no apparent reason. The authors further assert that their poor ability to regulate emotions leads to an inability to tolerate feelings such as frustration or anxiety.

In addition to possible emotional effects of CSA, social and/or relationship problems often manifest in children. It is not uncommon for children to regress to a younger developmental stage (Cohen & Mannarino, 2008b). In the parent-child relationship, the child may experience separation anxiety (Cohen & Mannarino, 2008b) or develop poor attachment to their caregiver following CSA. Other prevalent social symptoms include difficulty trusting (Goodman et al., 2010) or an inability to discriminate between safe and unsafe people. Additionally, children who have been sexually abused may be aggressive towards peers or may withdraw completely. Both aggressive and withdrawal behaviors are likely to impact their ability to make and keep friends. Further problems with peers and dating relationships may surface in adolescence (Goodman et al., 2010).

Besides social and relational problems, research with sexually abused children has reported a number of potential physical issues. For example, one study found immune system problems in girls who had experienced sexual abuse (DeBellis, Burke, Trickett, & Putnam, 1996). Other studies have documented abnormal levels of stress hormones (DeBellis et al., 1999) and elevated heart rates, blood pressures, and muscle tension in male and female child victims of sexual abuse (Cohen, Mannarino, & Deblinger, 2006). The biological makeup of the brain may

also be altered, resulting in an increased startle response in children who experience the frequent threat of danger (Goldfinch, 2009; Hull, 2002; van der Kolk, 2005), which may also lead to hypervigilance (Cohen et al., 2006).

In addition to potential physical problems, child victims of sexual abuse may also experience cognitive problems. As a result, they may be diagnosed with developmental delays and have lower IQ scores (DeBellis et al., 1999). According to Goldfinch (2009), children can develop memory or attention problems, which lead to academic challenges. Additionally, as mentioned in the social domain, CSA victims may exhibit a host of behavior problems and poor social skills, including aggressive, noncompliant, or withdrawn behaviors, which in turn affect their overall functioning in the classroom (Cohen & Mannarino, 2008b; Goldfinch, 2009). Dysfunctional cognitions related to their trauma are also common in this domain, such as feelings of guilt and shame. Children may also possess dysfunctional thoughts regarding their self image and personal worth.

As well as difficulties cognitively, spiritual problems may also manifest in children. Compared to the other domains, existential and spiritual challenges have been less explored in the literature, especially pertaining to children (Jenmorri, 2006; Nkongho, 2006). According to Jenmorri (2006), children may struggle to find meaning in their experience following their abuse. As a part of this process, children may have existential and spiritual questions, which they may or may not voice to others. In the aftermath of trauma, it is possible for children to lose their faith or experience anger towards God or a Higher Power. Nkongho's (2006) dissertation study with six adolescent participants who had been sexually abused pointed to the complexities of their changing views on religion and their relationship with God or a Higher Power. Evidence of

questioning, re-evaluating, strengthening, or forming new beliefs was uncovered in the qualitative analysis. Therefore, addressing children's spirituality and questions about meaning in a developmentally sensitive way is an important part of counseling (Jenmorri, 2006).

As noted, the experience of CSA can impact the functioning of children emotionally, relationally, physically, cognitively, and spiritually (Tomlinson, 2008). The potential negative impacts in one or more these domains can result in children having multifaceted needs that are observed in multiple settings and require proper intervention from parents/caregivers and those in the helping professions. The problems observed in each domain often result in symptomatology that is commonly observed in adult trauma survivors. The following section addresses common symptoms children may display that mimic those of adults.

Symptoms Experienced by Children

Children may exhibit symptoms similar to those seem in adults, such as flashbacks, abreaction, trauma-related fears (which may lead to other anxiety symptoms and disorders), and a sense of hopelessness about the future (Ogawa, 2004). Other challenges that have been documented in the adult population that can manifest in children include: depression, anxiety, substance abuse (Cohen & Mannarino, 2008b; Saywitz, Mannarino, Berliner, & Cohen, 2000) and eating disorders (Brewerton, 2007). Similar to some adult survivors, older children and adolescents may also grieve the loss of their childhood and innocence (Miller et al., 2007). Like adults, it is not uncommon for children experiencing intense feelings of loss or grief to be diagnosed with depression. Children can also develop Posttraumatic Stress Disorder (PTSD), which was first studied by Terr (1979) who conducted interviews with children who had been

kidnapped. Although the diagnosis is the same as adults, it may manifest differently in children resulting in unique symptoms due to their developmental stage (Carrion, Weems, Ray, & Reiss, 2002; Ogawa, 2004; Sandoval et al., 2009). As a result of children's unique responses to trauma, some children may be diagnosed incorrectly (DeAngelis, 2007). To account for this, a new diagnosis has been proposed for the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders titled Developmental Trauma Disorder, which includes symptoms in line with those experienced by children (DeAngelis, 2007).

In addition to the development of PTSD, some children display dissociative symptoms which have been documented with adult survivors. Children presenting with dissociation may be diagnosed with a dissociative disorder (Loewenstein, 1993). These children experience feelings of isolation and helplessness, which may result in withdrawing inward as a means of survival. In such situations, dissociation enables the child to endure their experience (Loewenstein, 1993; Oz, 2005). The level of the dissociation may vary from child to child. Children may feel as if they are outside of themselves as the trauma occurs, as if watching it from a distance or feeling as if they were in a dream. Dissociation may involve a purposeful forgetting of the abuse, which was discussed previously in the theory of betrayal trauma (Gobin & Freyd, 2009). Dissociating during abuse or failure to remember the experience is a method of survival that serves to protect victims.

Whereas children may receive the same mental health diagnoses as adult survivors of trauma, children's "feelings of fear, anger, and helplessness are often expressed differently from that of adults due to their limited development in the areas of cognition, verbalization, and abstract thinking" (Ogawa, 2004, p. 27). Diagnoses that were created and then validated with

adults may not fit well for children, and those in the counseling field acknowledge the difficulty of diagnosing children who have experienced trauma (Adler-Nevo, & Manassis, 2005). Therefore, an increased understanding of children's manifestations of trauma symptoms is needed in order to improve both the ability to diagnose and treat children. The current study presented an opportunity for enhanced understanding of children's experiences of trauma, including trauma symptoms. This enhanced understanding of children's experiences will aid counselors in early invention strategies with child victims.

Alternative Reactions to Trauma

Each child has a unique response to his or her trauma experience. Children's growth and development may progress normally, with children not experiencing any of the aforementioned difficulties or symptoms. In fact, some children may not perceive their sexual abuse experience as traumatic at the time that it occurs (Oz, 2005). For some children, the abusive event may not be experienced as traumatizing until witnessing others' reactions to the abuse, such as an adult's discovery. Another reason the abuse may not be perceived as traumatizing is because the experience may not have included violence or did not invoke fear (McNally, 2007). On the contrary, the child may have felt love and/or acceptance from his/her perpetrator, thereby hindering the child from viewing the abuse as a distressing or harmful experience (Oz, 2005). The age of the child at the time of the sexual abuse may also result in a failure to understand the extent of the betrayal or wrongful actions of the perpetrator (McNally, 2007). A number of children do not experience symptoms until later in their development when they are able to

realize the ramifications of the abuse experience, such as a loss of innocence as a result of sexual abuse.

Resiliency in Child Victims of Sexual Abuse

In the same way that children can experience negative outcomes as a result of CSA or fail to see the experience as traumatizing, children can also exhibit qualities of resilience (Jenmorri, 2006; Leckman & Mayes, 2007; Sandoval et al., 2009). In fact, Sandoval and colleagues assert that the majority of children are resilient and are able to cope with their trauma experience. Following trauma, some children can actually go beyond their normal level of functioning and flourish (Leckman & Mayes, 2007). Whereas some children are devastated by their trauma, others show no signs of poor functioning or mental health problems (Jenmorri, 2006). Further research is needed to investigate the protective factors that increase children's resiliency following traumatic experiences such as child sexual abuse. This study of trauma narratives served as a starting point to beginning to resilience through analyzing children's experiences of sexual abuse and recovery.

The previous sections detailed the numerous effects that CSA can have on children. Child growth and development may be negatively impacted as well as the child's wellbeing in one or more of five domains (emotional, social/relational, physical, academic/cognitive, and spiritual). Many children exhibit symptoms that are commonly observed in adult survivors of CSA. Yet, as it has been noted, not all children respond to CSA with negative reactions or outcomes. Some children do not initially perceive their CSA as traumatic, and many exhibit characteristics of resilience and the ability to thrive despite their experiences. Just as children's responses to their

CSA are vast, so are the treatment approaches to help child victims. The following sections discuss theoretical models for treating CSA that are relevant to the current study.

Theoretical Models for Trauma Treatment

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was created specifically for children and was utilized by the partnering agency with the children in this research study. The trauma narrative, a central intervention in TF-CBT, is rooted in the theoretical models of expressive writing, narrative therapy, and cognitive therapy, all of which can be tailored to use with children. Each of these theoretical approaches is reviewed as they relate to TF-CBT. This overview is followed by a detailed description of TF-CBT and trauma narratives.

Expressive Writing

As indicated above, a central component of TF-CBT is the trauma narrative, in which the victim of trauma writes about their experience (NCTSN, 2004). Telling stories allows children to understand themselves and the world around them. According to Mossige and colleagues (2005), children as young as six are able to tell stories. Consistent with the research literature, assisting children who have experienced trauma tell their story is vital to their mental and developmental wellbeing (Mossige et al., 2005). Even though this process may be difficult, the resulting narrative about one's trauma in the context of counseling often results in relief and helps the child move toward recovery (NCTSN, 2004).

The importance of writing about one's trauma stems from several theories and models of treatment, including the expressive writing model which was developed by Pennebaker and colleagues and used to help clients process a traumatic event (Pennebaker & Beall, 1986).

Expressive writing can be utilized by counselors practicing from a variety of theoretical orientations (e.g., client-centered, cognitive-behavioral, and solutions focused) and can be adapted to meet clients' individual needs and trauma experiences. The process is fairly straightforward but requires an understanding of the rationale for writing and how to guide the client through the process.

Prior to beginning an expressive writing exercise, the counselor should endeavor to establish a therapeutic relationship with the client and create a safe atmosphere for the exploration of the trauma. When clients are ready to begin exploring the traumatic experience, the counselor directs clients to write a narrative detailing their trauma. Expressive writing is generally conducted during counseling sessions in order to allow for the narrative to be processed directly after it is written (as opposed to a take home assignment). During this process, counselors help clients identify cognitive dysfunctions related to the trauma. Many counselors have their clients revise and rewrite their narrative multiple times as their perceptions about their trauma change.

Expressive writing about trauma has been tested in numerous studies. Many of these studies indicated its potential to improve both physical and mental health (Frattaroli, 2006; Schoutrop, Lange, Hanewald, Davidovich, & Salomon, 2002; Schoutrop, Lange Hanewald, Duurland, & Bermond, 1997; Sloan & Marx, 2004; Sloan, Marx, & Epstein, 2005; Smythe et al., 2002). Other research studies investigating the effectiveness of expressive writing about trauma were unable to identify either physical or mental health improvement in clients (Batten, Follette, Hall, & Palm, 2002; Deters & Range, 2003; Gidron, Peri, Connolly, & Shalev, 1996). Although there is literature on both sides of the debate on expressive writing, there are two explanations

that support the potential effectiveness of the intervention: cognitive restructuring and decreased negative affect when recalling the traumatic memories.

One explanation for the benefit of the expressive writing about trauma is in the cognitive restructuring that occurs during the process (Kuiken, Dunn, & LoVerso, 2008). Cognitive restructuring involves counselors assisting clients to shift their perspectives and thoughts related to their trauma (Wright et al., 2007). Dysfunctional cognitions may be realized and replaced with more accurate thoughts. Additionally, clients may gain personal insights as a result of expressive writing about their trauma experiences. For example, in one study, participants asserted that changed thinking increased their insight, which attributed to improved physical or mental wellbeing (Pennebaker et al., 1990). Another study specifically directed the participants to record their innermost thoughts and feelings about the trauma, their efforts to make sense of it, and the ways in which their emotions changed over time (Ullrich & Lutgendorf, 2002). Participants reported improved personal growth following expressive writing about their cognitions and emotions related to the trauma.

Another explanation for the benefit of expressive writing is provided by Sloan and Marx (2004) and Sloan and colleagues (2005). According to the authors, the repeated nature of the writings of the trauma narrative may directly benefit the client. They concluded that intense emotions frequently accompanied early writings, but over time the negative affect associated with the traumatic memories decreased. It seems when clients increase their familiarity with their narrative and place it in the context of their life, improved overall health may coincide.

Both sides of the argument regarding the efficacy of expressive writing about traumatic experiences present sound research; thereby indicating it may be beneficial for some clients but

not for all. Further research is needed to uncover which clients may benefit the most from expressive writing about personal trauma experiences. Additionally, research is needed to explore the usefulness of expressive writing about trauma with child victims. This study examined the use of trauma narratives with children, which addressed this gap in the research.

Narrative Therapy

In addition to the influences of the expressive writing model (Pennebaker & Beall, 1986), TF-CBT's trauma narrative process shares similarities to narrative therapy, which was created by Michael White and David Epston (1990). According to the research literature, narrative therapy's effectiveness has been documented for a wide range of presenting issues in counseling (Miller et al., 2007). Specifically, writing a coherent narrative has been shown to promote recovery for trauma survivors (Gidron et al., 2002; Pennebaker & Seagal, 1999). According to the literature, narrative therapy is especially beneficial in work with CSA victims as it addresses oppression, which is part of the abuse experience (Miller et al., 2007).

White and Epston (1990) asserted that narrative therapy allows counselors to investigate the way in which clients generate stories about their life and then use the stories to facilitate change. Narrative therapy honors clients' stories and enhances their ability to freely explore their stories. The focus is on helping clients' heal from their oppressive experience(s) through externalizing the problem, a technique which is central to narrative therapy. Another important aspect of narrative therapy is assisting clients in finding their voice to express and process their experience in a safe, nonjudgmental therapeutic relationship (White & Epston, 1990).

In the same way that the expressive writing model asserts the importance of the relationship, narrative therapy also emphasizes the necessity of a strong therapeutic alliance. Narrative counselors begin by creating a nonjudgmental environment in which it is safe for the client's story to be heard. Safety and trust within the therapeutic relationship are established over time and is a process that cannot be rushed. Narrative counselors acknowledge that the establishment of the relationship is central to the effectiveness of counseling (White & Epston, 1990).

As clients tell their stories, the narrative counselor listens for what is referred to as the *dominant story* (White & Epston, 1990). Clients with a CSA history explore the ways in which various systems (e.g., family, culture, community, and the judicial system) have impacted their experience and its meaning. The commonly experienced injustices and oppression are explored.

Narrative therapy for CSA victims often uncovers a dominant story about the impact of gender. Males who experience CSA may benefit from exploring societal messages about masculinity and homosexuality as it relates to their experience (Grossman, Sorsoli, Kia-Keating, 2006; Harker, 1997). In many cultures, men are expected to be unemotional, strong, aggressive, sexual, protectors, and providers, which may make it difficult to acknowledge the need for help and receive it in adulthood for CSA (Grossman et al., 2006). Females also benefit from exploring the cultural messages about women and sexuality as well as societal issues of vulnerability and exploitation. By addressing dominant discourses such as gender, clients are able to understand their story in a larger societal context. Over time, they begin to take ownership of their story and author a new life story, which is referred to as *restorying* (Grossman et al., 2006).

During the process of restorying, various problems may surface for the client. In narrative therapy, the problems that are identified within clients' stories are externalized (Grossman et al, 2006). For victims of child sexual abuse, many of their presenting problems are internally focused, such as self-blame, guilt, and shame (Miller et al., 2007; Ogawa, 2004). The counselor works with CSA victims to view these problems in a different light. Helping victims view the problems outside of themselves allows for them to process the thoughts, feelings and beliefs that correspond with the problem.

In an effort to help the clients externalize the problem, narrative counselors may encourage clients to personify their struggle (Grossman et al., 2006). For example, clients experiencing feelings of shame may be asked to create and describe a *shame monster*. The counselor would then encourage the clients to discuss what this monster does and how it negatively impacts them. Clients may be asked to directly address this monster through dialogue. Over time the clients develop the ability to assert power over the monster and thus create a new way of dealing with the feelings of shame that were once internalized.

In narrative therapy, clients have an opportunity to develop an acceptance of their CSA experience through ending their silence and voicing their story (Miller et al., 2007). Owning their past experience allows clients to shift their focus to the future. As counseling progresses, the counselor gives clients the opportunity to restory their life. For clients who have experienced CSA, there is often a shift from viewing themselves as *victims* of their experience to viewing themselves as *survivors*. Over time, survivors develop a plan, along with the skills, to move forward with their life in a positive way (Merscham, 2000). When counseling reaches completion, clients possess an acceptance of themselves and their experience as well as the

strength and courage to fully live and thrive. The trauma narrative, which is influenced by the tenets of narrative therapy, provides a vehicle for clients during this healing journey.

Cognitive Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is based not only on aspects of expressive writing techniques and narrative therapy but also on the foundation of cognitive therapy, which was developed by Aaron T. Beck (1963). According to Beck (1995), cognitive therapy is a structured approach in which counselors partner with their clients to identify and solve problems, including trauma-related difficulties. Counseling from this orientation targets clients' presenting symptoms (such as depression, anxiety, or PTSD) and focuses on the counselor and the client working together to identify dysfunctional thoughts and their corresponding behaviors. Counselors help clients learn how to identify problematic thoughts, behaviors, and emotional responses and change them into more productive ones. Cognitive therapy also teaches clients the necessary skills with which to cope with stressors and to maintain their therapeutic gains (Beck, 1995).

The use of cognitive therapy (CT) and cognitive behavioral therapy (CBT) has been well documented with adults with a trauma history who have been diagnosed with PTSD (Scheeringa et al., 2007), and several studies have documented its effectiveness with children (Cohen & Mannarino, 1996; Deblinger et al., 2001; Scheeringa et al., 2007; Wethington et al., 2008). Scheeringa and colleagues (2007) found that children as young as preschool age may be able to participate in CBT-based counseling to address their trauma through the use of exposure activities and relaxation skills. Additionally, both individual and group cognitive behavioral

treatments were found to be extremely effective in treating traumatized children (Wethington et al., 2008). The results of a meta-analysis of treatments for traumatized children further asserted that cognitive behavioral therapies were frequently successful in decreasing trauma symptoms in children and adolescents (Silverman et al., 2008). When compared to non cognitive behavioral treatments, CBTs were more effective at symptom reduction in the following areas: posttraumatic stress symptoms, depression, anxiety, and externalizing behavior problems. In sum, research has documented that cognitive behavioral therapies that focus on the trauma have the greatest amount of evidence for effectiveness with children and youth.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a unique approach to working with children who have experienced various types of trauma, including child sexual abuse, which was developed by Judith Cohen, Esther Deblinger, and Anthony Mannarino (Cohen et al., 2000). It is based on the core tenets of cognitive behavioral therapy and incorporates aspects of expressive writing and narrative therapy in the trauma narrative portion of treatment. TF-CBT is unique in its focus on trauma specific symptoms, dysfunctional cognitions, and trauma related fears (Cohen et al., 2000). In addition, TF-CBT is designed to help the child victim "integrate the abuse experience into their view of themselves, others and their world" (Cohen et al., 2005, p. 138). The following sections provide an overview of TF-CBT, including the model's (a) tenets, goals and values, (b) training program for counselors, (c) use in group settings, (d) research support, and (e) implementation with victims of CSA.

Tenets, goals and values of TF-CBT. Trauma-Focused Cognitive Behavioral Therapy is comprised of eight components that are utilized to provide services to the child victim of the trauma, nonoffending parents or caregivers of the child, and to the family unit (Cohen & Mannarino, 2008b). The eight components include: (a) psychoeducation and parenting skills, (b) relaxation skills, (c) affective regulation skills, (d) cognitive coping skills, (e) trauma narrative and cognitive processing of the traumatic event(s), (f) in vivo mastery of trauma reminders, (g) conjoint child-parent sessions, and (h) enhancing safety and future developmental trajectory. Details about some of these elements are provided in the following section titled Implementation of TF-CBT with Child Victims of Sexual Abuse. For full descriptions of the eight components, please see Cohen and Mannarino (2008b) and Cohen et al. (2006).

The overarching goal of the model is to utilize gradual exposure to the trauma in order to decrease trauma-related symptoms and improve clients' overall functioning. In addition to this goal, Cohen et al. (2006) identified six values that are held by the creators of the model and are necessary for counselors utilizing TF-CBT to embrace. The first value is to offer a flexible approach that can be individualized to the clients, which includes teaching them basic skills that build upon one another. Second, the developers of TF-CBT value respect for the clients' worldview. The third core value is the use of creative means, adapted for the client, in the delivery of TF-CBT. Fourth, TF-CBT values the inclusion of the family in counseling. TF-CBT recognizes that parental involvement and family sessions are a significant piece of treatment success. Building on the fourth value, the fifth recognizes that the therapeutic relationship with the child and family is central to the healing process. The sixth and last core value is self-efficacy

of the child and his or her family, which is a quality that helps the child and family sustain the gains that were made in treatment.

Training for counselors in TF-CBT. As with any therapeutic approach, proper training is necessary in order to ethically and safely use it with clients. Training for practitioners in TF-CBT is available through TF-CBT*Web* (www.musc.edu/tfctb) and through in person trainings delivered by certified staff. The website, developed by the Medical University of South Carolina (MUSC), allows for counselors to receive free training (10 continuing education credits) in the use of TF-CBT. The website includes information on the core components of TF-CBT, sample session transcripts, and videos of sessions. Counselors are able to print scripts (e.g., relaxation scripts) as well as handouts for both parents/caregivers and children on various topics such as child sexual abuse. The site also includes information about how to adjust counseling to meet each family's needs and cultural differences. Finally, there are links to a plethora of resources as well as a complete guide for the implementation of TF-CBT which is published by the Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network (2004).

Counselors who register for the free course are able to login at any time to review the training modules and utilize the resources provided. The course provides counselors with the basics of TF-CBT and the online manual provides additional detailed information. Although there is a significant amount of information in the web course and manual, the ten hour training likely falls short in fully preparing individuals for the use of TF-CBT. Additional training and supervision are necessary components for the successful and ethical treatment of trauma

survivors. Individuals completing the online training are encouraged to participate in a face-to-face workshop to receive a more in-depth training experience. Following a face-to-face training, consultation is offered as an ongoing support to individuals and agencies (Cohen & Mannarino, 2008a).

The counselors at the partnering agency completed the online training in TF-CBT. Additionally, the staff attended a face-to-face training in 2007 to attain additional skills in the use of the approach. Although the counselors' personal theoretical orientations and styles of counseling vary, all of the staff integrates components of TF-CBT in their work with their clients.

Use of TF-CBT in group settings. TF-CBT is versatile as it can be utilized to address many different types of trauma in both individual counseling and group treatment settings. Studies on the use of group counseling with children and adults who have experienced sexual abuse indicate there are numerous benefits such as decreased feelings of loneliness and isolation and increased ability to connect and share with others (Deblinger et al., 2001; Lundqvist, Hansson, & Svedin, 2009; Nisbet-Wallis, 2002). The partnering agency utilizes TF-CBT, including the trauma narrative intervention, in both individual and group settings. In the current study, some of the children completed their trauma narratives in individual counseling, whereas others completed their narratives in a group setting. Children discussed their counseling experiences at the agency in their narratives. Themes related to counseling are reported in Chapter Four.

Research support for TF-CBT. Research has indicated that TF-CBT can be a very successful approach for children who have experienced trauma, including sexual abuse. For example, randomized controlled studies have shown that TF-CBT is more effective in reducing symptoms (e.g., PTSD, depression, anxiety, and sexual problems) than other therapies for children, including play therapy (Cohen & Mannarino, 1996, 1997) and nondirective counseling (Cohen et al., 2005). The studies indicated that TF-CBT is more effective than other types of counseling both immediately following treatment and at one year following the intervention (Cohen & Mannarino, 1996, 1997; Cohen et al., 2005).

The most convincing evidence for the effectiveness of TF-CBT was found in a meta-analysis of 21 randomized controlled studies of trauma treatments (Silverman et al., 2008). According to these authors, only TF-CBT met the "well-established criteria for children and adolescents exposed to trauma. TF-CBT met the well-established criteria because the treatment was found to be statistically significantly superior to psychosocial placebo or to other treatment." (p. 160). The plethora of research studies supporting TF-CBT, specifically with CSA victims, makes it an evidence-based treatment option that is the foundation of this study.

Implementation of TF-CBT with child victims of sexual abuse. The following sections discuss how TF-CBT is implemented with victims of CSA. The discussion includes: (a) assessing child readiness and suitability for TF-CBT, (b) counselor readiness for work with child victims of sexual abuse, (c) establishing the therapeutic relationship with sexually abused children, (d) assessment of child victims of sexual abuse, (e) psychoeducation, (f) inclusion of parents and caregivers in counseling, (g) family sessions, and (h) teaching positive coping skills.

The descriptions in each of the following sections reflect the way in which TF-CBT was implemented at the partnering community agency for the current study.

Assessing child readiness and suitability for TF-CBT. Cohen and Mannarino (2008b) noted several important aspects to the proper utilization of TF-CBT. First, the counselor must ensure that the child is appropriate for trauma treatment and is ready to begin counseling. The authors of TF-CBT note that the approach is not appropriate for every child who has experienced trauma. It is most appropriate for children who are presenting with symptoms related to their traumatic experience. It is not likely the best approach for children whose primary symptoms are not trauma-related or who are not experiencing symptoms as a result of their trauma. The partnering agency only accepts children who present with symptoms related to their sexual abuse, which is determined during a comprehensive intake assessment. Following the intake, the children receive counseling to address their symptoms, which includes TF-CBT.

When working with children, it is important to remember that children often experience some ambivalence between having a desire to protect the secret of CSA as well as unburden their story to a safe and caring person (Crenshaw & Hardy, 2007). In order to begin the unburdening process, children must feel secure, supported, and believed about the abuse. According to Crenshaw and Hardy (2007), readiness for a child includes:

> …timing, the child's internal resources, strengths, and coping abilities, the degree of additional stress in the child's external life at the time, the strength of the relationship with the counselor and the availability of support for the child outside of therapy. (p. 165)

Increased readiness may be observed when children begin to talk about their experiences through metaphors, which often occurs before speaking about their abuse directly (Gil, 2006). As counseling progresses, it is essential for counselors to be in tune with each child's level of readiness as it relates to disclosing their CSA experiences. Children in the current study were deemed ready by their counselors to proceed with TF-CBT, including the trauma narrative intervention, based on their willingness to talk about their abuse and the establishment of coping skills prior to addressing the trauma. Child readiness must be paired with counselor readiness, which is discussed in the following section.

Counselor readiness for work with child victims of sexual abuse. Along with children's readiness, it is important for counselors to be prepared to hear the difficult and often painful details of the CSA prior to beginning TF-CBT with a child. “To hear a child talk of abuse, to see her fear, even without hearing the details, can be distressing even for experienced therapists” (Jones & Morris, 2007, p. 236). A prevalent issue in counseling today is the failure of counselors to directly address clients' trauma histories (Davidson et al., 2009). Some counselors fear that they will retraumatize their child clients (Cavanagh, Read, & New, 2004) while others feel unprepared to treat child abuse victims at all (Winkelspecht & Singg, 1998). Those who are inexperienced or unprepared may unknowing withdraw empathy and distance themselves from clients disclosing their trauma in a form of self protection (McGregor et al., 2006). Emotional distance may hinder clients' progress in counseling and communicate that the sexual abuse is something to be ashamed of (Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008). Therefore, proper training and supervision are essential elements to trauma work in order to protect CSA

victims (Jones, Robinson, Minatrea, & Hayes, 1998). Training and supervision help counselors learn that moving away from the topic of CSA or discouraging disclosure in counseling would be damaging to the client. Additionally, it only further communicates the societal message that sexual abuse experiences must be kept silent (Crenshaw & Hardy, 2007). Counselors must be ready to respond with empathy rather than fear.

It is especially important for counselors to respond with empathy during the trauma narrative component of TF-CBT. Counselors must be prepared to listen to the narrative and be fully present with their clients during the process. The empathetic listener of the narrative plays a vital and active role in helping the trauma survivor both share and re-author their story (Jenmorri, 2006; Laub & Felman, 1992). The listener's provision of a safe place for the story to be told is incredibly powerful and helps facilitate the healing process. In order for the trauma to be shared openly and for healing to take place, the counselor must communicate his/her own readiness to the client.

While helping clients tell their stories, counselors may develop compassion fatigue or secondary traumatic stress (also referred to as vicarious traumatization) (Boscario, Figley, & Adams, 2004; Jenmorri, 2006). In order to maintain effectiveness, counselors must engage in activities to decrease these risks, such self-care and supervision. Counselors who lack necessary trauma related training may be especially at risk for compassion fatigue. Proper education about trauma and effective therapeutic methods helps increase counselors' readiness to work effectively with CSA victims.

The work that counselors do with child victims of sexual abuse can be difficult. The challenge of hearing their trauma should not be minimized. "Hearing a person talk about trauma

can stir up nearly every fear to which human beings are subject" (Klempner, 2000, p. 76). Working with trauma survivors makes counselors aware of their own vulnerability to pain, violence, and mortality. Counselors must be conscious of their reactions to the CSA victims' pain and respond with empathy and active listening rather than by pulling away. Children are highly perceptive to their counselors' readiness to hear about the abuse and may not share their abuse if they believe the counselor is unavailable (Jones & Morris, 2007). By turning towards clients, counselors offer hope can tremendously assist clients' in their healing journeys (Jenmorri, 2006).

Establishing the therapeutic relationship with sexually abused children. In addition to the child's and counselor's readiness, TF-CBT begins with establishing a therapeutic relationship between the child and counselor (NCTSN, 2004). Developing a relationship with a child who has experienced extreme trauma, including sexual abuse, has been described as "a harrowing feat" (Crenshaw & Hardy, 2007). Due to the nature of CSA, trust is a central issue. Many children tend to respond to others with either blind trust (that does not distinguish between safe and unsafe people) or an inability to trust anyone in any circumstance. Many victims of CSA fear that the counselor will betray their trust or harm them again (McGregor et al., 2006).

An important component to the healing process is for children to learn how to trust others again, a process which begins in the counseling relationship. With child victims of sexual abuse, trust is built over a period of time, and the length of time needed differs from child to child (Kaminer, 2006). Failure to establish a safe, trusting relationship often leads to the failure of any method or technique implored since the efficacy of counseling is directly related to the

therapeutic relationship (Gil, 2006; Kaminer, 2006). Trust in the therapeutic relationship is central to counseling with child victims of sexual abuse. Along with building a relationship with the child victim of sexual abuse, the counselor must also possess competency in assessing the child. The importance of completing a thorough assessment is described in the next section.

Assessment of child victims of sexual abuse. Along with time and attention devoted to establishing the therapeutic relationship, counselors also must gather relevant information and history of the child victim (Cohen & Mannarino, 2008b; NCTSN, 2004). Nonoffending parents or caregivers can be asked to assist in providing information by completing assessments such as The Trauma Symptom Checklist for Young Children (TSCYC) (ages 3-12) (Briere et al., 2001) and the Child Behavior Checklist (CBC; Achenbach, 1991; Achenbach & Rescorla, 2001). The TSCYC (Briere et al., 2001) provides information on eight clinical scales: anxiety, depression, anger/aggression, posttraumatic stress-intrusion, posttraumatic stress-avoidance, posttraumatic stress-arousal, dissociation, and sexual concerns. It also yields a posttraumatic stress total score. The information may be used to help diagnosis children as young as 5-years-old with Posttraumatic Stress Disorder. The Child Behavior Checklist (Achenbach, 1991; Achenbach & Rescorla, 2001) is designed for use with children ages 6-18. It measures a wide range of behavioral and emotional problems occurring in the past three months. The teacher's version focuses on academic performance and adaptive functioning in addition to behavioral and emotional problems. The results of the CBC provide information on six scales: affective problems, attention deficit/hyperactivity, anxiety, oppositional defiance, somatic problems and

conduct problems. An additional version is available for parents or caregivers of children ages 1.5 to 5.

In addition to attaining parents, caregivers or teachers perspectives, several instruments are available for children to complete regarding their perspectives of their behaviors and symptoms. The Child Behavior Checklist Youth Self-Report (CBC-YSR; Achenbach, 1991; Achenbach & Rescorla, 2001) for children ages 11-18 allows children to rate themselves on how true each item is of them in the last six months. For children with difficulties reading, the CBC-YSR can be administered orally. The test provides scores for internalizing, externalizing, and total problems.

Another useful self-report instrument is the Trauma Symptom Checklist for Children (TSCC) (Briere, 1996b), which can be completed by children ages 8 to 17. The instrument is useful in assessing the affects of child abuse and neglect as well as other forms of trauma (witnessing a traumatic event, major accident, or disaster). The 54-item assessment includes two validity scales (under-response and hyper-response) and six clinical scales (anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger). Children rate the symptoms listed in terms of severity on a Likert scale; the instrument takes approximately 10 minutes to complete.

In addition to formal assessments, questionnaires are also useful. A commonly used questionnaire is the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), which is appropriate for individuals 12 and older. The questionnaire consists of 28 items in which clients select a response on a Likert scale. The assessment takes approximately five minutes to administer and is simple to score. The questionnaire provides an overview of clients' experiences

related to several areas of victimization with subtests in the following areas: emotional abuse, physical abuse, sexual abuse, physical neglect, and minimization/denial.

The semi-structured interview is another assessment method that can be utilized in conjunction with a questionnaire. Lobbestael, Arntz, Harkema-Schouten, and Bernstein (2009) developed the Interview for Traumatic Events in Childhood (ITEC), which is specifically designed to gather information on childhood trauma. Using an interview format provides the counselor with the benefits of being able probe, clarify, and ask additional questions. The instrument provides a supplementary method of attaining relevant information from clients regarding their trauma histories.

The assessments discussed are useful in providing the counselor with information from various perspectives on the child's trauma experiences, symptoms, and current level of functioning. This information is especially useful in formulating a diagnosis and creating a TF-CBT treatment plan that is tailored to meet the child's individual needs. Assessments can be utilized at multiple points throughout counseling and at termination to measure symptom reduction and treatment outcomes. The present study explored children's perceptions of sexual abuse and treatment as described in trauma narratives, which included descriptions of symptoms, which are reported in Chapter Four.

Psychoeducation. In addition to learning about the child's history in the early stages of counseling through various forms of assessment, counselors also have an educational role in TF-CBT. The counselor begins by teaching children and parents/caregivers about counseling and the process of trauma work. A research study that surveyed and interviewed survivors of CSA

documented the positive impact of sharing information about the process of counseling (e.g., client rights and responsibilities and what to expect), as well as the harmful effects of neglecting to share such information (McGregor et al., 2006).

Children need to know about their role and the role of the counselor as well as what to expect in counseling. It is important to inform clients (in child friendly terms) that it is not uncommon during the healing process for some symptoms to worsen before they improve (Chasson, Vincent, & Harris, 2008). Parents and caregivers should also be informed of the potential for worsened symptoms and decline in functioning during treatment. Parents or caregivers not only need to know what to expect but also how to respond to their child during this time. Although the increase in symptoms is often temporary in TF-CBT, it is important to address the risks and benefits of counseling openly.

Another component of psychoeducation with CSA victims is the provision of education about sexual abuse. Both the child and nonoffending parent or caregiver need to receive information specific to the trauma that is appropriate for the child's developmental level. Myths and facts, definitions of terms related to CSA, information about perpetrators and grooming behaviors, and current statistics all help educate children and adults about sexual abuse. The purpose of this education is not only to inform children and parents/caregivers about CSA but also to normalize the experience and reduce feelings of isolation, which research has shown brings relief (McGregor et al., 2006).

Inclusion of Parents and Caregivers in Counseling. Before beginning therapeutic work related to the trauma, children must have an established, healthy support system to assist them

during treatment (Oz, 2005). Proceeding with counseling without this in place puts the child as risk of being unable to cope with the challenges of trauma work. At the very least, the counselor needs to ensure that the child has one nonoffending parent or caregiver who is willing to participate in the child's healing process.

In addition, it is also helpful to brainstorm with the child a list of other individuals such as teachers, friends, or other family members who support them. Various activities can be utilized in counseling to help the child identify their support system. One example of such an activity involves children naming individuals in their support system and assigning a color to each individual. The children then use colored sand to fill clear jars representing each person in their life who they can depend on. The jar serves as a visual reminder of their support system.

Involvement of supportive parents or caregivers in treatment is recommended for children who have experienced sexual abuse (Lanktree & Briere, 2008) and has been shown in research studies to improve treatment outcomes for children (Cohen & Mannarino, 2000; Feather & Ronan, 2009) as well as help promote positive family relationships (Sheinberg & True, 2008). A meta-analysis of numerous treatments for trauma indicated that parental involvement in a child's counseling helped decrease symptoms of anxiety and depression in children (Silverman et al., 2008). Counselors can help parents/caregivers become supportive and empathetic towards the child victim, thus potentially increasing the effectiveness of counseling through follow-up support at home.

As part of TF-CBT, nonoffending parents/caregivers are included in treatment in order to provide them with support as they provide support for their child. One of the major goals is to increase parents' or caregivers' ability to talk openly about the trauma with their child (Cohen &

Mannarino, 2008b). Many adults experience difficulty talking about sexual abuse, which often leaves children feeling isolated and alone. Adults may also fear that openly talking about the abuse will retraumatize the child, and therefore they avoid the topic altogether (Ogawa, 2004). Children are aware of whether or not the abuse can be talked about openly with adults, and they too may avoid the topic out of fear that it will make their parents/caregivers sad or angry.

Parents or caregivers may perceive children's lack of discussing the abuse as a positive sign of their ability to cope with the trauma; however, children may be internalizing feelings of sadness, anger, guilt, and/or shame. Many parents/caregivers misjudge the severity of their child's symptoms and may be unaware of their child's need to talk about the trauma. Counselors can help parents/caregivers overcome these obstacles and support their child through involvement in his or her trauma work (Cohen & Mannarino, 2008b).

Parents or caregivers of sexually abused children also frequently struggle with their own feelings about the abuse. Through the help of a supportive counselor, parents and caregivers can express and process their emotions related to the child's sexual abuse. In addition to exploring the personal impact, TF-CBT also addresses the impact of the sexual abuse on children. Issues such as behavioral problems experienced by the child are addressed, and parenting skills are taught to equip parents/caregivers with knowledge that will help them handle trauma related symptoms and behaviors (Cohen & Mannarino, 2008b).

Parents and caregivers may benefit from TF-CBT in either a group or individual setting. Group counseling provides an environment for both education and support. The group can address a variety of topics relevant to parenting a child who has experienced sexual abuse, such as understanding trauma, signs and symptoms of sexual abuse, and how to support children

during the therapeutic process. Individual counseling may be beneficial prior to or in conjunction with group counseling for parents or caregivers with their own sexual abuse history. The counseling that the parents or caregivers receive supports them in their healing process and equips them with the tools necessary to help the child victim (Cohen & Mannarino, 2008b).

Support for children by the inclusion of a nonoffending parent or caregiver is central to TF-CBT, making it unique from other therapeutic models. In the current study, all children who completed a trauma narrative at the partnering agency had a minimum of one nonoffending parent or caregiver participate with them in therapy. The agency offers counseling to parents or caregivers in both group and individual settings. In addition, the counselors at the agency facilitate family sessions, which are described in the next section.

Family Sessions. Family sessions are utilized in TF-CBT at various points throughout counseling. In early sessions, it is often helpful to assist the family in developing healthy ways of communicating. Children may be hesitant to talk openly about their abuse experience and subsequent feelings with their nonoffending parents or caregivers. Exploring children's concern regarding sharing is often helpful to understanding their resistance. The counselor can help children express their fears to their parents/caregivers (such as the fear that talking about the abuse will make the parent sad or angry). The practice of open communication between children and parents or caregivers is helpful in restoring healthy patterns of relating. This intervention lays the groundwork for the child's sharing of their trauma narrative later on in counseling. The details of this session are described in a subsequent section titled The Trauma Narrative Family Session (Cohen & Mannarino, 2008b).

Teaching positive coping skills. Early in TF-CBT, clinicians help children develop coping skills. Coping skills equip children with strategies and resources that can be utilized to manage the challenges experienced during trauma work. Some children entering counseling have employed skills for coping that are unhealthy, such as avoidant coping strategies, which may include, "denial, distancing, disengagement, and self-isolation" (Wright et al., 2007, p. 598). According to research on adults, avoidant coping significantly correlates with depressive symptoms (Wright et al., 2007) and places clients at risk for poor therapeutic outcomes (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). Whereas avoidant coping may have served a purpose for the child prior to treatment, it is important for him or her to learn healthier coping behaviors.

For some children, due to their level of readiness to address the trauma, counseling may primarily focus on teaching positive coping skills, psychoeducation about the abuse, and the development of age appropriate problem solving and socialization skills (Crenshaw & Hardy, 2007). The ability to self-soothe, breathe deeply, utilize progressive muscle relaxation, and implore other relaxation techniques is vital for children to learn prior to exploration of the trauma. The use of relaxation skills helps children learn to reduce feelings of stress, improve sleep, and manage symptoms of anxiety. Parents and caregivers can also be taught relaxation skills so that they can utilize them at home with their children.

One helpful technique that many counselors use with CSA victims is the establishment of a safe place (Schmookler, 1996). The safe place is a mental image created by children that is unique to them. Children are asked to describe their safe place in as much detail as possible utilizing their five senses. The description of the safe place can be audibly recorded and/or written as a script for the child to read. Children can also draw, paint, or create the safe place in a

sand tray, which can be photographed so that they can keep the visual reminder of their place. As trauma work progresses, children can use their safe place when they begin to feel afraid as well as at the end of sessions to remind them that the trauma is not happening to them now and that they are safe.

Another aspect to helping children develop coping skills is to assist them in increasing their ability to express their feelings (Cohen & Mannarino, 2008b). Many children have limited feeling word vocabularies. They can benefit from education and activities that improve their ability to accurately describe their emotions. Having the child draw specific situations in which the child recalls feeling different emotions is a helpful activity that can increase the child's range of feeling vocabulary. A strong vocabulary to identify and communicate emotions will assist children in expressing themselves when they write their narratives.

Cognitive coping is also addressed during this stage of TF-CBT. Children and parents/caregivers are introduced to the interrelationship of thoughts, feelings and behaviors through a variety of activities. Children are taught how to identify dysfunctional thoughts and replace them with more functional ones. Initially, this focus is on general thoughts about self and others. Later in counseling, this skill is built upon during the exploration of the trauma narrative in which trauma related cognitions are identified and explored. Trauma work should not proceed until a child has established healthy affective and cognitive coping skills (Cohen & Mannarino, 2008b).

As discussed in the above sections, prior to addressing the CSA, the counselor must lay a solid foundation. This begins with ensuring the child is both appropriate and ready for TF-CBT. Once this is established, the counselor works to both establish the therapeutic relationship and

gather relevant information from the child and parents/caregivers regarding the child's and family's history. This is followed by psychoeducation on both the therapeutic process and CSA, which is provided to both the child client and nonoffending adult participating in treatment. The counselor also investigates the child's level of support and concurrently provides support for the parent or caregiver. The final step of preparation before exploring the trauma is to teach the child and parent coping strategies. Once these vital tasks are accomplished, the counselor then begins to assist the child in exploring his or her sexual abuse through the use of the trauma narrative (which is discussed in detail in the next section).

In sum, Trauma-Focused Cognitive Behavioral Therapy offers an evidence-based approach to working with victims of various traumas, including child sexual abuse. It can be implemented in both individual and group settings and offers a family component. As noted, research has indicated that TF-CBT is effective in reducing symptoms related to trauma including: depression, anxiety, PTSD, and sexual problems. Additional studies have indicated that clients were able to sustain their improved level of functioning as evidenced by one year follow-up studies (Cohen & Mannarino, 1996, 1997; Cohen et al., 2005; Silverman et al., 2008). Finally, qualitative exploration of the perceptions of children and parents/caregivers who completed TF-CBT indicated that they view their experience with this form of counseling as beneficial (Feather & Ronan, 2009). This study focuses on children who received TF-CBT at a local community agency and completed a trauma narrative, which is discussed in detail in the following section.

Trauma Narratives

The present study analyzed trauma narratives, which are a main component of TF-CBT. Trauma narratives, as defined in Chapter One, are written descriptions of the sexual abuse that are completed during individual or group counseling sessions with a counselor present. This section details the neurological basis for the effectiveness of trauma narratives followed by a description of the use of trauma narratives in counseling. The description of the implementation of trauma narratives includes a discussion of the following: (a) the counselor's role during the trauma narrative, (b) the organization of the narrative, (c) processing the narrative, (d) the trauma narrative family session, (e) moving towards closure, and (f) navigating common challenges. The information provided reflects the process by which trauma narratives are utilized in the partnering community agency.

Neurological Basis for Trauma Narratives

Advances in neurobiology have shaped the understanding of victims of trauma in the last two decades, including the ways in which trauma can effect brain development and functioning. Counseling and psychology are collaborating with the neuroscience field to conduct new research which is helping identify ways to better assess, diagnose, and treat trauma survivors (Wolf et al., 2009). Recent research has helped scientists and clinicians discover the biological reasons why traumatic memories are often fragmented rather than remembered as a unified whole (Kaminer, 2006). Fragmented, disorganized memories of trauma have been associated with narratives of clients with Posttraumatic Stress Disorder (PTSD), with studies supporting the assertion that there is a neurological rationale for the inability to remember and organize

traumatic memories linguistically (Harvey & Bryant, 1999). Trauma narratives can help alleviate trauma symptoms, including PTSD, by providing clients with a format to organize and express their trauma experiences.

In order for clients to disclose and explore their trauma, they must feel safe. Studies in neuroscience have also indicated that a secure therapeutic relationship enables clients to explore the difficult emotional aspects of their traumas. The feeling of safety allows clients to store their once fragmented, implicit trauma memories as a complete narrative in their explicit memory (Schore, 2003a; Schore, 2003b; Siegel, 1999, 2007 as cited in Crenshaw & Hardy, 2007). In the context of the therapeutic relationship, clients develop the ability to both organize and integrate their traumatic memories, which is an important step in the healing process (Foa, Molnar, & Cashman, 1995).

The Counselor's Role during the Trauma Narrative

During the trauma narrative intervention, the counselor works closely with the child during the individual or group session to help him or her recall, write about, and process the experience. Children may initially fear recalling their trauma, believing that the remembering will lead to an unbearable reliving of the events. When fears are expressed, it is helpful for the counselor to explain the rationale of the trauma narrative and what the counselor will do if symptoms arise. It is also important to assure the child that they will work at his/her pace. At this stage, it is vital for the counselor to be an empathetic, nonjudgmental listener as the child prepares to tell his or her story (Kaminer, 2006).

Kaminer (2006) described the counselor's role as an "empathetic witness of injustice" (p. 488). Although empathy is an important quality of any counselor, it is especially essential for a counselor working with a client who has experienced trauma. Empathy, as defined by Clark (1980) is "the unique capacity of the human being to feel the experiences, needs, aspirations, frustrations, sorrows, joys, anxieties, hurt, or hunger of others as if they were his or her own" (p. 190). According to Gil (2006), child victims of trauma will not begin to express their experiences until they are certain that the counselor cares for them and empathizes with them. It is the counselor's empathy that empowers clients to voice their stories.

In addition to demonstrating empathy, counselors must also exhibit trustworthiness. As an empathetic witness, the counselor is able to help the child begin to restore faith and trust in others as well as a belief in him or herself. Later in counseling, the story may be shared with other empathetic listeners in group counseling or in a family session. The first step in preparing to share the narrative with others is to disclose the trauma in the safety of the therapeutic relationship (Gil, 2006).

The Organization of the Narrative

When the child is ready to address his/her sexual abuse, the counselor begins the trauma narrative process. Over the following weeks or months, the child is asked to write about his/her memories of the sexual abuse. The narrative includes information about life before, during, and after sexual abuse and is organized into chapters. The following sections describe the chapters utilized at the partnering community agency, which include: (a) Life Before the Abuse, (b) The First Time the Abuse Occurred, (c) My Worst Memories, (d) The Disclosure, (e) The

Investigation and Court, (f) How My Life has Changed, (g) My Counseling Experience, and (h) My Hopes and Dreams.

In the first chapter, Life Before the Abuse, children are asked to reflect on what their life was like before experiencing sexual abuse. The length and amount of detail in this chapter greatly depends on the age of the child when the sexual abuse began. Children who cannot remember their life prior to the sexual abuse can write their thoughts and feelings about not remembering a time before abuse.

The second chapter, The First Time the Abuse Occurred, asks children to remember and write about the first time that they were abused. The majority of child victims of sexual abuse have been victimized numerous times, frequently over the course of several years; therefore, writing about the first time is especially pertinent. Children who experienced single-incident abuse can alter the title to something more fitting such as The Day that the Abuse Occurred. In the recalling of the event(s), it may be helpful to review the definition of sexual abuse to help the children pinpoint the first time that they were abused. They can explore what they were thinking and how they felt during their first sexual abuse experience.

The third chapter, My Worst Memories, is often the most difficult for children to write. They are asked to describe the worst parts of the abuse, which is unique to each child. During this chapter, it is often necessary for the counselor to utilize relaxation and the safe place techniques (discussed previously) with clients. Depending on the child, this chapter may take one session or multiple sessions to write. The counselor encourages the clients to write in as much detail as they are able, using their five senses to remember their worst memories.

Once children have completed writing about their worst memories, they write the fourth chapter: The Disclosure. For many children, the disclosure of the abuse was very difficult. In some cases, they were not believed or the topic was dismissed and not discussed further. In other cases, parents or caregivers became angry or distraught, which led the children to believe that the adults were angry at them for the abuse. While writing this chapter, children are asked to describe the adult's reaction to their disclosure as well as their thoughts or feelings about disclosing the abuse.

The fifth chapter, titled The Investigation and Court, is where children describe the events surrounding the investigation into the alleged sexual abuse. This chapter again varies as not all children experience the same extent of investigation. Some children are interviewed once; whereas, others are questioned numerous times by various people. Additionally, not all cases of child sexual abuse reach the court system. Children have an opportunity to explore what it was like to be interviewed about their abuse and if applicable, what their court experience entailed. This chapter may be omitted from the narrative if children do not recall any aspects of the investigation process or if a formal investigation was not conducted.

The sixth chapter, How My Life has Changed, explores the ways children perceive life to be different as a result of disclosing the abuse. For some children, it may be difficult to identify many differences. Others may have experienced drastic changes such as being removed from their home or having their perpetrator go to jail. Children may also be required to move or change schools. This may happen in cases in which the perpetrator is not charged with the abuse and the family resides near the individual accused of the abuse. While writing this chapter,

children are also asked to describe their trauma related symptoms, such as difficulty sleeping or fear of being alone.

In the seventh chapter, My Counseling Experience, children have an opportunity to discuss the challenges and/or benefits of talking to someone about their sexual abuse. Many children talk about their initial difficulty trusting and opening up to their counselor. Children may also share parts of counseling that they liked as well as parts that were difficult or challenging.

The final chapter, My Hopes and Dreams, focuses the child on his or her future. Children are able to imagine what they want their life to be like. Some children write about the immediate future; others discuss what they want in adulthood, such as a career and/or family. Children are asked about the steps it would take to achieve their goals and dreams and to write about that process in the chapter.

The trauma narratives about sexual abuse implemented at the partnering community agency included the eight chapters as described above. Although the structure of the narrative is the same for each child, the content greatly varies based on the child's experience. This study identified common themes in the narratives to inform the field about sexual abuse from the child victim's perspective.

Processing the Narrative

After the draft of the narrative is completed, it is beneficial for both the counselor to read the narrative to the child and have the child read it aloud. This process is described in detail in the TF-CBT manual (NCTSN, 2004). Children can be asked to use their five senses to recall any

additional details about their abuse experience. If children remember more about the abuse, the memories are added to the narrative. Over time, the narrative becomes a more complete account of their experience, resulting in a much less fragmented description compare to what was initially written. As children continue to read and reread the narrative, they begin to experience some empowerment by giving voice to their experience. This powerful experience is described by Crenshaw and Hardy (2007):

> It is through children telling their story. . . and having it understood and witnessed by someone trusted that they can begin to weave a new story, a new meaning and perspective on their lives. It is through the experience of being accepted even after sharing their most secret and shameful feelings and thoughts that these children come to accept themselves. (p. 164)

Another important aspect to processing the narrative is helping children uncover and process cognitions, emotions, and underlying beliefs about the trauma (Ehlers & Clark, 2000; Foa & Rothebaum, 1998; Kaminer, 2006). During this process, counselors help children explore their understanding of the sexual abuse experience. According to Sandoval and colleagues (2009), "the child's subjective understanding of the traumatic event can sometimes be more important than the event itself. That is, the more the child perceives an event as threatening or frightening, the greater the chance of increased psychological distress" (p. 251).

As children express their subjective view of the sexual abuse and subsequent events, counselors often uncover dysfunctional thoughts and beliefs that are held by the victims. According to Briere and Lanktree (2008), the counselor should view children's current thoughts about the trauma as reasonable reactions to the experience, which may have helped them survive.

During counseling, children have an opportunity to reevaluate these original thoughts and beliefs by considering them in a safe therapeutic environment. Open-ended questions are useful to carefully explore children's perceptions of the trauma experience (Briere & Lanktree, 2008).

Cognitive-behavioral strategies can be employed to combat cognitive dysfunctions (often related to guilt, shame and personal responsibility for the trauma) and to target common symptoms such as depression and anxiety (Beck, 1995; Cohen & Mannarino, 2008b, NCTSN, 2004). As maladaptive thoughts and beliefs are explored, children may alter their original assumptions, and faulty cognitions can be replaced with more functional, healthier ones. For example, instead of comments related to self blame, the child may be able to articulate that "The abuser was an adult and knew better. I was just a child."

In addition to exploring cognitions, counselors invite children to recall emotions that they experienced at the time of the trauma as well as current emotions about the abuse. As children voice their emotions, these are included in the trauma narrative if they have not already been recorded. Children are reminded that all feelings are valid and are encouraged to explore them in depth verbally, in writing, or in some form of creative expression. It is not uncommon for clients processing their trauma to experience deep feelings of sadness, emptiness, loss, anger, hatred, and desire for revenge. The benefit of working through these emotions is that it helps bring internalized emotions to the external. This allows child victims to explore new meanings and reassess the event through new eyes, a process which often releases victims from feelings of guilt and shame. In the safety of the therapeutic relationship, children are able to express and explore a wide range of emotions about the trauma (Cohen & Mannarino, 2008b; NCTSN, 2004).

It is important for counselors to be aware of potential social or family norms that restrict children's ability to freely express their feelings of grief or sadness about their trauma (Sandoval et al., 2009). Children may be told not to cry, to get over it, or to act like a grownup. All of these messages are detrimental to children's ability to heal from their sexual abuse. Counselors must work with parents or caregivers to help them understand the importance of emotional expression and teach them that all emotions are valid while remaining respectful of cultural differences.

When children are given permission to express their emotions, many child victims of sexual abuse grieve the losses associated with their trauma. Their ability to express their feelings of sadness, grief, or sorrow is an important part of the healing process (Sandoval et al., 2009). For sexually abused children, commonly experienced losses are: a loss of innocence, relationship with the perpetrator or other unbelieving family members or friends, and trust in others. Experiencing the pain of loss is an important step that allows many clients to move forward.

Processing the trauma narrative is a necessary component to children's recovery. Understanding children's subjective experiences is the first step in this process. Counselors then explore and process children's thoughts, feelings, and beliefs about the trauma. Over time, children increase ownership of their story and are able to integrate it into the greater context of their life story. By providing children with an avenue to linguistically share their trauma in the format of a trauma narrative, trauma related symptoms are decreased and recovery begins. After ample time is spent processing the narrative preparation for sharing their narrative with a nonoffending parent or caregiver begins (Cohen & Mannarino, 2008b; NCTSN, 2004).

The Trauma Narrative Family Session

Once the parent or caregiver (as well as the child) has been prepared, a session is scheduled with the purpose of the child sharing his or her narrative. The goal of this session is to increase the child and parent's ability to talk about the traumatic experience and to provide an opportunity for the parent or caregiver to respond to the child with empathy, love, and support. Sharing the details of the abuse in the form of the narrative with a safe and empathetic parent or caregiver is inevitably a powerful experience for the entire family (Cohen & Mannarino, 2008b). The inclusion of the family in TF-CBT is vital to helping a child adapt following an abuse experience (Green, 2008), and the experience often results in healing the family as a whole.

Utilizing the Narrative to Move Towards Closure

When children share trauma in the form of the narrative, they are actively involved in the process of moving towards closure. Closure is defined as the survivor becoming free from habitually thinking about the trauma in such a way that causes distress (Klempner, 2000). During this process, children seek to understand their trauma and its impact, which may involve addressing why the trauma happened to them (Tuval-Mashiach et al., 2004). It also involves exploration of the ways in which the experience has changed their view of self, others, and the world. Children (when developmentally capable) can explore and discover personal meanings within the traumatic experience. The act of making meaning out of trauma often helps children attain some level of closure (Briere & Lanktree, 2008).

Integrating the traumatic experience into one's life is the last portion of trauma recovery (Sewell & Williams, 2001 as cited in Wright et al., 2007). For children, the ability to adapt and

move forward often lies in their courage to face their pain and process the emotional impact of the abuse on their life. It is important to remember that children need ample time to successfully complete treatment. In one study, this involved up to 45 face-to-face services (e.g., individual, family, etc.) (Feather & Ronan, 2009). At the end of counseling, the vast majority of children return to their previous level of functioning. Some may even exhibit improved functioning from where they were before the trauma occurred (Linley, 2003).

The above sections provided an overview of how the trauma narrative is utilized in the context of counseling with child victims of sexual abuse. The trauma narrative, which details the child's life before, during, and after sexual abuse, is an integral part of TF-CBT and ultimately recovery. Proper implementation of the narrative involves understanding the counselor's role, organizing and adapting the narrative to meet the child's individual experience, processing the narrative, and planning for and facilitating a family session. During this process, the counselor must navigate challenges that frequently arise during trauma work through working collaboratively with the family, which is discussed in the next section.

Navigating Common Challenges in Trauma Work

Trauma work is not without its challenges, especially during the period of counseling that directly explores the trauma (which includes the trauma narrative intervention). For children, writing about and processing their sexual abuse is often an extremely difficult task. Counselors must be aware of potential challenges that children may experience in order to intervene appropriately. Common challenges that counselors can prepare for are: (a) increased symptomatology, (b) slowed or halted progress, and (c) dropout. As each issue is explored

below, counselors are encouraged to combat these challenges through providing adequate levels of challenge and support.

Symptoms related to the trauma often vary throughout treatment, with both temporary increases and decreases in functioning (Chasson et al., 2008). Hellawell and Brewin (2002) conducted a study that asked participants diagnosed with PTSD to write about their trauma in the form of a narrative. They noted that at times during the writing, the participants experienced flashbacks, especially when they recalled feelings of "fear, helplessness, and horror" (p. 11). Flashbacks also occurred when participants wrote about fear of death as it related to their trauma experience. Counselors need to be prepared to assist children who experience increased symptoms during treatment.

Just as children's symptoms may increase during the writing of the narrative and general trauma work, children may also plateau or regress in their progress towards identified goals (Oz, 2005). According to Oz (2005), children may also feel unable to move forward at various points in counseling. It is helpful during these times to encourage clients to recall their progress and review what they have accomplished thus far in counseling. Counselors must remember that progress in counseling is not linear, and at times clients may take several steps back before they are able to move forward again. It is possible for initial positive feelings about counseling to change into fear and resistance as the trauma work progresses. Counselors can encourage clients to openly discuss and explore their fears or resistance in sessions. It may be necessary for the counselor to adjust the pace of counseling until the client is ready to proceed.

In addition to being prepared to address increased symptomatology and changes in client progress, counselors must also be ready for client dropout. During treatment that specifically

addresses the trauma, dropout is a frequent problem (Chasson et al., 2008). According to Chasson and colleagues (2008), dropout is of concern as it impairs clients' ability to receive treatment that has the potential to improve mental health and wellness. The authors theorize that dropout is the result of increased anxiety and client avoidant behavior. In their study on dropout rates of children receiving exposure-based cognitive behavioral therapy for trauma, Chasson et al. found that the severity of the child's symptoms directly prior to termination predicted dropout. Specifically, avoidant behavior measured right before premature termination predicted the number of sessions completed. Interestingly, differences in symptom distress among children at the beginning of counseling did not correlate with increased dropout rates. Parents or caregivers may prematurely end treatment if they see their children in distress or experience uncertainty about the benefits of directly addressing the trauma. Counselors can regularly assess children's symptoms throughout counseling and address them directly with the family to decrease the likelihood of dropout.

With the above challenges of trauma counseling with children, counselors need to be proactive in their approach and provide a balance of support and challenge, which is conceptualized as working within the "therapeutic window" (Briere, 1996a as cited in Briere, 2002). When counselors work within this window, they protect clients from both debilitating trauma exposure as well as extreme avoidance of the trauma. Techniques and interventions are tailored to the child and based upon individual readiness. Failure to address trauma with children who are ready to proceed is not likely to be harmful, but it fails to provide them with the challenge that they needs to move towards healing. Exposure to trauma memories and content before children are ready can be damaging to their wellbeing and the therapeutic relationship.

The concept of the therapeutic window helps avoid both retraumatization and failure to move towards recovery (Briere, 1996a as cited in Briere, 2002).

To conclude, counselors who address child victims' sexual abuse may experience one of several challenges, which were detailed above. Knowledge of potential challenges helps counselors be proactive in helping children and families navigate the difficulties associated with trauma work. Additionally, providing an appropriate amount of challenge and support helps children and families move towards recovery. It is important for counselors to candidly address issues such as increased symptomatology, slowed or halted progress, and desire to end treatment with children and their caregivers. Trauma work with CSA victims can be a complex process; therefore, awareness of the potential challenges is of central importance.

Research on Child Victims of Sexual Abuse

As with any research study, it is necessary to first identify the research that has been previously conducted on the topic. The study of trauma has expanded in recent years resulting in numerous research studies that have increased professionals' understanding of the experiences of trauma survivors (Klempner, 2000). The vast majority of CSA research has been conducted with adults survivors, which results in a lack of children's perspectives of the abuse experience (McGregor et al., 2006; Nkongho, 2006; Sar et al., 2006; Urman et al., 2001; Walker et al., 2009).

Studies with children were mostly quantitative and focused on providing evidence for various CSA treatments, which varied significantly in both methodology and rigor. Between 1996 and the present, multiple randomized controlled clinical trials and follow up studies have

specifically examined treatment for CSA (Berliner & Saunders, 1996; Celano, Hazzard, Webb, & McCall, 1996; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996; Cohen & Mannarino, 1997; Cohen & Mannarino, 1998; Cohen et al., 2005; Deblinger, Lippman, & Steer, 1996; Deblinger, Stauffer, & Steer, 2001; Deblinger, Steer, & Lippmann, 1999; King et al., 2000; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004; Trowell et al., 2002) . These quantitative studies primarily focused on the mental health outcomes of child victims and the success of varying treatment interventions, which aides clinicians in the provision of effective services (Nkongho, 2006).

The few qualitative studies conducted with child victims were mostly related to forensic interviewing (Nkongho, 2006). For example, Leander, Christianson, and Granhag (2007) analyzed children's interviews with law enforcement about sexual victimization by a perpetrator who was unknown to the victims. Their findings indicated that children had difficulty discussing the abuse, omitted details, and in some cases denied that the sexual abuse occurred (despite forensic evidence that verified the sexual abuse). Although forensic interviews are useful in understanding how children disclose their sexual abuse, they provide limited insight into how children perceive their sexual abuse experience.

An exception to the vast number of forensic studies with child victims was conducted by Nelson-Gardell (2001) and investigated children's perspectives of their counseling experience for sexual abuse. Nelson-Gardell utilized focus groups to interview 34 female child victims of sexual abuse ages 10 to 18 on what they thought counseling should involve and how support persons (e.g., family members, mental health service providers, and law enforcement) could have helped them cope with their abuse. The findings indicated that the individuals who believed the

children about their abuse were viewed as supportive and helpful. They also indicated that talking about their abuse in counseling, including their feelings, was an important part of their healing. It is important to note that prior to Nelson-Gardell's study, a comprehensive review of the literature failed to uncover any studies that utilized child participants to investigate issuses of treatment and support for CSA.

Another qualitiative study that added to the literature investigated children's views on recovery from CSA was conducted by Nkongho (2006). Nkongho studied how adolescents with a CSA history utilized religion to cope with their abuse experiences. The results of the study indicated that following abuse children engage in questioning, re-evaluating, strengthening, or forming new beliefs, which is a complex and highly individual process. Through this process, the adolescents experienced a changed (or changing) relationship with God or a Higher Power.

An additional study that utilized child victims of sexual abuse was conducted by Jensen et al. (2005) on the topic of disclosure. The authors used data from counseling sessions and follow-up interviews with children and families to investigate the disclosure process. The results of the study indicated there are numerous challenges that children face during disclosure such as initiating a conversation, feeling concerned about their parent or caregiver's reaction, and experiencing fear about possible consequences. This study supports other research findings on the multiple challenges involved with disclosure of CSA (Crenshaw & Mordock, 2004; Kilpatrick et al., 2003; Klempner, 2000; Lanktree & Briere, 2008; London et al., 2005; Ullman, 2003).

Another qualitative study that is especially relevant to the current research was conducted by Mossige and colleagues (2005) who analyzed verbal accounts of sexual abuse which were

taken from transcripts of counseling sessions with ten child victims of sexual abuse. The counselors utilized open-ended questions to help children tell about their abuse. Although the children were in a safe environment to disclose their abuse, only 4 of the 10 children were able to orally narrate their sexual abuse. Other children were able to discuss events surrounding the abuse such as their disclosure. Several qualitative analysis strategies were used to compare oral narratives related to the sexual abuse with positive stories and stories about other stressful events that were told by the children during counseling. Mossige and colleagues concluded that "both the sexual abuse narratives and the surrounding abuse narratives were generally less elaborate, more disorganized, less contextually embedded, and less coherent than the stressful event narratives" (p. 395). The researchers noted that the children studied had difficulty making meaning of their abuse experience and struggled to find some type of explanation for the situation. “Why” questions were common and often unable to be answered, which according to the researchers could explain the children's inability to talk directly about their sexual abuse.

The qualitative studies discussed above (Jensen et al., 2005; Leander et al., 2007; Mossige et al., 2005; Nelson-Gardell, 2001; Nkongho, 2006) are significant as they represent some of the first published studies that utilized child victims of sexual abuse as research participants. Additionally, their results further the field’s understanding CSA from the perspective of the child victim on the topics of counseling, religious coping, abuse descriptions, and disclosure. Yet, the studies fell short in providing detailed information on how children perceive their trauma and the meanings that are attributed to it. Specifically, children’s thoughts, feelings, and beliefs about their life prior to, during, and after sexual abuse as described in

trauma narratives remain largely unknown. Therefore, the current study was designed to uncover children's perspectives of their abuse experiences.

The Need for Further Research

To this author's knowledge following an extensive review of the literature, there have not been any qualitative studies that have examined the subjective experience of children who were victims of sexual abuse through the analysis of trauma narratives completed in the context of Trauma-Focused Cognitive Behavioral Therapy. According to Goodman and colleagues (2010), there is a tremendous need for further research on children who have experienced maltreatment, which includes child sexual abuse. Areas that are specifically lacking research include: developmentally sensitive treatments (Adler-Nevo & Manassis, 2005), children's memories of trauma (Goodman et al., 2010), children's subjective trauma experience (Walker et al., 2009), and issues related to the disclosure of trauma (Mossige et al., 2005; Sar et al., 2006). Each of these areas in need of further study is briefly discussed below.

To start, there is a need to explore developmentally sensitive treatments for children who have experienced trauma (Adler-Nevo & Manassis, 2005). The current treatments rely mostly on the research that has been conducted with adults and may not account for children’s unique perspectives of their abuse and related experiences. The present study uncovered children's experiences in counseling following their sexual abuse, which will inform the field and may lead to developmentally sensitive treatments.

Another area in need of investigation is children's ability to accurately remember traumatic events (Goodman et al., 2010). Research is also lacking on the study of maltreated

children's autobiographical memory (Goodman et al., 2010). Often reports given by adolescents or adults further removed from the traumatic event are generalized and without relevant details. Children's accounts of trauma may provide more detailed and specific information than those of adults who are further removed from the experience. The present study addressed this gap in the research by analyzing trauma narratives written by children in therapy about their sexual abuse. In many cases, the children entered therapy shortly after their disclosure, and therefore were able to provide detailed accounts of their abuse.

In addition to investigating memory, there is a need for research related to children's decision to disclose their trauma. According to Sar et al. (2006), "developing complete awareness about and being able to disclose traumatic experiences are complex processes that are also relevant issues for psychotherapy research. . ." (p. 1587). The counseling field needs to understand children's challenge to disclose their sexual trauma, which includes examination of sociocultural and emotional factors that make disclosure difficult (Mossige et al., 2005). To date, little is known about the disclosure process from the perspective of the child. The present study analyzed trauma narratives, which included a chapter about the disclosure, and added to the field's understanding of children's perceptions on their disclosure.

Furthermore, research is needed to investigate children and adolescents' experiences following their abuse to attain relevant information from their perspectives (Walker et al., 2009). A recent study indicated that children's perceptions of their trauma correlate with the emotional challenges that they experience (Taylor & Weems, 2009). Therefore, future research must not only consider the traumatic event itself, but also children's subjective experience of the trauma and the subsequent events. The current study addressed this need for further research by

analyzing children's perceptions of their trauma and the challenges that they face following their abuse.

Although there is a clear need for further research in the above areas, studies investigating children's perspectives are challenging to conduct (Walker et al., 2009). Researchers may experience children's reluctance to discuss their abuse, especially when the researcher does not have an established relationship with the child. Further, attaining consent to interview children in treatment for child sexual abuse is often extremely difficult if not impossible. Despite the numerous challenges and roadblocks to research with child victims of sexual abuse, the potential benefits of carefully conducted research that protects children in the process are vast. The results of such research can improve prevention efforts, lead to the creation of developmentally appropriate treatment methods, be used to train current and future counselors, enhance the theoretical understanding of child sexual abuse in the field of counseling, and educate community members.

The present research offered a noninvasive method of studying children's perceptions of CSA following their abuse experiences through an examination of trauma narratives. Their narratives provided direct insight into their experiences of life prior to, during, and after the sexual abuse, the disclosure process, experiences with the legal system, and perceptions of trauma treatment. Few studies have attempted to research the perspective of the CSA victim (McGregor et al., 2006). This study heightens the field's awareness of the experiences of child victims of sexual abuse.

Research utilizing trauma narratives completed in the context of TF-CBT informs the field on children's thoughts and feelings about their sexual abuse. Through the use of de-

identified narratives, children's identities were protected. Additionally, thematic analysis allowed the researcher to conduct the study without personal contact with the children as all narratives were completed in the context of counseling prior to the start of the research. Most importantly, the narratives allowed the researcher to explore the world of the sexually abuse child.

Summary

In this chapter, a review of the literature on CSA was presented. The reader was provided with an overview of current information about child sexual abuse. This was followed by a description of the effects of CSA on both adult survivors and children. Theoretical models for the treatment of child sexual abuse were discussed, including a detailed description of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which was utilized by the partnering agency in this study. Trauma narratives, a key intervention in TF-CBT, were described. The final sections included an overview of the current research that has been conducted with child victims of sexual abuse, and the rationale for further research with children. The literature review exposed the limited number of studies investigating children's perspectives of their sexual abuse experiences. The study addressed the gap in the literature through the use of thematic analysis to uncover firsthand accounts of sexual abuse, which were recorded in trauma narratives. The following chapter discusses the methodology for this study.

CHAPTER THREE: RESEARCH METHODOLOGY

Overview

The purpose of the current study was to investigate the experiences of child victims of sexual abuse through the analysis of trauma narratives. A qualitative design was selected as the best methodology for this study based on the assertion that the children who received treatment for CSA possess an understanding of their experience that would be beneficial for practitioners, counselor educators, supervisors, students, and community members to understand. As described in the previous chapters, this information lays the groundwork for sexual abuse prevention programs, the creation of developmentally appropriate treatment for child sexual abuse victims, and the training of current and future counselors. Further, the present study provides the field of counseling and community members an opportunity to understand CSA from the perspective of a child as written in trauma narratives about the abuse.

This chapter begins with a discussion of the ethical implications of conducting research with children, including safeguards which were put into place to protect the identity of the children involved in the present study. This is followed by the research questions and an overview of the study's qualitative design. The target population and sample size are described. Finally, information regarding data collection, data analysis, and verification strategies is provided.

Conducting Research with Children

Due to the potential risks and benefits of research, regulations and guidelines have been put into place by the United States government as well as the American Psychological

Association (2010). The American Psychological Association has published general ethical principles that guide research and practice: (a) beneficence and nonmaleficence, (b) fidelity and responsibility, (c) integrity, (d) justice, and (e) respect for people's rights and dignity. Additionally, the standards assert that researchers who conduct studies with clients need to consider ways to protect the participants from harm. The United States federal regulations for human research also address protection of participants and have published guidelines for research conducted with children (Title 45 Part 46.401-409; Code of Federal Regulations, 2005).

Researchers conducting studies with children are required to demonstrate that the potential benefits of the study outweigh the negative consequences or risks (Chu et al., 2008). Studies conducted with children exposed to trauma pose additional ethical concerns of retraumatization (Chu et al., 2008). Although studies have been published documenting the benefits of conducting research with adult trauma survivors, only three empirical studies (Chu et al., 2008; Dyregrov, Dyregrov, & Raundalen, 2000; Kassam-Adams & Newman, 2005) could be identified on the topic of trauma as it relates to children. Only one studied children who had experienced interpersonal trauma, which included sexual abuse (Chu et al., 2008).

Chu and colleagues (2008) conducted a study to examine the perspectives of both children with and without a trauma history on the topic of research. Results of the study indicated that children in both groups viewed the benefits of participating in research as greater than the costs. According to Chu and colleagues, ". . . there is no reason to assume that trauma-exposed children recruited from the community are inherently more vulnerable in the general research process than their non exposed peers" (p. 56).

The benefits of the current study with children who have experienced sexual abuse outweighed any potential risks. Specifically, risks of harm were eliminated through the use of de-identified, retrospective data in the form of trauma narratives. As a result of the guidelines set forth by the Institutional Review Board, children's identities were protected. As discussed in previous chapters, there are numerous benefits to this research study. Child victims' perspectives of their experiences will inform prevention programs aimed at decreasing the prevalence of CSA, lead to the creation of interventions that are tailored to children's developmental needs, and educate practitioners, students, and community members.

Research Questions

The following research questions guided the study:

1. How do children express their thoughts, feelings, and beliefs about their life prior to, during, and after sexual abuse in the form of trauma narratives?
2. What themes emerge from childhood accounts of CSA from a trauma narrative intervention that can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members?

Research Design

Qualitative research studies are designed to attain information that will be both useful and credible in order to answer the research questions. The design of this qualitative study is both exploratory and descriptive. It is directed by the assertion that children's descriptions of CSA will assist prevention efforts, lead to the creation of treatment that is developmentally appropriate, be

utilized in the training of future and current counselors, and inform the counseling profession as well as the community. Thematic and content analysis of personal documents uncovered themes and descriptions of abuse experiences and perspectives derived from trauma narratives written by children while in counseling (Creswell, 2002; Glesne, 2006; Grbich, 2007). This method allowed for the collection of rich data that, due to Institutional Review Board restrictions as noted previously, would be unattainable through extensive interviews with child sexual abuse victims.

Allport (1942) defined the personal narrative as an account of one's life that is self-revealing in nature and provides information on the private life of the author, thereby providing a window into significant life experiences. According to Allport, narratives are especially helpful in gaining an understanding about complex topics in which little is known. Allport further asserted that other qualitative methods such as observation are inferior to personal narratives when the researcher is investigating the subjective meaning of life experiences, including those that are painful. The present study utilized trauma narratives as a window into the experience of child victims of sexual abuse in order to attain an understanding the abuse from their perspective.

Analysis of personal documents is a reliable method of uncovering participants' thoughts, feelings, and actions related to a specific experience (Grbich, 2007). According to Grbich (2007), an additional benefit of analysis of documents is that the approach is not subject to stability problems because the researcher does not have contact with the participants. The approach also allows for the participants to describe their experiences in their own words rather than the words of the researcher (Clandinin & Connelly, 2000).

Since the perspectives of children derived from trauma narratives conducted in the context of TF-CBT have not yet been investigated, a qualitative approach was necessary to

explore the children's experiences of abuse (Strauss & Corbin, 1990). Specifically, this research explored the themes in children's trauma narratives. Although quantitative measures for sexual abuse victims (many of which were discussed in Chapter Two) are useful in trauma work to measure symptoms, therapeutic progress, and treatment outcomes, such measures would not uncover descriptions of thoughts, feelings, and actions surrounding children's CSA experiences. The qualitative approach in this study allowed the researcher to investigate victims' descriptions of their experiences prior to, during, and after CSA.

Population and Sample

The Partnering Agency

The population for this research study included children and adolescents, ages 6-17, who experienced sexual abuse and completed a trauma narrative as part of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) at a large community agency located in the southern United States that specializes in the treatment of CSA. The treatment methods utilized by the agency, including TF-CBT, are evidence-based and built upon years of empirical research with sexual trauma victims. The counselors are certified in TF-CBT and possess skills specific to work with CSA survivors. The researcher in this study was formerly employed by the partnering agency, and thus had established a strong relationship prior to the start of the study. This pre-existing, trusting relationship helped the researcher gain access to a highly protected population.

The agency provides specialized outpatient mental health counseling to child victims and their nonoffending caregivers and siblings. In order to qualify for services the child must have been determined to be sexually abused, have a primary diagnosis related to their sexual abuse,

considered nonoffending (the child is not acting out as a sexual perpetrator toward others), and have a parent or guardian who is willing to participate in the treatment process. Treatment modalities include individual, group, and family counseling as well as psychoeducation programs, case management, and referral services. Children who receive group counseling are divided into groups based on their age: latency (6-8 and young 9-year-olds), pre-adolescents (9-12), and adolescents (13-17).

In the last fiscal year (July 1, 2009 - June 30, 2010), the agency provided counseling services to 289 child victims of sexual abuse. The majority of clients were female (72%). Reported ethnic background for the children is as follows: 38% Caucasian, 34% Hispanic, 21% Black or African, 4% more than one race, 2% "other", less than 1% Asian, and less than 1% Native Hawaiian or other Pacific Islander. According to the clients' charts, 263 reported English as their first language, followed by 15 Spanish-speaking, 10 bilingual, and 1 Creole. The breakdown of clients' ages includes: 9% were under 6, 23% were between the ages of 6 and 8, 25% were between the ages of 9 and 12, and 43% were between the ages of 13 and 18. Reported family income for the children served at the agency is as follows: 24% less than 10,000, 16% between $10,000 and 14,999, 12% between 15,000 and 19,999, 19% between 20,000 and 29,999, 16% between 30,000 and 49,999, and 14% over 50,000. The agency is grant funded and able to provide counseling services to low income families for free or at minimal cost.

The collaborating agency has been recognized within its state as a leader in providing specialized services to child victims of sexual abuse. The agency is connected with a local hospital and is part of a Children's Advocacy Center (CAC). The CAC staff includes police officers, Department of Children and Family (DCF) workers, school officials, and medical

professionals who collaborate to investigate abuse and provide services to victims and families. The common goal of the CAC is to reduce revictimization, connect abuse victims with resources for healing, and to prosecute offenders.

Sample Size

Sampling is often an ambiguous issue in qualitative research. There are no specific rules regarding the sample size. Each study is unique in terms of its scope and focus, which often has a great deal to do with the time and resources available to the researcher (Patton, 2002). In this study, approximately 100 trauma narratives were archived in clients' files. Consent was not needed according to the Institutional Review Board since the narratives were de-identified prior to being shared with the researcher.

In qualitative research, more data is not always better or necessary (Patton, 2002). The purpose of the current study was to perform an in-depth analysis of children's experiences of sexual abuse. The goal was not to generalize the findings to a much larger population. Thus, 21 narratives were selected through purposive, stratified sampling. In order to attain the narratives, the researcher identified and trained (see Appendix D) five master's level interns working at the community agency who agreed to collect and de-identify the data so that the participants' identities could remain completely confidential. The interns were instructed to gather information-rich narratives of 7 children in the following age ranges: 6-8 (and young 9- year-olds), 9-12, and 13-17. The ranges used in the study reflected the method in which children are grouped for counseling services at the partnering agency. Each age range represents a different cognitive developmental stage.

Along with selecting seven children from each age range, the researcher instructed the interns to purposely select several boys to be represented in the study. The majority of children receiving counseling services at the partnering agency are female (72%), so an equivalent number of males and females was not the aim of the researcher. The goal was to represent both genders in the data.

The selection of 21 total narratives for the initial analysis was determined to be a sufficient number by consulting with qualitative experts and through examining similar qualitative studies. A comparable study conducted by Mossige et al. (2005) analyzed verbal accounts of sexual abuse experiences which were taken from transcripts of counseling sessions with 10 child victims of sexual abuse. Another study on CSA interviewed 10 counselors with expertise in the field (Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008). Two other studies were identified that conducted interviews with CSA victims, one with 20 adult women (McGregor et al., 2006) and one with 16 adult men (Grossman et al., 2006). Additionally, a dissertation study interviewed six adolescent girls with a sexual abuse history on the topic of religious coping (Nkongho, 2006). A final study worth noting conducted five focus groups to interview a total of 34 female child victims of sexual abuse on therapy and support (Nelson-Gardell, 2001). In sum, the published qualitative studies above on the topic of CSA included between 6 and 34 participants.

In the current study, 21 narratives allowed for an equal number of children to be represented in each of the age groups that are used in the provision of group counseling services at the partnering agency. Clients' age was utilized during sampling to attain children from

different developmental levels. The researcher discusses age as it relates to the children's narratives of the sexual abuse in Chapters Four and Five.

Instrumentation and Qualitative Research Protocols

Qualitative research differs greatly from quantitative. Quantitative relies on specific tests or measures and the researcher has greater distance from the project; whereas, in qualitative research, the researcher is the instrument for conducting the research and is connected with the study on some level (Glesne, 2006). The following sections detail the researcher's method of data collection and analysis, which included coding and subjective analysis.

Data Collection

Upon Institutional Review Board (IRB) approval from the hospital (which oversees research conducted at the agency) and university, the narratives and corresponding demographic information were collected by master's level interns at the partnering community agency. According to the IRB, research that involves the use of de-identified protected health information (PHI) is exempt from HIPAA requirements if all subject identifiers are removed. Prior to the start of the study, the interns received training in the procedures for de-identification of the data (a detailed description of intern training is provided in Appendix D). As part of this training, the interns received a list of information that was *not* collected for the purposes of the research (e.g., names, addresses, dates other than the year, telephone numbers, and social security numbers). When the above information appeared in the trauma narratives, the interns photocopied the narrative and deleted (i.e. "blacked out") such information. The interns then recorded demographic information from each client's file on the demographic form provided (Appendix

C). The de-identified narrative and corresponding demographic sheet were then scanned as a portable document format (pdf) and saved to a password protected, encrypted jump drive. The interns collected a total of 21trauma narratives which were completed prior to the start of the study. Once the data collection was completed, the interns supplied the researcher with the password protected jump drive.

The documents, which were handwritten by children, were typed into Microsoft Word by the researcher, who saved the typed files to the password protected jump drive. The researcher secured the help of a data analysis assistant (a colleague with experience counseling sexual abuse victims) who checked the researcher's transcription to ensure the handwritten information was accurately typed.

Data Analysis

Once the narratives were typed, the researcher and research assistant utilized various qualitative methods to analyze the data. Coding and subjective analysis were used to organize, examine and reflect on the data and subsequent findings (Creswell, 2009). The following sections detail the coding and subjective analysis processes and how it was determined to end data collection.

In order to execute the data analysis process, the researcher and research assistant became fully immersed in the narrative data and reflected on the findings. The researcher's aim was to demonstrate that as many angles as possible were pursued resulting in a saturation of data. This process, which includes immersion and crystallization, is described by Borkan in Crabtree and Miller's text (1999) as "prolonged immersion into and experience of the text and then emerging,

after reflection, with an intuitive crystallization of the text" (p. 179). As a result of immersion in the data, themes were identified, which are discussed in Chapter Four.

Coding. The study utilized exploratory inquiry to code the narratives. The coding process was done by hand and in Microsoft Word. The narratives were systematically analyzed, compared, explored, and assembled into significant segments. Through saving each step of the coding process in Microsoft Word, the researcher documented the steps of data reduction, organization, and categorization. Initial codes were recorded to explore themes. Over time codes were merged and classified as themes and subthemes. This documentation of the qualitative coding methods enhanced the reliability of the research.

Microsoft Word and Concordance © (Watt, 2009) enabled the researcher to conduct enumerative analysis by counting repeated words as well as words that group together as synonyms through the use of the thesaurus. Additionally, Microsoft Word was utilized to conduct a word count of each narrative and readability level. Average number of words and readability level were reported for the three age groups in Chapter Four. The results chapter also includes details of the coding process and a table with the final themes derived from multiple analyses.

Subjective Analysis. In addition to coding, subjective analysis was used prior to the start of the study and throughout the research process (Creswell, 2009). The researcher explored personal subjectivity and reflexivity on the topic of child sexual abuse. The researcher wrote a formal statement of positionality on the topic which is included in Appendix B. The statement

described how the researcher developed interest in the topic and why this research study was selected (Creswell, 2009). It included personal information about the researcher's work as a counselor and interactions with others that led to the desire to study CSA.

Throughout the data analysis process, the investigator kept a reflexive journal of reactions to the narratives, including thoughts and feelings about what was uncovered. This served as a record of the investigator's interaction with the topic, which is an important part of qualitative research. A summary of the journal is included in Appendix E.

Termination of Data Collection. There are no precise rules for ending data collection in qualitative studies. Generally, data collection ceases when the resources are exhausted, detailed themes emerge and new data is redundant, or further data collection is beyond the scope of the project (Guba, 1978). Upon analyzing the 21 narratives, the researcher identified distinct themes that were repeated throughout the data. Furthermore, in the analysis of the last several narratives, new information ceased to emerge. Since clear themes emerged in the 21 narratives, additional narratives for each age group were not needed for this study.

The above sections on data collection provided details of the process by which the researcher coded the data, documented subjectivity and reflexivity, and how data collection was determined to be complete. Additional information on the data analysis process is recorded in Chapter Four. The following section discusses the study's validity and the verification strategies utilized by the researcher.

Validity and Verification Strategies

Validity, which in qualitative research is defined as how accurately the account reflects the realities of the participants (Creswell & Miller, 2009), is an important factor to address in the design of a research study. Creswell (1998) listed eight verification strategies that are used to validate qualitative research. Later, a ninth verification strategy was added (Creswell & Miller, 2009). The researcher addressed five of these strategies in order to create a valid study of participants' accounts of CSA.

Verification strategies identified by Creswell (1998) and Creswell and Miller (2009) are categorized into three lenses and three paradigms. According to the authors, each lens represents a different perspective that should be taken into account during qualitative research. These include the lens of: (a) the researcher, (b) the participants, and (c) those external to the study.

The strategies associated with each paradigm encompass each perspective's worldview (Creswell & Miller, 2009). The *postpositivist* paradigm represents the perspective that like quantitative research, qualitative inquiry is composed of rigorous methodology that is established through various protocols. The postpositivist upholds a high standard of research rigor through the verification strategies of triangulation, member checking, and an external audit.

The *constructivist* paradigm asserts that individuals (both participants and researchers) create perceptions of the world around them that are neither right nor wrong but are important to understand. The constructivist approaches research in search of multiple truths that are unique to the individuals that hold them through the use of disconfirming evidence, prolonged engagement in the field, and thick, rich description of observations or documents.

The *critical* paradigm emphasizes what the researcher brings to the research in terms of personal beliefs and assumptions. It also calls for researchers to explore beyond the narrative text to consider the context in which the narrative is created and understood (e.g., the social, cultural, political, economic, ethnic, and gender contexts) (Creswell & Miller, 2009, p. 126). A researcher functioning from the critical paradigm utilizes reflexivity to explore one's personal connection to the research along with collaboration with participants and a peer review.

In the current study, a blend of the three paradigms was used to analyze the data through the lens of the researcher and the lens of those outside the study. The verification of the lens of the researcher was conducted through the use of disconfirming evidence and reflexivity (Creswell & Miller, 2009). The researcher utilized disconfirming evidence by playing "devil's advocate" after initial themes were identified. The researcher and assistant who aided in the coding process purposefully looked for exceptions to the established themes and reconsidered original thoughts and ideas. In addition to disconfirming evidence, reflexivity was used to disclose how the researcher's life intersects with this research topic and why this study was chosen, including a statement of positionality (see Appendix B) and reflexive journal that was kept during data analysis (see Appendix E).

Verification strategies through the lens of those outside of the study include: (a) external audit, (b) thick, rich description, and (c) peer review. An external audit was utilized through the use of dissertation committee members. The researcher "opened the books" and allowed the committee access to the code book, research notes, and other relevant materials to ensure that protocols of data analysis were properly followed. In Chapter Four, thick, rich descriptions of the findings, including the themes are discussed. Finally, with the help of a research assistant, the

researcher had an individual outside of the study analyze the data and create codes. This collaboration increased the validity of the study through taking into account the perspective of someone with a greater distance from the research project than that of the researcher.

The final lens, that of the participants, was addressed through use of direct quotes and summaries of portions of the trauma narratives. As stated previously, this study relied on the use of de-identified data to remove any risk to participants and to ensure confidentiality. Although this strategy allowed the researcher access to rich information from child trauma victims, there was a drawback to the method as the researcher was not be able to use verification strategies from the lens of the participant. The researcher was not able to utilize member checking, such as conducting a focus group with participants, or collaborate with participants. The benefit of understanding children's experience of CSA in the form of de-identified trauma narratives outweighed the lack of contact with research participants for this study.

The researcher selected thematic analysis to study trauma narratives written by children about their life prior to, during, and after sexual abuse. This approach allowed the researcher a window into the world of the child to uncover what is currently unknown in the counseling literature (Walker et al., 2009). An understanding of children's perceptions of CSA will enhance prevention efforts and lead to interventions that are based on children's developmental perceptions of their trauma. The information attained will also educate practicing counselors and counselors-in-training, as well as inform those in the counseling field and community members on the experiences of CSA victims.

Summary

In this chapter, the methodology for the study on children's descriptions of life before, during, and after sexual abuse was discussed. To start, the unique challenges of research with children were explored. This discussion was followed by a statement of the research questions and description of the study's design. Information on the partnering agency, the target population, and purposive sampling utilized to select information-rich cases was provided. The researcher discussed the research protocols, including information on data collection and analysis used to investigate the world of the child victim. Validity of the study was addressed and verification strategies were put into place. This study is important to the field of counseling and community at the local and national levels as it is the first known study to investigate children's written accounts of their sexual abuse in the form of trauma narratives completed during TF-CBT. The results uncovered in the analysis will benefit practitioners, counselor educators, supervisors, students, and community members as it will inform them on children's perceptions of their life before, during, and after sexual abuse.

CHAPTER FOUR: FINDINGS

The purpose of the study was to investigate children's perceptions of their sexual abuse and recovery process as described in trauma narratives that were written during counseling. The researcher utilized qualitative analysis to organize the data and identify its meaning. Thematic analysis of 21 trauma narratives was performed, resulting in three distinct themes and one meta-theme, which were named by the researcher. The study's sample, verification strategies, and data analysis process are discussed. Detailed descriptions of the themes are provided, and conclusions reached by the researcher are delineated in this chapter.

Sample

The sample for this study consisted of children ages 6-17 who received treatment for sexual abuse at a large community agency located in the Southern United States that specializes in child sexual abuse treatment (Table 1). Each child completed a trauma narrative that included a description of life before, during, and after sexual abuse as part of Trauma-Focused Cognitive Behavioral treatment. The total sample size for this study was 21 children with 7 in each of the following age groups that were predetermined by the agency: 6-8 (and young 9-year- olds), 9-12, and 13-17.

The sample consisted of 86% females (*n* = 18) and 14% males (*n = 3*). In addition, the racial composition included: Hispanic, 33% (*n* = 7), African American, 33% (*n* = 7), Caucasian, 24% (*n* = 5), "More than one race", 5% (*n* = 1), and Other, 5% (*n* = 1). Reported annual family income of the children ranged from $7,700 to $90,000, with a mean reported income of $30,180 and a median income of $22,000. The family income for four children was not reported as they

reside in foster care. Since the agency is grant funded and can offer counseling for free or at a minimal cost, families with limited incomes are likely to utilize services at the partnering agency.

In terms of primary diagnosis as determined by the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), 57% were diagnosed with Posttraumatic Stress Disorder (DSM IV-TR Diagnostic Classification 309.81) (*n* = 12), 19% with Adjustment Disorder with Anxiety (309.24) (*n* = 4), 9.5% with Adjustment Disorder with Depressed Mood (309.0) (*n* = 2), 5% with Major Depressive Disorder (296.22) (*n* = 1), 5% with Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.3) (*n* = 1), and 5% with Adjustment Disorder Unspecified (309.9) (*n* = 1). The children were between 6 and 17 years old at the time of treatment with a mean age of 11. Age at the beginning of the abuse ranged from 5 to 15 with a mean age of 9 when the abuse occurred. The age at the start of the abuse was estimated for several children and unknown for two of the children in the latency age range. Abuse duration ranged from a single time to abuse that occurred over several years.

The perpetrators' relationship with the child victims included: biological father (*n* = 4), biological mother (*n* = 1), step-father (*n* = 3), adoptive father (*n* = 2), step-brother's father (*n* = 1), mother's ex-boyfriend (*n* = 1), uncle (*n* = 1), step-father's uncle (*n* = 1), friend's uncle (*n* = 1), classmate (*n* = 1), child in daycare (*n* = 1), neighbor's son (*n* = 1), cousin (*n* = 2), brother, (*n* = 1), step-brother (*n* = 1), grandson of family friend (*n* = 1), and friend's boyfriend (*n* = 1). The relationships can be divided into four categories: parent or parental figure (*n*=12), adult relative (*n* =2), adult family friend (*n*=1), and child or adolescent (*n* =9). The age of the perpetrators was unknown. Three children were reported to have more than one perpetrator (father and mother,

father and uncle, and friend's uncle and child in daycare). One child in the study was considered a secondary victim by the agency for witnessing his sister's sexual abuse by their step-father. The trauma narratives indicated that all children in this sample were abused by someone known to them.

The overall demographics of the 21 children in this study closely reflect the population served at the partnering community agency, which was reported in Chapter Three. Table 1 provides an overview of the children's demographics on the following page. The direct quotes in the results section correspond with the demographics table.

Table 1 Children's Demographics

Child	Gender	Ethnicity	Reported Family Income	Age when Abuse Began	Age at Start of Therapy	Perpetrator	Primary Diagnosis
1	Female	Hispanic	24,000	6	6	Father	309.81
2	Female	Caucasian	7,670	8	8	Grandson of Family Friend	309.24
3	Female	Caucasian	12,000	Unknown	7	Father	309.81
4	Female	Hispanic	22,000	8	9	Mother's Ex-Boyfriend	309.81
5	Female	Hispanic	50,000	Unknown	7	Father & Mother	309.24
6	Female	Other	90,000	8	8	Cousin	309.24
7	Female	African American	22,000	8	8	Friend's Uncle & Child in Daycare	309.4
8	Female	Hispanic	19,600	8	11	Step-Father	309.81
9	Male	Caucasian	18,600	9	11	Classmate	309.9
10	Male	Hispanic	21,600	5	11	Cousin	296.22
11	Female	African American	42,000	10 or 11	11	Brother	309.0
12	Female	Caucasian	78,000	10	11	Step-Father's Uncle	309.81; 311.0
13	Female	African American	Foster Care	9	12	Step-Brother's Father	309.81
14	Female	Hispanic	14,000	10 (estimate)	12	Step-Father	309.81
15	Female	African American	Foster Care	11 (estimate)	13	Adoptive Father	309.24
16	Female	African American	25,240	13	14	Friend's Boyfriend	309.81
17	Female	Caucasian	25,000	15	17	Step-Brother	309.81
18	Female	More than one	Foster Care	8	14	Adoptive Father	309.0
19	Female	African American	Foster Care	13	13	Father & Uncle	309.81
20	Female	African American	9,400	6	14	Neighbor's Son	309.81
21	Male	Hispanic	32,000	15	15	Step-Father *Secondary Victim	309.81

Verification of the Results

The researcher, as discussed in Chapter Three, utilized five verification strategies (disconfirming evidence, reflexivity, external audit, thick, rich description, and peer review) to demonstrate the validity of the study (Creswell & Miller, 2009). The researcher asserts that the results are confirmable, credible, dependable, and transferable, which are four criteria described by Lincoln and Guba (1985) to demonstrate the trustworthiness of a study. The confirmability of the study was established through the use of researcher reflexivity, which included a journal throughout the data analysis process (see Appendix E) and statement of positionality (see Appendix B). Credibility was confirmed through prolonged engagement with the data, peer review, and negative case analysis (also referred to as disconfirming evidence). Dependability was verified through the dissertation committee external audit. Finally, transferability involves the application of the information uncovered to other similar situations or contexts (Lincoln & Guba, 1985). Readers can consider the information presented and apply the theoretical understanding to other similar contexts, in this case work with child victims of sexual abuse. The transferability of the results to other similar cases was enhanced by the provision of thick, rich description in the results section. In sum, the researcher utilized multiple verification strategies in order to accurately reflect the experiences of the child sexual abuse victims. The path the researcher took to attain the results is described in the following section on data analysis.

Data Analysis

Understanding qualitative data has been described as a complex process that is not necessarily linear (Crabtree & Miller, 1999). Many of the steps are repeated and conducted

concurrently with other steps. This section describes the researcher's data analysis process including: (a) transcription of the narratives, (b) content analysis of the documents, and (c) thematic analysis.

Transcription of the Narratives

Data analysis in the present study began with transcribing the children's narratives. Spelling errors were corrected for readability, but the grammar errors were left in an effort to preserve the children's voices. The transcription process involved several challenges including: (a) the quality of the scanned documents, (b) the researcher's ability to read and understand the children's writing, and (c) blacked out protected health information. Each of these challenges and how they were dealt with are discussed below.

The partnering community agency no longer keeps paper files for clients; therefore, hard copies of the narratives were not available. The researcher had to rely solely on the scanned documents. The researcher's assistant checked the scanned documents against the researcher's transcription of the narratives to avoid errors. When words or phrases were unknown, the researcher utilized brackets to indicate the missing data. There were 49 unknown words or phrases in the narratives, which represented less than 1% of the total data.

In addition to the challenge of reading some words and phrases in the scanned documents, children's handwriting was at times difficult to read (19 narratives were handwritten and 2 were typed). Their writing also frequently included various spelling and grammar errors. Additionally, the narratives' content included confusing wording and fragmented thoughts along with descriptions that alternated between past and present tense. Mossige et al. (2005) found

similar challenges in a study that examined transcriptions of children's oral narratives about trauma. The researcher and assistant in the present study collaborated in an effort to accurately report and understand the children's descriptions of life before, during, and after sexual abuse.

A final challenge was the use of de-identified data, which was necessary in order to protect the clients' identities. As described previously, agency interns blacked out all protected health information (PHI), which included 172 pieces of information in the 21 narratives. Although de-identification was necessary for the use of the narratives in this research study, it had an impact on the readability of the documents. Despite these challenges, the data provided for the first time voices of children on their life before, during, and after sexual abuse through an analysis of trauma narratives that were completed during Trauma-Focused Cognitive Behavioral Therapy.

Content Analysis

Once the narratives were transcribed, they were examined to document qualities of the children's writing. First a word count was conducted for each age range (latency 6-8 and young 9-year-olds, preadolescent 9-12, and adolescent 13-17). The mean number of words written by each group in the narratives is as follows: latency: 495 words, preadolescent: 856 words, adolescent: 1160 words. Second, the researcher performed an analysis of the grade level in which the narratives were written. The researcher utilized Microsoft Word's Flesch-Kincaid reading level analysis, which used a formula to provide an estimated grade level for the text. Children in the latency group were an average age of 8 years old (second and third graders). Their writing had a mean reading level score of 3.1 (low third grade level). Children in the preadolescent group

were an average age of 11(fifth and sixth graders); the mean score of their narratives was at the 4.6 grade level. Children in the adolescent age group were an average age of 14 (eighth and ninth graders), and their narratives scored on a 4.8 grade level. The word counts and reading level analyses provided an overview of the text included in the children's trauma narratives.

In addition to examining the documents' reading level and word counts, the researcher made some general observations about the children's writing. First, the researcher noted that in addition to content about the sexual abuse and recovery, there was also the presence of other information about the children and their lives. They wrote about their favorite foods and animals, having a crush on a boy at school, the difficulty of being picked on by other children, wanting to be allowed to go out with friends, and needing a cell phone. This information served as a constant reminder that the narratives were from the perspective of children.

A further observation made by the researcher was that the handwriting seemed more difficult to read in the chapters that required children to write directly about the sexual abuse, to include sections titled The First Time the Abuse Occurred and My Worst Memories. These chapters had more unknown words than the other chapters due to the researcher's inability to read all of the content. This observation may point to the children's difficulty recording the sexual abuse in narrative form. A larger sample of narratives is needed to further evaluate children's handwriting in chapters about the abuse.

In addition to general observations, the researcher utilized Microsoft Word and Concordance © (Watt, 2009), a text analysis program to count words and make word frequency lists. All 21 narratives were viewed in a full word list to examine word frequency and the context

in which the selected words were used. Word frequencies as they relate to the themes are reported in the following section which discusses the thematic analysis of the narratives.

Thematic Analysis

Following content analysis, data analysis to uncover themes was performed. This involved an iterative process in which the narratives were read and re-read multiple times by the researcher and assistant. This was followed with breaking down the data from the original narrative chapter organization (which was discussed in Chapter Three). The segments of data were then coded by hand. As themes emerged from the trauma narratives, they were given preliminary names. Upon the review of the first 6 narratives (2 from each age group), an initial list of codes was created by the researcher and assistant. The researcher and assistant came to full agreement on the codes and worked together to create code names. A codebook representing the emerging thematic categories was created, which was used as a guide to code the remaining 15 documents. The open coding process resulted in a list of descriptive categories that evolved over time (Strauss & Corbin, 1990).

As content of the narratives was reduced and analyzed, it was tracked by the narrative number from which it was taken and was organized into subthemes, themes, and one meta-theme. The researcher utilized axial coding to look for connections between meaning units and subthemes (Strauss & Corbin, 1990). The data which was broken down in the beginning was put back together into categories. In some cases, categories were merged in an effort to classify the perspectives of the children on CSA. As themes emerged, the researcher looked for data to support the interpretation. The researcher also looked for exceptions to the themes

(disconfirming evidence) in the children's descriptions of CSA. Several times, the researcher and assistant returned to the raw data to re-examine and redefine the original codes in order to more accurately reflect the themes that were uncovered.

The researcher and assistant engaged in prolonged immersion into the entire data set. During the immersion-crystallization process, the researcher wrote personal reactions to the content in a reflexive journal (Appendix E). Over the course of analysis, several meetings were held with the researcher and assistant to discuss the narratives, codes, emerging themes, and personal reactions to the data. Once the analysis of the 21 narratives was completed, the researcher and assistant collaborated to interpret the data and derive the study's key findings.

Upon consultation with qualitative research experts, it was determined that additional data collection was not necessary for two reasons. First, detailed themes emerged in the analysis of the 21 narratives. Second, there were no identifiable gaps in the data. At the end of the analysis process, the information in the last narratives was redundant and did not lead to the formation of new themes. The data analysis process allowed for the researcher to explore answers to the research questions that were asked at the onset of the study about CSA.

Results

The overarching goal of the research was to understand child sexual abuse from the perspective of the child victim through the use of qualitative research. In order to achieve this, the researcher captured both the unique qualities of each narrative as well as the themes which were consistent throughout. This involved converting raw data into groups that made sense and

were meaningful. The results of the present study uncovered children's views about their abuse as well as the subjective meaning of those experiences.

As a result of the data analysis, one meta-theme and three themes emerged. The themes were evident in all three groups, which were utilized in sampling (latency, pre-adolescent, and adolescent). The only difference between the age groups that was identified was related to word count and the reading level of the narratives, which was discussed previously. Differences in the narratives' content based on children's ages were not observed by the researcher.

The meta-theme, titled Fear and Safety, was evident throughout all sections of the narratives and was discussed by all 21 children in the study. Children's past and current fears, as well as concerns about their safety and the safety of others, were described within all three themes: (1) Memories of the Abuse, (2) The Disclosure and Subsequent Events, and (3) The Healing Journey. The first theme, Memories of the Abuse, included subthemes that described (a) the children's sexual abuse, (b) their perpetrators, and (c) their thoughts and feelings about the abuse. The second theme, The Disclosure and Subsequent Events, explored children's (a) perceptions of their disclosure, (b) experiences during the investigation, and (c) experiences with the justice system. The third theme and final theme, The Healing Journey, discussed children's (a) experiences in counseling, (b) the many ways in which their lives had changed, and (c) their future hopes and dreams. The themes are presented on Table 2 on the following page.

Table 2 Themes and Subthemes

Meta-Theme	Themes	Subthemes
Fear and Safety	1. Memories of the Abuse	1.1 Abuse Descriptions 1.2 Perpetrators of the Abuse 1.3 Thoughts and Feelings
	2. The Disclosure and Subsequent Events	2.1 The Disclosure 2.2 The Investigation 2.3 The Justice System
	3. The Healing Journey	3.1 Counseling 3.2 Life Changes 3.3 The Future

Theme One: Memories of the Abuse

The first theme, Memories of the Abuse, included three distinct subthemes: (a) Abuse Descriptions, (b) Perpetrators of the Abuse, and (c) Thoughts and Feelings. Each of these subthemes are described below utilizing quotations from the children's narratives to provide thick, rich descriptions of children's perspectives of their sexual abuse.

Subtheme 1.1: Abuse Descriptions. According to the trauma narratives, children in the present study experienced a range of forms of sexual victimization including: exposure to pornography, adults having sex in front of a child, touching private parts, forced oral sex, vaginal penetration, and anal penetration. Some children provided detailed accounts of their sexual abuse; whereas others were more evasive in their descriptions. Most children were able to identify the time and location in which they were abused. Only a few indicated that they had difficulty remembering parts of their abuse (e.g., recalling the first time the abuse happened). All 21 children were able to provide a written description of their abuse. Below are statements from six children that describe the sexual abuse (recall that numbers identify the child in relation to Table 1):

> *Daddy bit the front and my bottom two times. It hurt and I cried.* (Child 3, age 7) *He touched me in a way and I did not like it. He touched me (and) sucked my private.* (Child 10, age 11) *What he did was start rubbing me in weird places. There were only two places and the two were my butt and my vagina. I was just squirming around.* (Child 13, age 12) *My dad was laying there. He said he was sick. He told me to come here so I stood next to his bed while he laid there. He put his hand up my shirt. First he rubbed my stomach. Then he moved up.* (Child 15, age 13) *He said come here so I did. He pushed me on the bed and got on top of me. I said stop. He wouldn't stop and I asked why you are doing this.* (Child 16, age 14) *Then he grabbed me as if he was going to give me a hug but instead he started to grab and touch my butt and my private area.* (Child 18, age 14)

Subtheme 1.2: Perpetrators of the Abuse. In addition to writing descriptions of the sexual abuse, children were able to provide details about their perpetrators and their feelings about them. The trauma narratives indicated that all of the children in the sample knew their perpetrators, and as a result many stated that their trust was broken. This is illustrated in the following statement: *Before the abuse happened I trusted him a lot and we played games together and he even let me play his PlayStation.* (Child 11, age 11)

Children believed that many of their perpetrators planned the abuse. For example, Child 19 (age 13) shared, "*I knew he was going to try and do something with me or to me because he was acting too nice. He want [sic] and cook breakfast and he pick out my clothes.*" Child 13 (age 12) recorded that her perpetrator brought her a drink when she wrote, "*I guess he must have had a plan or wanted an excuse to come in.*" Child 20's (age 14) perpetrator lured her into a room by offering to play a game, and then he locked the door behind her.

Several of the children recorded things that their perpetrator said to them during the abuse. For example, one perpetrator asked Child 4 (age 9), "*Do you like it*?" Child 14 (age 12) recorded, "*Then I said get off me. And he said no. Then he told me to shhhh*." Child 9 (age 11) shared that "*During the abuse he was telling me it's normal and not to worry, and after that he started licking my vagina and tried to take my virginity*." Child 19 (age 13) wrote, "*He told me what he would do for me if I just have sex with him and be his girlfriend.*" This same child later added, "*He said that he loves me and he wants to be my partner*."

Some children also recorded statements made by their perpetrators following the abuse. Several of the perpetrators told the children not to tell. For example in Child 15's (age 13) narrative, she wrote, "*He called me back in the room. He said don't tell anyone what happened.*

He asked if I knew what he did was wrong. I said yes I knew it was wrong." Child 20 (age 14) was threatened by her perpetrator who said if you "*ever tell anyone I will hurt you and your mommy and daddy . . . . He then wipes my tears and tells me to suck it up and leave*."

Children expressed a wide range of feelings about their perpetrators. Some wanted to see the person again and expressed missing him or her. Others stated that they wanted the perpetrator to get help. While still others expressed that they hated their perpetrator. In the Hopes and Dreams Chapter, Child 5 (age 7) expressed wanting to go back to her mom and dad, who were her perpetrators. Child 11 (age 11) shared that he was separated from his cousin following the abuse, which makes him feel sad. Child 12 (age 11) stated she was glad her brother was getting help but felt sad because she misses him. Child 13 (age 12) shared her feelings about her perpetrator when she wrote, "*He is a fucker. . . burn to hell for all I care.*" Child 18 (age 14) expressed quite opposite feelings about her perpetrator compared to some of the other children when she wrote that regardless of what happened she still loves her dad even though he abused her.

Subtheme 1.3: Thoughts and Feelings. In addition to sharing their experiences with their perpetrators, children also reflected on their thoughts and feelings about the sexual abuse. Some of the thoughts centered on why the abuse was happening. For example, Child 15 (age 13) shared, "*All these thoughts were going through my head. Like why was he touching my chest? Why me? What just happened?*" Child 9 (age 11) stated, "*During the abuse I was wondering why he was doing this to me*." Child 8 (age 11) expressed her thought regarding not stopping the

abuse when she said, "*Why was I letting him do this to me?*" Child 14 (age 12) wrote her thoughts about abuse in general and stated, "*It was not right to be doing that to lil girls.*"

In addition to thoughts about their abuse and questions about why it happened, the 21 child victims reported a wide range of feelings about their experience. In an analysis of the narratives in their entirety, a thesaurus along with Concordance © (Watt, 2009) was utilized to identify the number of times children described specific feelings. Some of the most commonly cited feelings were confusion, guilt, anger, sadness, and fear. Words related to confusion (e.g., confused, unsure) occurred 16 times; words related to guilt (e.g., guilty, responsible) were noted 16 times; words describing anger (e.g., angry, mad, upset) appeared 27 times; words related to sadness (e.g., sad, depressed) appeared 40 times; and lastly words related to feelings of fear (e.g., frightened, afraid, scared, anxious, worried) occurred 50 times. Below are sample statements from children describing those and other reported feelings:

Anger:	*After the abuse I felt mad. After weeks I felt angry.* (Child 1, age 6)
Confusion:	*I didn't truly understand what was going on at the time so I was confused. . . . During the abuse I had a feeling that something was wrong but I was too little to understand.* (Child 9, age 11)
Fear:	*The first time the abuse happened I felt scared.* (Child 6, age 8)
Guilt:	*I came down with guilt because I felt very responsible for it. It felt as if I let him in.* (Child 21, age 15)
Self Blame:	*I washed myself. I felt like I did something wrong.* (Child 10, age 11)
Sadness:	*I felt so sad when he was touching me.* (Child 11, age 11)
Denial:	*A few days later I was still in shock and I was trying to deny it because it was with my dad.* (Child 19, age 13)
Various:	*I would always feel so dirty, helpless, scared, and angry. I was angry at him but mostly myself. I felt it was my fault.* (Child 15, age 13)
	During the abuse it felt disgusting and weird. After the abuse I felt dirty and worried. (Child 8, age 11)

Theme One, Memories of the Abuse, provides insight into (a) children's perceptions of their abuse, (b) descriptions of their perpetrators, and (c) their thoughts and feelings about the

sexual abuse. The first subtheme, Abuse Descriptions, described a wide range of types of sexual victimization. Some children described their sexual abuse in detail whereas other children were vague in their descriptions. One child in the study summed up the experience when she said, *"[Sexual abuse] is the worst thing that can happen to a kid.*" (Child 19, age 13) In the second subtheme, Perpetrators of the Abuse, children recorded ways in which their perpetrators violated their trust. Some children described how they believed their perpetrators planned the abuse. Children also reported things that their perpetrators said to them during and after the sexual abuse. Children's disclosures of a wide range of current feelings about their perpetrators were also documented in this section. In the third and final subtheme, Thoughts and Feelings, children described their efforts to understand what was happening and why it was happening to them. Children also expressed how they felt when the abuse occurred. Theme One provides a window into the world of the sexually abused child and provides information that can enhance counselors' and community members' understanding of the experience of child victims.

Theme Two: The Disclosure and Subsequent Events

The second theme, The Disclosure and Subsequent Events, included three distinct subthemes: (a) The Disclosure, (b) The Investigation, and (c) The Justice System. The three subthemes are described below through the use of quotations from the children's narratives in order to provide insight into their experiences of the disclosure and subsequent events.

Subtheme 2.1: The Disclosure. Many (9 out of 21) of the children stated they frequently thought about telling someone about the abuse so that it would end. Although the

children wanted to disclose, many waited weeks, months, or years to reveal the abuse. Some children reported feeling afraid that they would not be believed, that they would get in trouble, and/or that they were unsure about what would happen to themselves and/or their perpetrators following disclosure. The following are examples of the children's thought process prior to disclosing the abuse:

> *I waited two years until I told my mom and my brother. I felt guilty and like a bad person about waiting. I couldn't take it any more so I had to tell.* (Child 4, age 9) *I thought about telling maybe like thirty or ninety times.* (Child 8, age 11) *I waited for six or seven months to tell and while I waited to tell I was depressed and afraid for what happened and what was going to happen.* (Child 9, age 11) *I waited practically years to say anything to anybody. . . . I made up my mind about telling someone so many times before I actually did because I didn't know what to say or how to say it.* (Child 18, age 14) *I really didn't know who to tell because it was just embarrassing.* (Child 19, age 13)

Eighteen of the children decided to disclose their abuse. In the narratives in which children disclosed, they recorded what they said and who they disclosed to. Nine of the children disclosed to one or both parents, one disclosed to a grandparent, one to a godmother, one to a step-sister, one to a classmate, four to an adult at school, and one was unspecified. The remaining three children's abuse was discovered by a parent. For example, Child 8 (age 11) wrote, "*and then my mom was coming and she push open the door and he jumped back and then he started kissing me on my cheek and my mom was like 'What were you doing to her?'. . . I waited until my mother found out . . . because I wanted her to see what was happening*."

The children who disclosed their sexual abuse recorded what they said in their narratives. The following quotes from children provide a description of the disclosure from their perspective:

> *I said that he was touching my private body parts.* (Child 11, age 11) *So yes I did confess because I knew it wasn't good to hold things back for a while things could get very worst.* (Child 12, age 11) *The day I told I wrote it on a piece of paper, showed her, cried,*

> *hugged, and took a nap.* (Child 9, age 11) *One day I broke down at school and at that point I felt like it was necessary to say something.* (Child 18, age 14) *I told him what my father be doing to me and why I missed so many days of school. I had told my teacher. I just told him everything.* (Child 19, age 13)

In addition to what they said and who they told, children recorded the wide range of feelings that occurred during the disclosure. Multiple children recalled feeling scared and nervous. The following statements by children shed light on their diverse emotions:

> *I feel when I told brave and happy.* (Child 7, age 8) *I was crying and I was scared.* (Child 15, age 13) *I felt really nervous when I told because I didn't want her to tell anyone.* (Child 9, age 11) *The day I told was like hell to me. It was full of chaos, tears, and confusion. . . . When I was telling her I felt relieved but I also felt scared, anxious, hurt, overwhelmed, and guilty. After I told I still felt the same way as before but even more because I had to see my family cry and suffer because of what had happened.* (Child 18, age 14)

Seven of the children specifically recalled feelings of relief after disclosure. Below are several examples:

> *I have less stress now that I told.* (Child 15, age 13) *Now I feel relieved about telling.* (Child 18, age 14) *I feels [sic] great because life without the abuse is so much better because I don't have nothing to worry about at night. . . . I just felt scared but at the same time I was just kind of relieved.* (Child 19, age 13)

According to the narratives, all children except one were believed by those that they told. The child who was not believed said this about her disclosure:

> *I told [blacked out names]. I told them what happen. [blacked out names] said stop tell [sic] stories. You better stop. Angry because I was tell what happen and she took it as a joke. They believed me after they found out I was pregnant.* (Child 14, age 12)

In the descriptions of the disclosure, children also shared their perception of the person's reaction when they told. The most common reactions to the disclosure recorded in the narratives were shock, sadness, and anger.

> *Momma felt sad and she cried. She felt angry about daddy because he did a bad thing to me.* (Child 3, age 7) *I told my mom what my perpetrator did to me and she started to*

> *burst into tears.* (Child 4, age 9) *She felt bad and shocked and gave me a hug and told me everything is going to be all right.* (Child 9, age 11) *He kept on saying your father wow. They just had a blanked [sic] look like why would anyone find their own child attractive.* (Child 19, age 13) *My mom was really shocked and scared. She was really mad and she went told him to get out the house.* (Child 8, age 11)

Some adults' responses were helpful. For example, Child 2 (age 8) recorded, "*My mom said it wasn't my fault and it wasn't.*" Other adult responses may have left children feeling partially responsible for the abuse or blamed for not disclosing sooner. For instance, one child recalled that her parent asked her why she had participated in the abuse. Another child wrote in her narrative, "*She started to be angry. . . started to cry. . . and told me why didn't I told her about what happened*." (Child 1, age 6)

Subtheme 2.2: The Investigation. Following the disclosure, the majority of the children recorded their experiences during the investigation process in their narratives. The chapter, The Investigation and Court, was not included in five of the children's narratives. It is possible that the children did not remember the investigation process or a formal investigation may not have been conducted; thus the chapter was omitted. In the narratives that described the investigation, some children reported having to tell their story to numerous people. Five of the children shared that they had to have a physical exam. Below are excerpts from five of the narratives to illustrate children's varying experiences and perceptions of the investigation process.

> *I talked to the police and the police asked me: Where did it happen? And who touched you? The doctor checked where [blacked out perpetrator's name] touched me and I felt happy because I was okay.* (Child 1, age 6) *My mom did call the police and the police said to me "No one is mad at you. Your mom isn't mad at you. No one is mad at you. We just want you to know nobody is mad at you."* (Child 4, age 9) *Then I had to go tell the guidance counselor and officer [blacked out name] and a bunch of other people I did not know at all. . . . He [the school resource officer] told me that I had to fill out a statement about all the times that it happened and add ALL the details.* (Child 13, age 12) *The*

> *investigation was long, hard, brutal, and seemed like never ending. I have written, seen/talk, sat through, etc. more than I can count the times how many cops, therapists I have talked to through the process. It's horrible!* (Child 17, age 17) *Yes, I did have to talk to the police at first and I felt sad, confused, mad, and scared. They asked me everything possible. I also did have a physical exam. And it felt like an invasion of privacy and very uncomfortable for me.* (Child 18, age 14)

For some children, the investigation was the beginning and end of their experience with the justice system. For various reasons they did not go to court and their abuser remained free. According to Child 15 (age 13), "*There was no court because they said there was no evidence*." Child 14 (age 12) stated, "*He did not get time. It didn't please me. He sexually abused his step-daughter, my sister, me. He should have gotten 40 years in prison. All sexually [sic] molesters should have 40 years. I was shocked and angry.*" In two narratives, children recorded that the police could not proceed with the investigation because the whereabouts of the perpetrator was unknown. Overall, for many children the investigation process was difficult. Child 21 (age 15) summarized the experience when he said, "*It was a lot to bare, to handle. Questions would be constantly pounding on me. I would have to recite my story countlessly [sic]*."

Subtheme 2.3 The Justice System. Some children's cases went to court. These children discussed their anticipation of the court date and their fear of seeing the perpetrator again. Child 8 (age 11) stated, "*If I have to go to court I will be scared if I have to see his face, but either way I will be strong. I will survive*." Several children also recorded whether or not their perpetrator was charged and sentenced. In the narratives, some of the children's perpetrators received punishment, whereas others went free. Below are some descriptions of children's court experiences:

> *I went to court. I was nervous. . . . I was mad when I saw [the perpetrator].* (Child 1, age 6) *Court just bounce my abuser from place to place even one time letting him come back home for a year so that he could do the abuse all over again!* (Child 17, age 17) *I do go to court all the time and I hate it. Why? Well because I feel like they are all up in my business all the time and I feel like they make decisions based on what they think is best and don't consider my opinion.* (Child 18, age 14) *[The perpetrator] took a plea deal of 15 years in prison and in 10 years chance of parole.* (Child 16, age 14) *But finally . . . he got his punishment! And the abused got justice!* (Child 17, age 17)

Some children expressed their views on their perpetrators' punishment or the punishment of perpetrators in general. Their writing on this subject expressed a wide range of what they thought was just. For example, Child 1 (age 6) wrote, "*I would like for [the perpetrator] to stay in jail for 1,000 years!*" Child 8 (age 11) stated, "*I don't know how much time should the abuser serve but all I know he should get time in prison so he could learn from the mistakes that he did to me.*" Child 19 (age 13) expressed, "*I feel that he shouldn't get any time more than a month then just kill him that's how I feel.*"

To conclude, Theme Two, The Disclosure and Subsequent Events, uncovered children's experiences in telling someone about the abuse and the immediate consequences (both positive and negative) that occurred. The first subtheme, The Disclosure, revealed that many of children wrestled with a desire to tell, did not know how to tell, and dealt with fears related to the idea of telling someone about the abuse. Children who decided to disclose their abuse explained the process of sharing, their feelings during the disclosure, and their perceptions of the individuals' reactions to the disclosure. In the second subtheme, The Investigation, children described what it was like to be interviewed, in some cases multiple times. Some children received a physical exam in an effort to gather evidence of the abuse, which was also described in this section. In the last subtheme, The Justice System, children detailed their apprehension about attending court and seeing their abuser. Some children described their court experience and discussed the outcome of

the case against their perpetrator. Multiple children made statements about what they considered to be just punishment for their perpetrator. Theme Two revealed information about the disclosure experience of sexually abused children and the following events. As a result of telling, the children in the current study were interviewed and a number of children had further interactions with the justice system (e.g., depositions, court appearances). Theme Two provides important information that will help inform those both in and outside of the counseling field on child victims' perspectives of the challenges of disclosure and the subsequent events.

Theme Three: The Healing Journey

The third theme, The Healing Journey, included three distinct subthemes: (a) Counseling, (b) Life Changes, and (c) The Future. Detailed descriptions of the three subthemes are provided below. Direct quotes are used from the children's narratives to illustrate their experiences in counseling, their thoughts and feelings about how life had changed, and their view of the future.

Subtheme 3.1: Counseling. All 21 children in the present study entered counseling with diagnosable mental health disorders that included symptoms directly related to their sexual abuse. Some of the narratives provided children's descriptions of their symptoms. The most common symptoms reported were nightmares, flashbacks, intrusive thoughts, and difficulties recalling aspects of the trauma. This is not surprising since the symptoms are part of the criteria for Posttraumatic Stress Disorder (PTSD), with which over half of the children (57%) in the study were diagnosed.

> *My worst memories come to me at night, in nightmares. It's almost like living through the abuse night after night with no happy ending.* (Child 17, age 17) *I've been having many*

> *flashbacks, many triggers, and intrusive thoughts . . . on the way to [counseling], leaving [counseling], at the store, at Subway, or at the mall. I would get flashbacks, triggers, or intrusive thoughts at many places. It isn't easy for me to handle.* (Child 4, age 9) *I can't explain all of it but I remember some.* (Child 19, age 13) *I honestly do not remember the first time it happened.* (Child 18, age 14)

The children reported that they did not have much choice about going to counseling; parents or guardians brought them to the agency. Children expressed concerns about whether or not counseling would help and even wondered why they had to attend counseling. Some expressed anger about having to go, feeling nervous, concerns about being judged, and feeling like they were in trouble. Below are some examples of their initial thoughts about counseling:

> *I thought counseling was not really going to help me.* (Child 8, age 11) *When I found out that I had to go to counseling I was worried because I don't like telling people about my life. I also thought that it would be sort of scary.* (Child 13, age 12) *I felt suspicious like why did I have to go.* (Child 14, age 12) *The first time they told me that I had to go to counseling I felt like I was crazy and like if I did something wrong.* (Child 18, age 14)

Overtime, children reported that their negative thoughts and feelings about counseling improved. Although some said that participating in counseling was still hard at times, all of the children who specifically discussed this subject stated that they had found counseling to be beneficial. Some examples of children's current thoughts and feeling about counseling include:

> *What I thought was . . . helpful.* (Child 1, age 6) *Coming to [the agency] changed the way I felt about the abuse.* (Child 2, age 8) *I think counseling is a good place to go. You can be trained how to use your skills. I think counseling is very good for me. It really helps me. I have learned from myself and my counselors a lot, I really love this place. This place is always going to be stuck in my head. I will remember this. Thank-you.* (Child 8, age 11) *[The agency] has been so helpful to me without it I might still think it was my fault. I thank [blacked out names of counselors] for everything. They inspired me. This place is wonderful and so glad that I met everyone, and now I know that I'm not the only one who suffered.* (Child 20, age 14)

A handful of the children also provided insight into the trauma narrative part of the counseling process. A few children shared that it was a difficult process and brought back

memories, which resulted in feelings of sadness. Others shared that it brought relief and helped them feel better.

Most narratives included statements about what the children learned in counseling. One of the most common lessons shared by the children was that the abuse was not their fault. Children also stated that they learned about feelings, good and bad touches, abuse symptoms, coping strategies, relaxation, anger management, replacing bad thoughts with good thoughts, how to increase self-confidence, ways to make friends, how to handle stress, opening up to others, learning to trust, and taking care of oneself. Another lesson cited by several children was that they were not alone. Some examples of these lessons in children's own words included:

> *It is never a child's fault because it is the grownups' fault.* (Child 5, age 7) *At counseling I learned three things. One of those three things is to use coping skills. Another one was to talk to someone and be open. Last was that the abuse wasn't my fault.* (Child 9, age 11) *I've learned how to open up and know there are people in this world who care for me and want to listen and help me. I've learned I'm not alone and people do understand me and can relate to me. I've also learned to trust people and not block everyone out.* (Child 15, age 13)

Subtheme 3.2: Life Changes. In addition to describing their counseling experience, many children reported significant changes in their life following the abuse. In one child's words, "*After the sexual abuse happened, everything changed.*" (Child 9, age 11) Although many of these changes were made to keep children safe (e.g., separating the child from the perpetrator), some of the changes were extremely difficult. Child 10 (age 11) stated, "*My life was great until the abuse. My life was terrible after what happened.*" Children discussed the challenges of various changes such as moving (mentioned by eight children), switching schools (six children), and being placed in foster care (four children). Other changes discussed included losing contact

with perpetrators and their families. Some statements made by children that paint the picture of their changes are below:

> *My life has changed by living with my grandma and grandpa and they take care of us and let us take a bath and giving us food. They do not hurt us because they are good people. They love us.* (Child 5, age 7) *My life has changed by going to a new school and I don't see the abuser and I don't go to their house and we don't talk to them and my parents are sad what happened.* (Child 6, age 8) *Some are him and his wife has moved, also their daughter and her husband don't ever talk to my family anymore. . . . and [the perpetrator and his family] don't attend our church anymore.* (Child 13, age 12)

Additionally, some children commented on their changed view of self. For example, Child 16 (age 14) wrote, "*I was a young girl who was purified [sic] and not all yucky in the inside like I am now.* Child 19 (age 13) shared, "*I don't feel like a girly girl anymore."*

There were numerous changes in the narratives, and the children indicated that very little about their life prior to the abuse remained the same. The narratives detailed the children's process of adapting to these changes (e.g., new school, new home, changed relationship with the perpetrator and other family members). Many of the children showed signs of resiliency and adaptability to the changes that had occurred. For example, Child 15 (age 13) wrote, "*Yeah being in foster care sucks but at least I have a family or people to call family. I miss my school but I like my new one.*"

Subtheme 3.3: The Future. In addition to recording how life had changed, the trauma narratives asked children to imagine their future. In the chapter titled My Hopes and Dreams, the children frequently described ideas about their future careers. Careers in helping fields were often listed (e.g., teacher, doctor, nurse, and psychologist). Children also shared about their desire to help other children in the future through various efforts such as opening up a foster

home for kids in need, creating a culinary arts program for underprivileged kids, and adopting children. Another child talked about wanting to share her story of abuse with other women. Some statements that help illustrate what children hope for in the future are included below:

> *My dreams for my life is to move on and have a better life.* (Child 8, age 11) *Well my hopes and dreams are to one day sleep all the way through the night and wake up and everything that has happened will be dealt with.* (Child 17, age 17) *I want to live large and to the fullest. . . . I want to see the world and its many amenities before I die.* (Child 19, age 13)

In sum, Theme Three, The Healing Journey, explored (a) children's experiences in counseling, (b) their perceptions of how life changed, and (c) their thoughts and feelings about their future. The first subtheme, Counseling, described children's accounts of their trauma symptoms. Additionally, it revealed children's initial thoughts about counseling and how their views changed over time. Children also described the things that they learned since attending counseling. In the second subtheme, Life Changes, children provided details about the ways in which their life was different following the abuse. Although some changes were good (the abuse ending), others were difficult (moving, changing schools, being placed in the care of a relative or the state). A few children also explored their changed view of self. In the last subtheme, The Future, children shared their desire to help others through altruistic acts and in future careers. Children also reported positive thoughts about their life and readiness to move forward. Theme Three included children's accounts of their healing journey, which is important information to individuals both within and outside the field of counseling.

Meta-Theme: Fear and Safety

Throughout the narratives, the children returned again and again to issues of fear and safety. This was evident in the descriptions of the sexual abuse, the discussion of the disclosure and subsequent events, as well as with regards to their future. The children wrote about their own fear and concerns about their safety as well as the safety of others. Descriptions of fear, as stated in the section on children's feelings, occurred 50 times throughout the narratives. Additionally, children's thoughts related to safety were identified 13 times in the narratives. Discussion of fears and concerns about safety were identified in all 21 narratives, which indicated that it is not limited to specific demographic groups (e.g., age, diagnosis). Although all children discussed fear or concerns about safety, one account was different than the others. Child 21's (age 15) discussion of safety was related to his desire to protect his sister from future abuse. It is possible since Child 21 was not abused directly and was classified as a "secondary victim" by the agency, his experience did not include personal fear and concern for his own safety.

The results of the analysis revealed that issues of fear and safety were present throughout the narratives: during the sexual abuse, in the children's attempts to stop the perpetrator, and during the disclosure. Fear and issues of safety were also present in children's discussions of their lives today as well as in their writing about the future. Fear and safety are examined below in each of these areas, and direct quotes from children are utilized to help depict their perspectives.

In the early chapters, children recalled feeling afraid during their abuse:

> *I felt scared and worried but he kept doing it to me.* (Child 8, age 11) *When it was happening I was scared that he would hurt or kill me so I was moving around a lot.* (Child 13, age 12) *Then I was really starting to be afraid of him.* (Child 19, age 13)

In addition to expressing fear during the abuse, children also described their efforts to keep themselves safe and stop the abuse. Out of the 21 narratives, 6 detailed specific strategies that children utilized to try to prevent the abuse. These strategies included: saying no or stop, pushing the perpetrator, pretending to be asleep, trying to run, screaming, and crying. The following quotes from the narratives help illuminate some of these efforts:

> *I kept saying stop stop but he wouldn't.* (Child 16, age 14) *I was trying to push him off of me and it seemed like he wouldn't budge. He was stronger, bigger, mean and scary. He had the look of craziness. He wouldn't let go, wouldn't stop touching me. I tried to scream but it didn't work!* (Child 17, age 17) *Then he came in and shut the door and when I see the look on his face then I tried to run but I could not. . . . I kept on trying to push him and I even cried that still didn't help.* (Child 19, age 13)

In five of the six narratives that detailed efforts to end the abuse, the children stated that their actions did not have any impact on the perpetrator and did not stop the abuse from happening. The exception to this was Child 15 (age 13) who said she would pretend to fall asleep. She stated that eventually her perpetrator would leave the room, which only ended the abuse temporarily.

In the narratives, the children also shared their fears that the abuse would continue to happen. This paints a picture of living in constant fear.

> *The reason I don't like to go to school is because I'm afraid of him that he might do it again.* (Child 10, age 11) *I'm worried about court because if I lose the case then he will probably hate me and have freedom and can do whatever he wants to me.* (Child 13, age 12)

During the disclosure or in cases in which the abuse was found out, the children also described feeling afraid.

> *During the days and weeks afterwards I was scared to tell someone because I thought they were gonna be mean and yell at me or not believe in me.* (Child 8, age 11) *When my dad walked in I was so frightened. I did not know who he was going to believe.* (Child 11, age 11)

The child victims wrote that they continue to struggle with fear. They also expressed their need for protection. This is evidenced in the following quotations:

> *We have a new car and he can't find us.* (Child 1, age 6) *The reason I sleep with my mom even if I'm 10 is because I feel safe when I'm with my mommy and I feel like she can protect me from any harm.* (Child 6, age 8)

In addition to their need for protection, children frequently discussed their current safety and the safety of others in the narratives.

> *I would like my family to be protected and safe.* (Child 1, age 6) *Also I feel less safe. . . . Feeling less safe is one of my bad changes though.* (Child 13, age 12) *The police and [name of counselor] keep me safe.* (Child 3, age 7) *I'm more secure and watchful over my sister though.* (Child 21, age 15)

Several of the children, when reflecting on their future hopes and dreams, mentioned themes of safety, including wanting to protect their future children when they are parents.

> *I hope I will never get abused again. . . . I want to be with my parents and I want them to protect me.* (Child 6, age 8) *[I] pray and hope to grow up and become that successful heart surgeon so that when I have a daughter I can protect her from what happened to me.* (Child 16, age 14) *I want to be the mom that always there and very protective one too. I want to make sure to love and care for my kids.* (Child 19, age 13)

The meta-theme, Fear and Safety, was identified throughout the narratives and was present in all three themes: Memories of the Abuse, The Disclosure and Subsequent Events, and The Healing Journey. Past fears such as that the perpetrator would harm or kill them and that their abuse would not be believed are still remembered clearly. Fears of revictimization and feeling unsafe were evident in children's descriptions of their life now. Symptoms such as nightmares, intrusive thoughts, and flashbacks were also connected to feelings of fear. Children expressed their need for protection as well as their desire to protect their own future children from sexual abuse. The organization of the narrative did not require children to write specifically

about fears, therefore the frequent mention of fear and safety is an important part of understanding child victims' experiences during and after sexual abuse in the current study.

Summary

In this chapter, the results of the present study on children's descriptions of life before, during, and after sexual abuse were presented. To start, a description was provided of the sample of 21 children. This information was followed by a discussion of the verification of the results. The data analysis process was described, and the results were presented. The analysis of narratives resulted in three themes (Memories of the Abuse, The Disclosure and Subsequent Events, and The Healing Journey) and one meta-theme (Fear and Safety). The researcher focused on the voices of the children which were captured through the exploration of trauma narratives. Each theme was discussed using quotations from children's narratives to provide a rich description of children's experiences. The results of this study provide information that will further the field of counseling and educate community members at the local and national level as it is the first known study to investigate children's accounts of their sexual abuse in the form of trauma narratives.

CHAPTER FIVE: DISCUSSION

Summary of the Study

The present study investigated child sexual abuse (CSA), a crime against children that is estimated to affect 1 in 4 girls and 1 in 6 boys before the age of 18 (Centers for Disease Control and Prevention, 2005). A review of the literature revealed that little is known about CSA from the perspective of the child victim. Research has focused almost solely on adults with a CSA history. The vast majority of studies conducted on children have researched the effectiveness of various treatment interventions, but they have neglected to explore the subjective experiences of child victims of sexual abuse. In response to the gap in the research literature, the present study examined children's perspectives of sexual abuse through thematic analysis of trauma narratives, which were written during counseling and described life prior to, during, and after sexual abuse.

This study of trauma narratives written by child victims of sexual abuse utilized qualitative analysis procedures which were defined by Bogdan and Biklen (1982) as "working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others" (p. 145). As a result of the analysis, three themes and one meta-theme emerged. In this chapter, the themes are briefly reviewed. This is followed by a discussion of the limitations of the study. Although limitations exist, there are numerous implications of the present study that will impact child sexual abuse prevention initiatives, and will aide in the formation of developmentally appropriate treatment, and will inform the training of current and future counselors. The results also are useful to the practice of counseling and those in related fields as well as community members. Finally, recommendations for future research are provided.

Review of the Results

In this qualitative study of trauma narratives, the researcher set out to understand children's accounts of CSA from a trauma narrative intervention in order to improve prevention efforts, create developmentally appropriate treatment protocols, train current and future counselors, better inform the field of counseling, and educate community members. The thematic analysis uncovered one meta-theme: Fear and Safety and three themes: (1) Memories of the Abuse, (2) The Disclosure and Subsequent Events, and (3) The Healing Journey. The meta-theme and themes were reported by all 21 children in the study and differences in the themes based on children's ages were not identified.

In the first theme, Memories of the Abuse, children provided (a) descriptions of their abuse, (b) details about their perpetrators, and (c) their thoughts and feelings about the sexual abuse. Within the second theme, The Disclosure and Subsequent Events, children shared (a) information about their disclosure of the abuse, (b) their experiences during the investigation, and (c) interactions with the justice system. In the third theme, The Healing Journey, children wrote about (a) their perceptions of counseling, (b) the many ways in which their lives had changed, and (c) their dreams for their future. The meta-theme, Fear and Safety, was present throughout the children's narratives. Children were not directly asked to write about issues of fear and safety; therefore, the frequent mention of past, current, and future fears captures the experience of the child victim.

At the onset of the study, the investigator posed two broad research questions:

1. How do children express their thoughts, feelings, and beliefs about their life prior to, during, and after sexual abuse in the form of trauma narratives?

2. What themes emerge from childhood accounts of CSA from a trauma narrative intervention that can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members?

The first research question sought to uncover how children express their thoughts, feelings, and beliefs about their life prior to, during, and after sexual abuse in the form of trauma narratives. The first chapter of the narratives, Life Before the Abuse, provided insight into how children described their memories before the sexual abuse. In this introduction chapter, most children reported a happy life prior to the abuse. For example, Child 16 (age 14) shared, "*My life before the abuse was fun, less stress, exciting. Before the abuse I wasn't afraid to stay home late at night by myself with the abuser [blacked out name]*." According to Child 7 (age 8), "*My life before the abuse was fun, happy, and joyful.*"

Although many children reported positive childhood memories prior to the abuse, there were some exceptions. For example, Child 5 (age 7) stated, "*My life before my abuse is my sister had to take care of us because my mom and dad were lazy*." Child 14 (age 12) said, "*No there is no happy memories*." Life before the abuse was limited to the first chapter of the narratives and it did not result in a standalone theme. Some aspects of Chapter One discussed how life had changed through contrasting life before and after the abuse (which was included in Subtheme 3.2: Life Changes). This chapter set the stage for the rest of the narrative that focused on the sexual abuse.

In addition to exploring life before the sexual abuse, the first research question investigated how children express their thoughts, feelings, and beliefs about their life during their

sexual abuse in the form of trauma narratives. The accounts of their sexual abuse gathered from children's narratives painted a picture of their experiences that is largely unknown in the counseling field.

There were many differences in the 21children's accounts of their abuse experiences. Children experienced various forms of victimization, including: exposure to pornography, adults having sex in front of a child, touching private parts, forced oral sex, vaginal penetration, and anal penetration. Additionally, the length of time the abuse occurred varied for the victims, ranging from one day to over the course of several years. Despite these and other differences, themes and subthemes emerged.

Theme One, Memories of the Abuse, detailed what life was like for the children during this time and included (a) descriptions of the sexual abuse, (b) details about perpetrators, and (c) thoughts and feelings about the abuse experience. All 21 of the children were able to provide a description of their sexual abuse, although some were more detailed than others. These descriptions often included information about the perpetrator. In some cases, the children discussed how the perpetrator broke their trust. Others talked about how they thought the perpetrators planned the abuse. The children also recorded things that their perpetrators said to them during and immediately following the abuse. Feelings about the perpetrators were also reported and represented a wide range of variance (from love to hate). In addition to thoughts and feelings about the perpetrator, the narratives also incorporated thoughts and feelings about the abuse itself. The most commonly stated thoughts expressed uncertainty about the situation and questions regarding why the abuse was happening to them. A similar research study also found that children’s narratives of sexual abuse (transcribed from counseling sessions) frequently

contained “Why” questions and statements indicating the difficulty of making meaning of their sexual abuse (Mossige et al., 2005). Along with thoughts, children expressed their feelings during the abuse, with the most common feelings being fear, anger, sadness, and confusion. The narratives painted a picture of life during the abuse for children, which for most victims was full of both confusion and suffering.

Along with investigating life during the sexual abuse, the first research question asked how children express their thoughts, feelings, and beliefs about their life after sexual abuse in the form of trauma narratives. Similar to abuse experiences, there was a wide range of diversity in the accounts of life following the abuse. According to the narratives, four children were placed in protective custody following the disclosure and investigation, eight moved to a new home, and six changed schools. Some children's cases went to court, which in several situations led the perpetrator being charged and convicted of the crime. For other children, their perpetrators’ charges were dismissed. Despite these and other differences between the children's accounts of life after abuse, two themes emerged: The Disclosure and Subsequent Events and The Healing Journey. The themes provide information that prior to this study was largely undocumented in the counseling research literature, which has mainly been limited to studies with adult survivors of CSA.

In Theme Two: Disclosure and Subsequent Events, the narratives detailed children’s (a) perspectives on the disclosure, (b) views about the investigation, and (c) experiences with the justice system. To start, many children detailed their struggle to find a way to tell about the abuse. Many feared that they would not be believed and expressed wanting to tell but not knowing how. This was followed by a description of the disclosure, which included the

children's thoughts and feelings about telling. Commonly cited feelings were fear and anxiety, which were frequently followed by relief. Children also recorded their perceptions of the person's reaction to the disclosure, which often included shock, anger, and sadness. According to the narratives, 20 of the 21 children were immediately believed. Of the narratives in the sample, 16 discussed the investigation of the abuse. Children described what it was like to be interviewed, and some shared about having to have a physical exam in an effort to attain evidence. In some cases, the investigation led to the perpetrator being charged with the crime, which was followed by court. Children who experienced going to court recorded their feelings about it in their narratives. Many children, both those who went to court and those who had not, commented on punishment for their perpetrator and their perspectives on justice.

In Theme Three: The Healing Journey, children shared their (a) experiences in counseling, (b) views on how their lives had changed, and (c) hopes and dreams for their future. In the discussion about counseling, children provided descriptions of their experiences with trauma symptoms, most frequently those associated with Posttraumatic Stress Disorder (flashbacks, nightmares, and intrusive thoughts). A few children also shared their difficulty remembering parts of their abuse. Children's parents or caregivers brought the children to counseling to address symptoms related to the sexual abuse. Most children stated that they did not want to go to counseling and did not initially believe it would help them. Yet, children shared how this view changed and the ways in which they had benefited from counseling to address their sexual abuse. Children also listed the many things they had learned in counseling, some of the most common being that the abuse was not their fault and that they were not alone. The theme, The Healing Journey, also included descriptions of how life changed since the disclosure.

Multiple children said that they moved (eight children), changed schools (six children), or were placed in state custody (four children). A few children mentioned an altered view of self (e.g., no longer pure). The theme ended with children's thoughts and feelings about their future. Many of the children stated their desire to pursue a career in a helping profession (e.g., teacher, doctor, and psychologist). Other children stated their desire to help other children through adoption, foster care, and other altruistic acts. It appears that the challenges the children experienced may have enhanced their sensitivity to the needs of others, thereby creating a desire to help and provide care for those in need. In general, the children described their future hopes and dreams in positive terms, which may indicate traits of strength and resiliency as well as attest to their personal healing from the trauma.

The three themes, which were discussed above, provide answers to research question one and aide in the understanding of child victims' perspectives of life during and following sexual abuse. In addition to these three themes, life both during and after the abuse were both greatly affected by what was uncovered and categorized as a meta-theme: Fear and Safety. Words describing feelings of fear (e.g., afraid, scared, worried) appeared 50 times in the narratives, and words about safety were mentioned 13 times. Numerous children expressed that during the abuse they felt afraid of their perpetrator. Several children also discussed strategies to try and keep themselves safe from the abuse, such as saying stop, trying to scream, or attempting to get away. Issues of fear and safety continued for children during the disclosure (e.g., fear that they would not be believed and fear of what will happen to them and their perpetrator). Children also wrote about their current fears and need for protection. Children worried about both their safety and the

safety of their families. Some children also expressed a desire to protect their own future children from sexual abuse.

The narratives provided a response to the first research question through a very detailed description of children's views on life before, during, and after sexual abuse. The themes that emerged painted a picture of the children's experiences along with their thoughts, feelings, and beliefs about their sexual abuse and the recovery process. The information uncovered adds to counseling research literature as it is one of the first known studies to investigate children's perspectives of their abuse through an analysis of trauma narratives.

The second research question focused on discovering themes emerging from childhood accounts of CSA that can be used to improve prevention efforts, create developmentally appropriate treatment protocols, prepare current and future counselors, better inform the field of counseling, and educate community members. The response to this question, which utilized information uncovered in the narratives, will be delineated in the implications section. First, a discussion of the study's limitations will be considered to provide a context for the implications.

Limitations

As with any research study, this study had its limitations. To start the narratives were collected from only one agency located in the southern United States. The researcher was formerly employeed by the partnering agency, and therefore had established a relationship with the director and staff prior to the start of the study. This positive relationship helped the reseacher gain access to data that is frequently denied to outside researchers due to the many protections that are put into place for this vulnerable population. Additional sites that utilize

trauma narratives with child victims of sexual abuse, specifically from other geographic locations, would have added to this study's transferability. Future research may be able to address this limitation.

Additionally, due to Intuitional Review Board stipulations, this study was limited to the use of de-identified, archival data. Therefore, consent was not attained, and the study only analyzed the narratives' text. Although eight of the narratives included pictures, permission was not granted to include them in this study. Future research may benefit from an analysis of the pictures that children draw in the narratives to accompany the text.

Another limitation to consider regarding the use of de-identified data is that the narratives had gaps in them that cannot be addressed (e.g., unknown words due to spelling, handwriting, and the quality of scanned documents). At times, the content of the narratives was difficult to understand due to the children's confusing wording, unfinished thoughts, and alternating between the past and present in the accounts. Although the documents allowed the researcher access into children's subjective experiences of sexual abuse, the researcher was not able to interact with the children. The use of interviews in addition to the documents would have allowed the researcher to use probes to uncover additional information and questions to clarify the narrative accounts, which would have strengthened the study.

The use of de-identified data meant that the researcher was not able to check with participants regarding the themes uncovered through verification strategies such as member checking and collaboration with participants. Focus groups and individual interviews with the children following the analysis of the narratives would have provided additional insight into children's perceptions of the study's themes. Despite this limitation, the use of a research

assistant, external audit, researcher reflexivity, thick, rich description, peer debriefing, and direct quotes from the participants helped the researcher stay true to the perspective of the children represented in the study (Creswell & Miller, 2009). Even though the study is limited to a retrospective analysis of archival client data, the findings are important as this is the first known study to examine children's perceptions of CSA through an analysis of trauma narratives completed during Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

An additional limitation to note regarding this study was that the trauma narratives were not created for the purpose of research. The trauma narratives were part of a therapeutic intervention conducted within the framework of TF-CBT (Cohen et al., 2000). Since the narratives were conducted in the context of counseling, there were several variables that could not be controlled or accounted for. One such variable is the relationship between the children in the study and their counselors. Research has shown this relationship has a strong influence on clients' therapeutic outcomes and the success of interventions (Norcross, 2002). A strong client-counselor relationship encompassing trust and empathy may allow a victim to feel safe enough to share his or her account of the abuse. This would likely have resulted in a narrative that was rich in detail. On the other hand, if a child does not feel the counselor can be trusted, the narrative may be superficial or an incomplete account of the abuse. Although the counseling chapter of the narratives indicated positive relationships between the children and their counselors in the present study, the strength of that relationship could not be measured.

Another factor to consider regarding the trauma narrative intervention is that counselors must use their judgment to determine the child's readiness to begin the trauma narrative process. Before beginning the narratives, children should demonstrate the ability to express emotions as

well as healthy coping skills (Cohen & Mannarino, 2008b). Since trauma narratives may be written at any time during treatment at the partnering agency, counselors must make a decision regarding when to begin the process. Therefore, the narratives in this study were completed by children after different lengths of time in treatment and readiness to begin was a judgment made by their individual counselor.

Along with the impact of the counseling relationship on the trauma narrative intervention and counselors' decisions on when to begin the process, individual characteristics of the counselors were not controlled by the current study. Counselors at the partnering agency vary in personal style and theoretical orientation, leading to unique views and approaches to the counseling process. One strong point of the study is that all counselors at the agency received TF-CBT training, which included specific preparation for trauma narratives and the implementation process.

A final limitation of the current study was the researcher’s inability to verify the validity of the narratives (Creswell, 1998). There was no way to determine if the children were truthful about their abuse experiences or accurate in their recall. In order to receive treatment for the CSA, the community agency had reason to believe the abuse occurred based on the child's disclosure, presenting symptoms, witness reports, or other forms of evidence (e.g., the results of a physical examination). The focus of this study was on the perspectives of children who were allegedly sexually abused, and the researcher did not attempt to verify their accounts. Instead, the current study sought to understand the experience of the CSA victim in order to gain insight into the events the child experienced before, during, and after the abuse.

In sum, the narratives were collected at only one agency located in the southern United States. Additionally, the use of retrospective, de-identified data meant that neither questions about the narratives could be addressed nor themes verified with the study's participants. Also, since the intervention was conducted in the context of therapy, several variables could not be controlled for, including: the therapeutic relationship, the varying lengths of time that the clients were in treatment prior to beginning the narrative, and counselors' differing theoretical orientations and individual characteristics. Lastly, the accuracy of the narratives on CSA was unable to be verified.

Despite these limitations, this research study provided the first known analysis of trauma narratives written by children, revealing their thoughts, feelings, and beliefs about life before, during, and after sexual abuse written during TF-CBT. The results of this study lead to several important implications for counselors and those in related fields, counselors-in-training, and community members, which are described in the following section.

Implications

The study's original purpose was twofold. First, the study aimed to identify themes derived from children's accounts of life before, during, and after sexual abuse in the form of trauma narratives. Second, the study set out to provide an enhanced understanding of child sexual abuse that may lead to improved prevention efforts, the creation of developmentally appropriate treatment protocols, the preparation of current and future counselors, and the education of those in field of counseling as well as community members. Implications are provided for each area based on the themes which were identified.

Prevention Efforts

As stated in the literature review, heightened awareness of CSA has resulted in improved prevention initiatives and services for children and families (Silverman et al., 2008). Programs often include components such as helping children understand what sexual abuse is and ways to increase their safety. According to Wurtele (2009), several studies have suggested that sexual abuse prevention programs have been successful in equipping children with skills which have led to a reduction in child sexual abuse. Although there has been some documented success, existing programs can be improved through revising and updating messages that are communicated to children about sexual abuse and increasing parental and community involvement. This section details the following improvements, which can strengthen CSA prevention initiatives: (a) providing children with accurate information about perpetrators, (b) removing messages that are misleading or may increase child victims' feeling at fault for the abuse, (c) providing opportunities for initial disclosure, (d) increasing parental involvement through parent-only sessions on the topics of perpetrators, protecting children, trauma symptoms, responding to disclosure, and healthy sexuality, and (e) enhancing community involvement through education about CSA.

The results of the present study investigating children's perspectives of their sexual abuse provide information that can lead to improved CSA prevention programs. The narratives offered an enhanced understanding of children's abuse experiences, including interactions with their perpetrators. Children's unique knowledge of their perpetrators and the perpetrators' behaviors can be incorporated into prevention initiatives. Child sexual abuse prevention curriculum must contain accurate and helpful information for children, which includes providing children with

correct information about perpetrators. Although stranger abuse occurs, out of the 21 narratives analyzed in the present study, all of the children indicated that they knew their perpetrators: 12 children were abused by a parent or parental figure (e.g., step-parent, adoptive parent), 2 children were abused by an adult relative, 1 child was abused by a family friend, and 9 children were abused by another child or adolescent whom they knew. The data reflects what has previously been cited in the research literature: many more children are abused by a family member (between 24% and 49% depending on the age of the child) than a stranger (between 3% and 10% of children), and sexual abuse perpetrated by juvenile offenders is accounts for approximately 23% of CSA crimes (Finkelhor et al., 2008). Prevention curriculum must debunk the myth that perpetrators are usually scary men in trench coats driving a van or hiding in the bushes. Perpetrators are often someone the child knows and trusts. Prevention programs must be careful to not create unnecessary fear in children about perpetrators (Robinson, Rotter, Fey, & Robinson, 1991), yet still provide children with accurate information that enhances their safety.

Along with information about perpetrators, many prevention programs for children tell the children to say no to the abuse and try to get away from the perpetrator. This message may be somewhat misleading as it suggests that it is often possible to escape an abusive situation. In the present study, 6 of the 21 children specifically discussed efforts that they utilized to stop or prevent the abuse, including: saying no or stop, pushing the perpetrator, pretending to fall asleep, trying to run away, yelling out, and crying. Yet in all of these cases, the child was still abused. Only the child who pretended to fall asleep thought that her actions may have helped because eventually the perpetrator left the room. In the majority of the 21 narratives analyzed, it was

evident that the children were powerless against the bigger, stronger older children or adults who abused them.

Not only is the message to say no and try to escape potentially misleading, it also is problematic in that it puts the burden of trying to stop the abuse on the child. Children in the current study frequently reported feeling confused by their perpetrators actions and stated that they were unsure if it was right or wrong. Additionally, many children had no indication that the abuse would happen. The advice of prevention programs to "trust your gut" is irrelevant in these types of situations. For multiple children in the present study, their perpetrators' actions (e.g., an invitation to play a game in another room) did not create cause for alarm or an apparent need to escape.

While many children in this study stated that they were confused by their perpetrators actions, others were more cognizant of what was occurring. Even still, several children shared that they were unable to react as they were paralyzed by fear and were unable to get away. Following the abuse, nearly all of children expressed feelings of self-blame and guilt. This included beliefs that the abuse was their fault or that they should have been able to stop the abuse. The strategies taught in prevention programs that tell children they can just say no or run away may not work and may leave the victim feeling even guiltier for not being able to stop the abuse. Therefore, prevention programs should clearly state that if a child's efforts to stop the abuse are not effective, it does not mean the abuse is the child's fault.

Prevention programs may present children with their first opportunity to disclose the abuse. Although disclosure during or after prevention programs does not stop the abuse from occurring in the first place, it may stop it from continuing. Many existing prevention programs

include a component that encourages children to confide in a safe person if they feel uncomfortable around a particular person. They also encourage children to tell a safe person if they have already been abused. Yet, most prevention programs do not provide a clear opportunity to disclose the abuse. The trauma narratives in the present study indicated that children wanted their abuse to end, but they often had numerous fears related to disclosing their abuse. Commonly cited concerns included that they would not be believed, that their parent(s) or caregiver(s) would be angry, or that the perpetrator would harm them or their family if they told. Children also shared that they did not know how to put into words that they were being abused or felt embarrassed to talk about it. Many of the children shared that they waited weeks, months, and in some cases years to tell.

To assist children in the disclosure process, prevention programs need to provide an opportunity for children to disclose their abuse for the first time. In the current study, one child described telling an adult after a presentation at her school on cyber dating and bullying. Although four children disclosed their abuse at school, telling one or both parents was most common (nine children). Having parents and caregivers attend prevention programs with children (e.g., family sessions) may increase children's ability to disclose if they have been abused or are currently being abused. Additionally, prevention programs can increase the likelihood of children disclosing by sharing with them that some adults such as teachers and counselors have promised to help children who are being abused (mandated reporters). Knowledge that there are adults who will not be angry at the child and who are willing to help may reduce children's fear that often accompanies disclosure of the abuse. Prior to implementing prevention programs in schools, counselors, teachers, and other school personnel must be trained

in CSA and be prepared to respond with empathy (as opposed to shock or demanding the child to report all the details immediately after disclosure, which were described by several children in the present study).

Most current prevention programs are designed for potential child victims, and parent education is often a small part of the curriculum (e.g., take home assignments) or is completely missing. Parents and caregivers have a vital role in the protection of children and the prevention of child sexual abuse. In addition to having parents and caregivers attend prevention programs with their children in a family session format (which was discussed above), they may benefit from parent-only educational sessions. These sessions can inform adults about perpetrators of sexual abuse and train them on ways to protect children. Parent sessions could also help parents/caregivers learn how to identify potential trauma symptoms, respond empathetically to disclosure of sexual abuse, and teach their children about healthy sexuality.

To start, parents and caregivers need current information about child sexual abuse and sexual perpetrators, including those who commit Internet crimes. As discussed previously with regards to educating children about perpetrators, most are individuals who are known and trusted by the victim and victim's family. Parents and caregivers need to be made aware of perpetrator grooming strategies (e.g., purchasing the child gifts, granting special privileges, etc.), which are utilized to attain children's trust and keep them engaged in sexual acts (Lanktree & Briere, 2008). Parents and caregivers should also be aware of common distorted cognitions held by perpetrators, such as the belief that sexual acts with a child are not wrong or harmful or that children are objects that can be used. Parents and caregivers also need to be informed of behaviors that may indicate their child is at risk for abusing other children (nine of the children

in the present study were abused by other children). Just as myths about perpetrators need to be addressed with children, they also need to be corrected with adults.

Parent-only sessions can also focus on suggestions for improving the protection of their children. A crucial element to prevention of CSA is the creation of an environment within the home in which there is open communication between parents/caregivers and children. Parents/caregivers must be approachable and actively listen to their children. Parent-only sessions can assist families in creating healthy boundaries and guide parents/caregivers in deciding who can be trusted to be alone with their children. There are numerous resources that can be given to parents during these sessions to help them employ strategies to protect their children. For example, A Parent's Guide to Internet Safety, created by the Federal Bureau of Investigation, is published free online (http://www.fbi.gov/stats-services/publications/parent-guide/parentsguide.pdf) and could be distributed to parents. Additionally, the organization Stop It Now, has created a free resource for parents that defines sexual abuse, provides information about potential sexual abuse symptoms, lists potential perpetrator behaviors in adults as well as children, provides an overview of age appropriate sexual behaviors, and discusses creating a family safety plan. This resource is also free online and is available at http://www.stopitnow.org/sites/stopitnow.rivervalleywebhosting.com/files/webfm/green/Prevent_CSA.pdf. In sum, parent education about child safety is a key component to child protection.

Parents/caregivers should also be informed about red flags of potential abuse to look for in their children. Providing parents and caregivers with a list of potential trauma symptoms and behaviors that indicate a child may have been abused is a helpful tool that may lead to early identification of sexual abuse. Prevention program presenters must help parents/caregivers

understand that having one or more symptoms from the list does not necessarily mean that a child has been abused; instead, they are warning signs that need to be paid attention to. Presenters can also inform parents that some children who are sexually abused do not have any readily apparent signs or symptoms. The information provided on potential victims and perpetrators needs to be accompanied with follow-up resources for families.

Parent sessions can also discuss the challenges of disclosure and how to respond in a healthy way. A helpful response is one that conveys empathy, care, support, and reassurance to the child. Parents or caregivers must express that they believe the child and assure the child that he or she is not at fault for the abuse. Parents or caregivers also need to listen and not ask the child numerous questions, which may feel like an interrogation. The analysis of narratives in the present study revealed that several children were hurt and confused by their parents'/caregivers' reactions to the disclosure (e.g., shock, anger, denial, or blaming). It is possible that parents/caregivers that expressed anger may have felt anger towards the perpetrator, but children internalized this reaction as anger directed at them for the abuse. Several children also recorded blaming statements that their parent/caregiver made, included asking why they did not tell sooner or why they did not do anything to stop the abuse. Parents or caregivers in prevention programs can learn from these problematic reactions to disclosure. Although parents or caregivers are never really prepared for a child’s disclosure of abuse, the information provided in prevention programs can equip them with tools that may help if it ever occurs.

Along with preparing parents or caregivers to respond in an empathetic manner to a child's disclosure of sexual abuse, it is imperative to help parents/caregivers increase their comfort in talking about healthy sexuality and personal boundaries. This part of the training

would emphasize that children need developmentally appropriate information starting in early childhood and throughout adolescence. A onetime talk about the "birds and the bees" is not enough to provide children with pertinent information, and often these conversations occur too late to be helpful. Prevention programs can provide parents and caregivers with resources to assist with these discussions.

Child sexual abuse prevention is the responsibility of parents and caregivers as well as community members. Children are defenseless against their perpetrators, and adults need to engage in efforts to protect them. Wurtele (2009) emphasized the importance of training for individuals in various helping professions that work with children and families (educators, childcare workers, individuals in the health field, religious leaders, law enforcement, lawyers, counselors and those in related fields). Wurtele pointed out that with all other forms of child abuse or maltreatment, the responsibility for prevention is placed on adults' shoulders. Wurtele called for ". . . a shift in responsibility from children to adults. It is time for adults to step up and do their job of protecting children by creating 'molester-free' environments" (p.14).

In sum, CSA prevention programs can be improved through providing children with accurate information about child sexual abuse and increasing parental and community involvement. The information uncovered in the trauma narratives about sexual abuse can be utilized in prevention initiatives designed for children as well as parents/caregivers and community members.

Treatment of Child Victims of Sexual Abuse

In addition to improving prevention efforts, the themes uncovered in the narratives also inform the treatment of child victims of sexual abuse. The literature has documented that children's responses to trauma are unique based on their developmental stage (Feather & Ronan, 2009), thus there is a need for treatment that accounts for the ways in which children differ from adults (Adler-Nevo & Manassis, 2005; Sandoval et al., 2009; Tomlinson, 2008). Unlike the vast majority of research that has been conducted on adults, this study examined the perspectives of children ages 6-17 on their lives before, during, and after sexual abuse. Although the analysis of narratives did not reveal thematic differences based on children's ages, the themes uncovered inform the field on children's perceptions of sexual abuse and their counseling experience. The results of this study indicate that treatment must: (a) address the unique challenges experienced by child victims, (b) effectively decrease trauma symptoms, (c) include interventions that target children's fears and concerns regarding safety, (d) consider children's initial thoughts and feelings about treatment, and (e) be prepared for the potential for initial thoughts and feelings to change overtime. Each of these areas informs counseling efforts and is described below.

As discussed in the literature review, the likelihood of experiencing a traumatic event during childhood in the United States is extremely high (Wethington et al., 2008), especially sexual abuse which is estimated to affect 1 in 4 girls and 1 in 6 boys before the age of 18 (Centers for Disease Control and Prevention, 2005). Whereas some children seem to be minimally affected by their traumatic experience, others experience a host of mental health and other problems which can continue into adulthood (Wethington et al., 2008). Common challenges experienced by child victims of sexual abuse were uncovered in the analysis of the

narratives. The most frequently cited problem faced by children was fear, which was discussed in all 21 narratives. Children expressed concerns that they would be revictimized. They also expressed feeling unsafe. Fear often manifested in symptoms such as nightmares, flashbacks, and intrusive thoughts. Therefore, effective treatment for child victims must address trauma symptoms, especially children's fears and their need for future protection.

Counselors working with children must utilize an approach to treatment that is evidence-based and shown to reduce trauma symptoms. Since dropout is a common problem when counseling trauma victims, especially following an increase in trauma symptoms (which is common during treatment) (Chasson et al., 2008), it is crucial that counselors use methods that are effective with child victims. Although there are many approaches to treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the only approach out of 21 counseling methods that was significantly more effective than a placebo and other forms of treatment (Silverman et al., 2008, p. 160). Randomized controlled studies have also supported TF-CBT's effectiveness in reducing trauma related symptoms, and they have indicated that TF-CBT is more effective than other types of counseling directly following treatment and at one year after the intervention (Cohen & Mannarino, 1996, 1997; Cohen et al., 2005).TF-CBT was designed specifically to target children's fears (Cohen et al., 2000), which makes it a good fit for child victims of sexual abuse. In order to address the presenting symptoms, which includes children's fears, counselors need methods which are proven to help child victims.

In addition to utilizing an evidence-based therapeutic method to target trauma symptoms, there are several supplementary tools counselors can use to explore issues related to fear and safety. One such technique, which was described in the literature review, is establishment of a

safe place (Schmookler, 1996). This imaginary place is described in detail by children can be turned into a script that they can read. It can also be created by the child in a medium of their choice, such as with paint or in a sand tray. As children recall their trauma during counseling (e.g., during the trauma narrative intervention), counselors can direct children at the end of the sessions to imagine themselves in their safe place. Children can also be taught to use their safe place outside of counseling when they experience fear.

Along with the safe place intervention, counselors may consider helping children cope with fear through the use of children's books. Books help normalize children's experiences and therapeutic stories can help children heal. The resource, *Once Upon a Time. . . Therapeutic Stories that Teach and Heal* (Davis, 1996), has several stories specifically written for children with PTSD and fears related to abuse experiences. Counselors can also create personalized stories with children about feeling scared.

Another intervention that may assist children in coping with fear is the creation of a comfort kit (Lowenstein, 1999). This idea was originally designed for children to learn how to replace self-harming behaviors with self-soothing behaviors. The comfort kit is a box of items that help children feel safe and is a tool that can be adapted to meet the needs of child victims of sexual abuse. The intervention begins with the counselor brainstorming with the child ideas for what he or she would like to include in their box (e.g., a favorite stuffed animal, music, the safe place script, a journal, paper and crayons, a list of self affirmations, etc.). The child selects a box for the items and can decorate it in the session. Items that help the child feel comforted are placed in the box. A set of directions can be taped to the inside of the box to remind them of ways that they can cope with their fears.

The above listed interventions are just a few ways that counselors can target issues of fear and safety within sessions and provide children with tools that they can utilize outside of the counseling office. In this study, the results of thematic analysis indicated that issues of fear and safety are a significant part of life following abuse. Further research is needed to ask children what counselors and nonoffending parents and caregivers can do to reduce their fears and help them feel safe. An enhanced understanding of children's perspectives of their abuse experience, specifically their fears, will help tailor CSA treatment to meet the needs of child victims.

In addition to addressing the unique challenges children face following sexual abuse which includes issues of fear and safety, treatment must consider children's thoughts and feelings before attending counseling and during the beginning stages of therapy. The trauma narratives illuminated a major difference between adults and children regarding treatment for sexual abuse: the choice to attend counseling. Children in the current study stated that they were brought to the agency by parents or caregivers, and the analysis of the narratives revealed that many children felt resistant at the beginning of counseling. Some were angry that they had to attend. Others stated that they felt nervous and worried that something was wrong with them. Some children mentioned feeling afraid to disclose their abuse as well as fear of being judged. Several said they were reluctant to talk about their abuse with someone that they did not know. Many did not think counseling would be able to help them.

Treatment tailored to meet child victims' needs can address common initial reactions to counseling. Addressing what counseling is and how it can be helpful is a good place to start. Exploring children's fears and concerns about being judged, talking about the abuse, and trusting someone are especially pertinent to the treatment of child victims of sexual abuse. It is likely that

additional time may need to be spent building the therapeutic relationship, since for child victims (including those in the current study) establishing trust can be difficult (Crenshaw & Hardy, 2007; Gobin & Freyd, 2009; McGregor et al., 2009). Counselors, particularly those without specific training in CSA, may become discouraged or think treatment is ineffective in the early stages based on children's initial responses. Parents or caregivers of children who do not understand the treatment process may be especially concerned when their child expresses resistance about attending counseling or experiences an increase in symptoms. Such concerns may lead to early termination of counseling services, which is a frequent problem in trauma treatment (Chasson et al., 2008). Counselors must understand children's unique needs during the initial stages of therapy and prepare parents/caregivers for the potential that children may not want to attend or that their symptoms may become worse before they become better (Chasson et al., 2008). Counselors working with child victims can normalize the experience and empathize with the challenge of attending counseling. A better understanding of the perspective of the child victim, including common initial thoughts and feelings about counseling, will lead to treatment that is designed to meet the needs of the child victim.

Along with revealing children's initial perceptions about counseling, the narratives included children's changed perspectives about counseling and statements about the things that they learned, both of which inform the treatment of child victims. To start, narratives written by children in the present study reported a shift to more positive thoughts and feelings about counseling. This included feeling that it was helpful to talk about their sexual abuse. This finding supports Nelson-Gardell's (2001) study which revealed that children perceived talking about the sexual abuse in counseling helpful. Children also shared the many things that they learned during

counseling such as: how to talk about feelings, good and bad touches, abuse symptoms, coping strategies, relaxation, anger management, thought replacement, improving self-confidence, how to make friends, ways to handle stress, how to be open and trust others, and the importance of self-care. Two of the most commonly cited lessons learned included: they were not alone in their suffering and the abuse was not their fault.

The narratives indicated that counseling is difficult in the beginning for many child victims, but over time it results in an opportunity to process the abuse, reduce presenting symptoms, and install hope for a positive future. Although some children stated that it continued to be difficult to work through their abuse, they also expressed how much counseling had helped them. Counselors as well as parents or caregivers can be encouraged that for many children, counseling is a critical part of their healing journey. The themes in the analysis of the narratives revealed the challenges experienced by child victims following abuse, specifically difficulties with fear and concerns for safety, their initial thoughts and feelings about counseling, and children's changed perspectives of counseling. Considering children's developmental understanding about counseling can lead to improved treatment strategies that are designed to meet the unique needs of child victims and their families.

Preparation of Current and Future Counselors

Just as there is a need for treatment that considers the perspectives of child victims of sexual abuse, there is a distinct need for adequate training of current and future counselors to work with this population. A vital aspect of training is to help counselors and counselors-in-training understand the world of the child victim. The themes uncovered in the narratives help

provide this unique perspective and can be used in workshops and courses aimed at educating counselors and counselors-in-training. The themes from the present research are especially important as they are some of the first to reflect children's perspectives on life before, during, and after sexual abuse as reported in trauma narratives.

According to the literature, failure to receive proper preparation often leads to insensitive and unprofessional responses to CSA victims' abuse disclosure (Gardner, 2008). In a review of 23 studies on counselor responses to clients sharing about their CSA, Ullman (2003) found the following negative reactions experienced by victims:

> blame, disbelief/invalidation, belittling, rejections, disgust, hostility, exploitation/victimization by therapists, denying, ignoring, or minimizing the abuse, claiming the victim made it up/fantasized it, overprescribing drugs to victims, lack of action to stop abuse/remove offender from home, punishing/scolding, hostile/angry responses, egocentric response, lack of caring/being let down by others, stigma, being made fun of by others. (p. 104)

Problematic reactions to disclosure, such as those described above, have the potential to negatively impact or even harm clients with a CSA history (Denov, 2003). Examples of the negative impact include: hindered progress in therapy, increased likelihood of dropout, and retraumatization.

Counselors' inability to respond in an empathetic manner is often related to their lack of specialized training for work with CSA victims. In fact, many counselors and counselors-in-training report feeling unprepared to meet the unique needs of this population (Winkelspecht & Singg, 1998). Lack of preparedness is especially problematic due to the extreme likelihood that

they will counsel clients with a CSA history (Jones et al., 1998). According to a meta-analysis conducted by Read and colleagues (2004), on average of 50% of women and 28% of men seeking treatment have a CSA history. Therefore, educating counselors and counselors-in-training is crucial so that they are prepared to respond disclosure of abuse in an empathetic and sensitive manner and are able to meet the unique needs of CSA victims (Gardner, 2008; Jones et al., 1998). The themes uncovered in the current study can be utilized in such training efforts to provide insight into child victims' experiences.

Training that provides information about children's perceptions of their sexual abuse (such as issues related to fear and safety) benefits the child clients, counselors, and counselors-in-training. Clients benefit when counselors learn about the nature of CSA, how to implement evidence-based treatment approaches, and how to respond in a healthy manner to disclosures of abuse. When counselors receive CSA training, they are able to respond to the clients in more positive ways (Gardner, 2008). Training also benefits the counselor. For example, in CSA training, counselors have an opportunity to learn about the importance of self-care and the role of supervision. Counselors can also be provided with an opportunity to explore and process their personal reactions to CSA clients (Jones et al., 1998). Training is especially important in counselor education programs as it helps institutions avoid potential liability for counselors-in-training retraumatizing CSA victims during their clinical experience (Gardner, 2008; Kitzrow, 2002). The importance of the counselor educator's role in training students cannot be emphasized enough (Jones et al., 1998). The themes uncovered in the trauma narratives can inform students as well as practicing counselors.

In counselor training programs, the ideal format for preparing students to work with clients who have a history of sexual abuse or have experienced another type of trauma is in a course that is required for all students regardless of track (e.g., school, mental health, and marital, couple, and family counseling). In the course, students could receive training in an evidence-based approach for the treatment of trauma such as Trauma-Focused Cognitive Behavioral Therapy. Students could also be exposed to victims' perspectives of their experiences through direct quotes as well as vignettes, which could be written based on trauma narratives. Hearing victims' stories may improve students' ability to empathize with victims as well as prepare them for exposure to difficult content related to the trauma. When preparing students to work with child victims of sexual abuse, it would be especially important to prepare them for the challenges that they experience in the areas of fear and safety. A required counseling course would help enhance students' ability to work with clients who have a trauma history.

Although a required course is the ideal format for trauma training, the current reality is that most counseling programs already require students to take a substantial number of courses. If a required course is not possible, an elective course could be offered. In addition to an elective, information about how to meet the needs of children and adults who have experienced trauma must be infused throughout the curriculum. Since different tracks are often required to take different course work, a broad range of courses should include information related to treatment of individuals who have experienced trauma (e.g., Children and Adolescents, Human Growth and Development, Ethics, Multicultural Counseling, and Diagnosis and Treatment). Infusion of important information about child sexual abuse as well as other forms of trauma experienced by children and adults will prepare counselors-in-training to meet the needs of their future clients.

The research literature indicates that there are some special considerations for the preparing of students to work with CSA. Students must be ready for the difficult content that they will be exposed to (e.g., content in trauma narratives) and the reactions that may occur. This preparation includes instruction on wellness and self-care (Jones, 2002). Following training on CSA, counselor educators need to be equipped for students' varying reactions to child abuse information, such as "anger, avoidant responses, overidentification, feeling overwhelmed, and experiencing shock and horror" (Jones, 2002, p. 50). Counselor educators must be prepared to provide opportunities for students to process their thoughts and feelings both in and outside of the classroom (Jones, 2002). It is highly probable that numerous students in counseling programs have a CSA history. In fact, research has indicated that nearly 30% of mental health professionals have a childhood trauma history, which may include CSA (Follette, Polusny, & Milbeck, 1994). Counselors who understand the pain of childhood trauma firsthand and have worked through their personal experiences have the potential to greatly assist CSA victims (Gardner, 2008). On the other hand, those with unresolved trauma are more likely to experience countertransference and be unable to provide effective counseling (Emerson, 1988). When unresolved childhood trauma becomes apparent, counselor educators and supervisors need to respond in an empathetic manner and refer the student to personal counseling.

Preparation of current and future counselors to work with CSA victims is extremely important so that they will be equipped to respond in a healthy manner to clients' disclosure of their abuse. Additionally, they must possess the necessary skills to treat victims or make an appropriate referral. Trauma narratives offer an opportunity for counselors and counselors-in-training to understand child victims' experiences both during and after the abuse, which

frequently involve issues of fear and safety as well as their perceptions of counseling. This information can be utilized in trainings and coursework to prepare individuals for work with child victims of sexual abuse.

Raising Awareness in the Counseling Field

The results of this study's analysis of trauma narratives can be utilized in several ways to increase the counseling field's awareness of children's perceptions of sexual abuse. This includes (a) trainings and coursework utilizing the themes derived from the analysis of narratives (which was discussed in the section above), (b) involvement in prevention efforts that advocate for the rights of children (which was also delineated in a previous section), and (c) additional research with child victims. Currently, the counseling field's understanding of the child victim's experience is extremely limited (McGregor et al., 2006; Nkongho, 2006; Sar et al., 2006; Urman et al., 2001; Walker et al., 2009), especially related to issues of fear and safety, which were uncovered in the present study. Additional research is needed to address this gap in the literature.

Once research is conducted with child victims of sexual abuse, it is necessary to share the results of studies with practicing counselors. This is at times challenging because of the disconnect between researchers and practitioners. Individuals in the field of counseling as well as related fields need to be informed of discoveries related to the treatment of child sexual abuse victims in order to provide the best possible services to children and their families.

The results of the present study of children's trauma narratives provide important information for the counseling field that can lead to improved prevention programs as well as services for victims. Moreover, the findings add to the limited research on child victims and can

be communicated to practitioners and utilized in trainings. Specific suggestions for future research with child victims will be provided in a following section.

Educating Community Members

Along with heightened awareness in the counseling field, information about child victims' experiences during and after sexual abuse needs to be communicated to communities on a local and national level. A large part of this awareness is through CSA prevention efforts, which were discussed above. According to Jones (1999),

> Child sexual abuse is a community problem; no single agency, individual, or discipline has the necessary knowledge, skills, resources, or societal mandate to provide the assistance needed by abused children and their families. (Implications section, para. 2)

The results of the present study on trauma narratives add to the existing knowledge on child sexual abuse. The information uncovered needs to be shared with audiences both within and outside of the counseling field. Conference presentations and articles in peer reviewed journals do not often reach community members who hold an important role in child sexual abuse prevention and intervention initiatives. Information can be presented through trainings on the topic of CSA as well as in prevention programs hosted in community centers, places of worship, and doctor's offices. Partnerships could be formed with local law enforcement to provide free self-defense trainings to older children and adult survivors of CSA, which may help decrease feelings of fear, which is a central issue for victims. Collaboration with various media sources could help share information about CSA with a much larger audience. The message that needs to

be communicated is that every community member is responsible for protecting children. CSA needs to be viewed as unacceptable under any circumstance and not tolerated. Increased community awareness of CSA and knowledge about victims experiences will both benefit victims of CSA and help decrease the prevalence of sexual abuse.

The present study on child victims' perspectives of life before, during, and after sexual abuse offers community members an enhanced understanding of the child victim's experience, especially related to issues of fear and safety during and following the abuse. Although the information is important to disseminate, there may be challenges. As opposed to other forms of child abuse, this form of abuse involves sexual acts, which makes it especially hard for many community members to discuss openly (Wurtele, 2009). Despite potential obstacles, it is vital to educate community members on children's experiences and perceptions of their sexual abuse. The results of this study could be presented to various community groups to help increase community members' understanding of CSA from child victims' perspectives and to promote efforts to protect children from sexual crimes.

In sum, the themes from an analysis of trauma narratives written by children about sexual abuse provide an enhanced understanding of children's experiences. This section discussed implications for improving prevention efforts and intervention services. The results of the study are relevant for trainings and coursework for current and future counselors. Further, this research can inform those in the field of counseling as well as community members on sexual abuse.

Recommendations for Future Research

Based on the findings of the present study, there are several recommendations for future research. This section presents a case for research in the following areas: (a) the impact of CSA on cognitive development and academic functioning, (b) the experiences of sexually abused boys, (c) an analysis of similarities and differences between children's perceptions of their sexual abuse based on various demographic qualities, (d) interviews and focus groups with counselors and family members of CSA victims about the trauma narrative experience, (e) interviews and focus groups with children regarding the trauma narrative intervention, and (f) longitudinal studies following child victims through various developmental stages.

Existing research has indicated that trauma, including child sexual abuse, can impede or impair normal cognitive development, and in some cases result in developmental delays and lower IQ scores (DeBellis et al., 1999; Feather & Ronan, 2009; Goodman et al., 2010; Keiley, Howe, Dodge, Bates, & Petit, 2001; Reyes & Asbrand, 2005; Sandoval, Scott, & Padilla, 2009). The initial results of this study may support the previous research. Trauma narratives were analyzed for the grade level in which they were written using Microsoft Word's Flesch-Kincaid reading level analysis (which was discussed in the results section). Whereas children in the latency group were closer to grade level in their writing (an average age of 8 and in second/third grade and wrote on a 3.1 grade level), older children exhibited some writing difficulties. Children in the preadolescent group were an average age of 11 (fifth/sixth grade) and wrote their narratives on a 4.6 grade level, and children in the adolescent age group were an average age of 14 (eighth/ninth grade) and wrote their narratives on a 4.8 grade level. Future research needs to be conducted with a larger data set in order to examine the chronological age of the children

during treatment compared to the level in which they write. Additionally, future studies could look for differences in other areas of academic ability based on the child's age when the abuse occurred. According to Nkongho (2006), "There remains much to be understood about how the process of development can be altered by the experience of child sexual abuse and how this might vary according to the time of occurrence during childhood" (p. 6).

Additionally, more research is needed with male victims of sexual abuse. The vast majority of research studies on sexual abuse are limited to female participants (Sorsoli, Kia-Keating, & Grossman, 2008). Males disclose sexual abuse less frequently than females and are unrepresented in the treatment for child sexual abuse (e.g., of the nearly 300 children who received treatment at the partnering agency in the last year, 28% were boys compared to 72% girls). In the current study, only three boys' narratives were analyzed. The sample of boys was too small to contrast with the 18 narratives written by girls. A study of narratives written solely by boys about their sexual abuse would address the gap in the research literature and inform treatment of male victims of sexual abuse.

In addition to a study of narratives targeting boys, more focused follow-up studies could be conducted based on other specific demographics. Some studies have suggested a connection between sexually abused children's demographics and developmental outcomes (Trickett & Putnam, 1998 as cited in Nkongho, 2006). Future research could explore the perspectives of children on sexual abuse as described in trauma narratives from specific ethnic backgrounds to understand cultural aspects of their abuse experience, an area in which there is a dearth of research (Katerndahl, Burge, Kellogg, & Parra, 2005). Additionally, studies on narratives could be confined to a specific type of relationship with the perpetrator (e.g., parental figure, relative,

friend of the family) or age of the perpetrator (e.g., same age peer, older child, or adult). Furthermore, studies could narrow the scope of focus to a more limited age range at the time of abuse to gain a better understanding of the impact of trauma on development. Studies could also examine similarities and differences between child victims based on reported family income. Through narrowing the demographics in the narratives collected, researchers have the opportunity to gain a more in-depth look at children's descriptions of life during and after sexual abuse.

Qualitative studies interviewing counselors about their experience using trauma narratives with children may also yield pertinent information about this therapeutic intervention. Additionally, interviews or focus groups with parents or caregivers who participated in treatment with child victims, including the trauma narrative family session, could provide the field with an enhanced understanding of their perspectives of counseling and the recovery process. Mothers of child victims may hold important knowledge, as they were frequently mentioned by the children in the trauma narratives (a total of 140 times). The perspectives of counselors and parents or caregivers have the potential to add to the findings of the present study.

In addition to qualitative studies with counselors and parents or caregivers, future research would also benefit from individual interviews and focus groups with children who have completed trauma narratives. These interviews could help verify themes identified in this initial study and may add additional information about how children perceive their experience of sexual abuse and the recovery process.

Along with interviews with children following completion of trauma narratives, a study with a longitudinal design could conduct multiple interviews with victims through various

developmental stages (e.g., middle childhood/preadolescence, adolescence, young adulthood, middle adulthood, and late adulthood). Such research would offer a lifespan perspective of child sexual abuse victims' experiences.

There would likely be some challenges to the above suggested research that involves direct contact with child victims. As discussed in Chapter Three, researchers conducting studies involving children must demonstrate that the potential benefits outweigh the risks and address the ethical concerns such as retraumatization (Chu et al., 2008). Therefore, attaining Institutional Review Board approval and securing parental consent and child assent may be difficult. Yet, it is possible to carefully design studies with children who have experienced sexual abuse and limit potential risks. Although there may be obstacles to research that involves direct contact with child victims, the challenge is worth overcoming as the studies would provide information that would further the field of counseling and benefit child victims of sexual abuse and their families.

The results of the present study enhance counselor educators, supervisors, counselors, students, and community members' knowledge about CSA from the child victims' perspective. It also serves as a springboard for additional studies that focus on the experience of the sexually abused child. Further research is needed to better understand the impact of sexual abuse on cognitive functioning, the experiences of child victims from specific demographic groups, the trauma narrative process from the perspective of counselors and family members, the views of children on the trauma narrative intervention, and longitudinal studies that follow child victims over their lifespan.

Conclusions

The present study investigated children's perceptions of CSA as recorded in trauma narratives. The trauma narrative is a critical intervention in TF-CBT that allows children to record their experiences in the presence of an empathetic counselor. The narratives provide children with an outlet for expressing not only what occurred but how it felt and the meaning that was attributed to it. With the help of the counselor, the child is able to combat dysfunctional thoughts and beliefs and express their most painful memories.

The children's narratives in this study provided a firsthand account of life before, during, and after sexual abuse that yielded valuable information. Thematic analysis of the narratives resulted in one meta theme, Fear and Safety, and three themes: Memories of the Abuse, The Disclosure and Subsequent Events, and The Healing Journey. The results provided insight into children's thoughts, feelings, and beliefs about their sexual abuse and recovery process. Although there were several limitations of the present study that may be addressed by future research, the results present important information that can aide prevention efforts, improve treatment, prepare current and future counselors, inform the field of counseling, and educate community members. Thus it seems most appropriate to conclude this chapter where the study began, with the voices of child victims on their perceptions of their lives in the wake of child sexual abuse.

> *I would like to change nothing because everything is fine because everything doesn't have to be perfect.* (Child 8, age 11) *Now I don't even think about [the sexual abuse] at all like it's in the past but it still sits on the right hand of my shoulder. I will never forget it.* (Child 16, age 14) *I could have listed a million things that I would have liked to change about my life and/or my family but now I say nothing because I have realized that everything happens for a reason, either good or bad. And that everybody makes mistakes but it gives us no excuse to stay in the past. We have a future and a present so what happened, happened. Now we've got to move on and live our lives to the fullest.* (Child 18, age 14)

APPENDIX A: UNIVERSITY IRB OUTCOME LETTER

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

From : **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To : **Jennifer M. Foster**

Date : **January 11, 2011**

Dear Researcher:

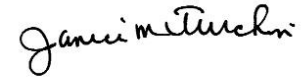
On 1/11/2011 the IRB determined that the following proposed activity is not human research as defined by DHHS regulations at 45 CFR 46 or FDA regulations at 21 CFR 50/56:

Type of Review:	UCF Initial Review Submission Form
Project Title:	An Analysis of Narratives: Perceptions of Children on Sexual Abuse
Investigator:	Jennifer M Foster
IRB ID:	SBE-10-07352
Funding Agency:	None

University of Central Florida IRB review and approval is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are to be made and there are questions about whether these activities are research involving human subjects, please contact the IRB office to discuss the proposed changes.

On behalf of the IRB Chair, Joseph Bielitzki, DVM, this letter is signed by:

Signature applied by Janice Turchin on 01/11/2011 03:31:34 PM EST



IRB Coordinator

APPENDIX B: STATEMENT OF POSITIONALITY

It is not by chance that I arrived at the topic of child sexual abuse for my dissertation. I believe that a unique combination of experiences and opportunities led me to study the experiences of child victims. I feel that I am part of a much larger plan that will lead to improved prevention efforts to decrease the occurrence of child sexual abuse as well as create interventions that will assist children in their recovery. The information uncovered in this study contributes to knowledge in the counseling field as well as the community. Additionally, it can be utilized in the training of both counseling students and clinicians. This research is deeply important to me. It is my intent to explain how I arrived at this topic and the way in which it intersects with my life.

I decided to enter the field of counseling during my twenties as a result of my experience as a special education teacher. Many of my students came from backgrounds of abuse and neglect and were in need of much more than academic support. Although I was skilled at assisting children improve their academic abilities, I lacked the tools that I needed to address the multitude of other issues in their lives. Thus I decided to pursue a graduate degree in counseling.

When I returned to school for my master's in counseling, I knew I wanted to specialize in childhood trauma. In order to gain experience, I spent my first internship working at a domestic violence shelter. Many of the children residing there had not only witnessed violence between their parents, they had also been victims of multiple forms of abuse as well as neglect. It was the first time I had to face the pain the children experienced. As I listened to their stories, it changed me and the way I looked at the world. My formerly safe world that was painted with warm, vibrant colors started to look very dark and cold. Yet despite the difficulty that I experienced, I

realized that I was privileged to be let into my clients' world, trusted with their deepest of secrets, and in a position to help them break their chains of silence.

I knew that I needed additional supervision and experience in order to really make a difference in the lives of children who had experienced trauma. I learned that there was a local agency that specifically specialized in the treatment of children and adolescents who had experienced sexual abuse. The agency was not only known for their expert provision of services to victims and their families, it was also revered as an excellent training facility for counseling students. Following acceptance for an internship, I began my training which included both individual and group supervision.

As part of my training, along with the staff, I received instruction in the use of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based approach to treating victims of trauma. One key component to TF-CBT is the trauma narrative, a written description of one's life before, during, and after a trauma, which is organized into chapters. At the agency I began utilizing TF-CBT with the children and their families.

While facilitating the trauma narrative process with my clients, I found that their descriptions of their experiences were extremely painful to listen to. It was at times difficult resist the urge to pull away emotionally or stop them from telling the difficult details. My supervisors helped me process my many emotions about the children's abuse, from sorrow for their lost innocence to anger towards the perpetrators as well as towards society for turning a blind eye. I found that ". . . I need to let my heart be touched by their pain in order to be a helpful companion in their journey of healing" (Miller et al., 2007). Over time, I gained the strength I needed to hear my clients' traumatic experiences.

During the trauma narrative intervention with my clients, I realized that the children possessed knowledge about sexual abuse that I had not learned in my training as a counselor nor had I seen it in any journal articles or books. What was unique was their perspective as children as well as their closeness to the time of the trauma. All of the literature that I read on child sexual abuse was from the perspective of adults reflecting on their childhood experiences. The children's thoughts, feelings, and beliefs about their life before, during, and after their abuse were unique because it was told through their eyes. Although each child's experience was different, I began to see some commonalities that were true of many of the children's abuse, such as the difficulty of disclosure. I had several conversations with my colleagues about the narratives, and they had observed many of the same similarities.

At the time, I lacked research skills or a platform from which to share the knowledge I was gaining. I desired to continue my education and gain competencies in conducting research. I received an opportunity to begin my doctorate degree at the University of Central Florida. Starting the doctoral program meant that I could not continue working as a counselor fulltime at the agency. It was difficult to say goodbye to my colleagues and clients. I found that despite my move into a new setting and focus on my doctoral work, I could not stop thinking about my experience working with child victims of sexual abuse. The topic would often come up in conversations with my family, friends, and colleagues. Many of these individuals sensed my comfort with the topic of child sexual abuse and opened up, sharing their child sexual abuse stories; some of them for the first time.

When it came time to decide on my dissertation topic, I knew that I wanted to explore children's perceptions of their abuse experiences as recorded in the form of trauma narratives.

From my literature review, I discovered that trauma narratives written in the context of TF-CBT had not yet been analyzed to understand how children perceive their sexual abuse. With the agreement of the community agency and the approval of both the hospital and university Institutional Review Boards, I was given the green light to begin my study of the trauma narratives.

As I begin this study, I am aware that there are multiple factors that influence me as a qualitative researcher. To start, I believe in absolute truth and that child sexual abuse is morally wrong and deserving of punishment. It is much easier for me to empathize with a victim of sexual abuse than it is to understand the perpetrator. It is more convenient for me to see them as monsters instead of hurting individuals who were likely victims at one time.

Another factor that impacts me as a researcher is my passion for social justice. I believe that I must advocate for justice for victims. I think that as a society we have a duty to protect those who cannot protect themselves, which includes children.

I also ascribe to the belief that child sexual abuse is often damaging to one's sense of self and can negatively impact children in various domains (e.g., emotional, social/relational, physical, academic/cognitive, and spiritual). Yet, I acknowledge that not all children display adverse symptoms directly following the abuse, and some display resilience in even the most horrific of situations. According to my review of the research, sexual abuse not only negatively impacts children, it also frequently affects adult survivors, resulting in a host of challenges. It is for these reasons that I believe it is vital to better understand the experience of the child victim in order to create better prevention programs and intervention services.

A final factor that will impact me as a researcher is that I have recently become a mother. I feel fiercely protective of my daughter, and although I do not want her to be sheltered, I also want to keep her safe. Having her has strengthened my passion for this research. This study and what is gleamed from it to improve prevention programs and intervention services is dedicated to her. All children deserve to be protected and loved.

My work with child victims of trauma has forever altered me, which a common experience for those who are exposed to such extreme suffering (Jenmorri, 2006). I have been challenged to explore deeply held beliefs about humanity, my faith, and the purpose of pain. I have also experienced personal growth and deeper relationships with those I love. I have found that even in the most horrific of circumstances there is the light of hope that pierces through the darkness. I have seen firsthand that healing can and does occur. My favorite quote by Patricia Reilly speaks to the healing process, "For as deep a cavern as sorrow has carved within you that shall be your capacity for joy" (p. 162). I consider it a privilege to conduct this study.

APPENDIX C: DEMOGRAPHICS COLLECTION SHEET

Trauma Narrative #	
Age at time of treatment	
Age at time of abuse	
Gender	
Ethnicity	
Reported family income	
Relationship to perpetrator	
Diagnosis	

APPENDIX D: DATA COLLECTION TRAINING PROTOCOL

Interns from the partnering community agency assisted the researcher in the data collection process. The interns collected 21 trauma narratives which were completed prior to the start of the study. The trauma narratives were de-identified by the interns in order to ensure the confidentiality of the clients. The interns also collected demographic data to correspond with each narrative, which was recorded on the demographic sheet (see Appendix C) and is presented on Table 1.

According to the Institutional Review Board (IRB), research that involves the use of "de-identified" protected health information (PHI) is exempt from HIPAA requirements if all of the following subject identifiers are removed from the documents. The following is a list of the identifiers that if present were removed from the narratives:

1. Names
2. Addresses
3. Dates (except year)
4. Telephone Numbers
5. Fax Numbers
6. E-mail Addresses
7. Web Universal Resource Locators (URLs)
8. Internet Protocol (IP) Address Numbers
9. Social Security Numbers
10. Medical Record Numbers
11. Health Plan Beneficiary Numbers
12. Account Numbers

13. Certificate / License Numbers

14. Vehicle Identifiers and Serial Numbers including License Plate Numbers

15. Device Identifiers and Serial Numbers

16. Biometric Identifiers (e.g. finger or voice prints)

17. Full face photographic images and any comparable images

18. Any other unique identifying number, characteristic, or code

In order to ensure proper adherence to the IRB de-identification requirements, the interns were trained utilizing two practice narratives (see the following page) which include protected health information that must be removed. The researcher gave a copy of the above list of 18 identifiers to each assistant and copies of the two fictional narratives. The researcher de-identified the first narrative with the interns and discussed examples of protected health information. Following the first practice narrative, the interns independently de-identified the second fictional narrative. The researcher reviewed the second narrative with the interns to ensure that all PHI was removed. The interns were required to cross-check each other's de-identification of the narratives collected for the study. The researcher also verified that the collected narratives did not contain any confidential information prior to data analysis.

De-Identification of Data Fictional Narrative One

Mandy Nicholas age 17

Before the Abuse: “I remember I loved my school, Pennbrooke High, and I was really good at making friends. My parents got me a dog, and I trained him all by myself. Everyone says I’m really good with animals. My dog and basketball were my life. People loved me, especially my best friend Melissa Kindo, because I was so funny and could make them laugh.”

The First Time the Abuse Happened: “I’ve played basketball for a long time. I started in 6th grade. Playing on the team was really hard. It started out as Coach Smith rubbing my shoulders after basketball games. I would never say anything. He told me I needed extra practice so I stayed late one time and he told me he wanted to massage me. He rubbed up under my shorts. I told him I better go home (that was when we still lived at 1063 V. Ave).

My Worst Memories: I wanted Coach Smith's attention. I didn't have a dad at home and coach made me feel so special, yet I knew what was happening was wrong. Since he was so young I used to pretend he was my boyfriend. Then I heard he did the same thing to some other girls on the team. I couldn't believe it. I felt so gross for going through with it.

The Disclosure: It started when Sally Lukins told her mom about it on May 23th, 2010. Her mom called the police and the whole school found out about it. One by one a lot of the girls on the team admitted it happened to them too. I was afraid no one would believe me, but thankfully my mom did!

Investigation and Court: Coach Smith was questioned, but since there wasn't any "real evidence" he never had to go to court. He was fired from our school, but I heard he's coaching again somewhere else.

How My Life has Changed: I have flashbacks of what happened and cannot sleep. I dream of him, his scent, touch, taste and sometimes I wake up screaming. I don't feel innocent anymore. I wish I could go back in time and never stay late. I think I'm wiser though now. I want to help prevent this from happening to other kids!

Counseling: This is the first time I've told my whole story to anyone other than my mom. It hurts a lot, but I feel like I'm working through things. I know the worst is over and I can make choices about how I live now.

My Hopes and Dreams: I plan to graduate and go to college. I really hope I can get a basketball scholarship to the University of Michigan. I don't know what I want to do for a career, but I do know I want to help people. I can also see myself getting married some day and having kids.

De-Identification of Data Fictional Narrative Two

Anne Green age 15

Before the Abuse: Before my sexual abuse I was very happy, outgoing, and trusting. I had heard stories and seen movies about children being sexually abused, but I never thought it would happen to me.

The First Time the Abuse Happened: It was a few days before my thirteenth birthday, February 18th, when I was sexually abused by my step-grandfather. I just blocked it out and made excuses and told myself it would not happen again. I was scared to tell.

My Worst Memories: My worst memories are feeling helpless like I had no control. I hated being alone with him and tired hard not to be, but that was hard since he moved into our house, which is on Lake St. in Columbus. The worst memories are the times I know I could have said something and I didn't. I hated myself for that.

The Disclosure: I finally told Ms. Jennings, our school counselor. She called the Columbus police, and I was questioned by Sergeant Lee. I felt really bad after telling, like I had done something wrong.

Investigation and Court: The police officer thought I was lying because I couldn't remember the exact details of what all had been happening. Because there was no proof, the charges were dropped.

How My Life has Changed: It would probably be shorter to tell you about the things that haven't changed - I could write a book about the changes. Only half of our family believed my step-grandpa would do such a thing - now holidays and family events aren't the same. I think it has made me stronger, though. I can talk about the abuse now.

Counseling: I hated counseling at the Columbus Community Counseling Agency at first. I didn't want to come. I didn't think I needed to. I was wrong. I slowly started opening up to my counselor, Hope Adams. Each week I realized she really did care. I had to work through blaming myself. I know now it wasn't my fault. I know how to deal with my feelings now and talking does help.

My Hopes and Dreams: I want to make something of myself and go places. I want to be happy. I know I can do it if I work hard.

APPENDIX E: DATA ANALYSIS JOURNAL EXCERPTS

Throughout the study I kept a handwritten, reflexive journal which included details about the analysis process, my reactions to the narratives, and my thoughts about child sexual abuse. This reflection allowed me to be aware of my personal reactions to the narratives. This Appendix includes excerpts of that journal which highlight important parts of the process and personal realizations I had which led to a greater understanding of CSA from the perspective of the child victim.

At the beginning of the research process, the thought of analyzing the narratives was both invigorating and daunting. The stack of raw data in front of me meant it was finally time to begin. After so much planning and time spent in the current literature, it was hard to believe that the time had come. I knew I needed a good system of organization in order to handle the volume of data that I needed to code. I looked at other qualitative research studies for ideas and blended several of their approaches to create one that fit me as a researcher and my study. I recorded the specific details of my data analysis process in Chapter Four. This journal includes what was not recorded there: my personal experience of reading and analyzing the narratives.

As I started to read the children's descriptions of life before, during, and after sexual abuse, I was initially overwhelmed at the content. Although I worked for several years as a mental health counselor with child sexual abuse victims and had conducted the trauma narrative intervention with numerous clients, reading their stories was still heartbreaking. I physically felt sick while reading some of the abuse descriptions. I was also filled with anger directed toward the perpetrators who harmed the children.

During the days that I spent reading and re-reading of the narratives, I made a point to engage in self-care activities (exercise, journaling, and guided imagery). I also processed my

reactions with my research assistant. The weather happened to be beautiful during this part of data analysis, which seemed paradoxical to the darkness of the abuse descriptions. Yet, it allowed me to go outdoors for walks with my infant, Savannah. This gave me space to process the narratives and their impact on me personally. I would look at my innocent daughter and think about how much I want to be able to protect her from any harm, especially sexual abuse. Yet, at the same time I would think about the reality that sexual abuse can happen even to children in homes with protective parents who educate them about safety. I thought about how it will be hard not to be overprotective in an effort to keep her safe. I see the narratives differently now. My viewpoint is no longer from only the perspectives of counselor and researcher; it is also from the vantage point of a mother.

As I reflected on the trauma narratives, I could not escape the fact that these were stories written by children. Looking at the documents, I was constantly reminded of this by their messy handwriting with its spelling and grammar errors. I also noticed that the narratives included a mix of both sexual abuse content and typical "kids stuff." It seemed like in one sentence children were discussing the abuse and the way in which it affected their lives and in the next they were telling the reader how much they like hotdogs and how the tiger is their favorite animal. I remember reading about one of the children having a crush on a boy at school. Another child shared the difficulty of being made fun of and bullied. Another complained that her mother does let her go out with her friends. One even told the reader about her "need" for a cell phone. Reading children's own words about their everyday life as well as their sexual abuse had a strong impact on me as a researcher. I decided that it would be important to include numerous quotes from victims to capture the voices and experiences of the children in my research.

During my analysis, I noticed that there were many different "faces of victims" represented in the study's sample. As the demographic summary revealed, the children were different ages at the time of the abuse and time of treatment, from different ethnic backgrounds, their families were from a wide range of income levels, they had different relationships with their perpetrators, and the list goes on. Yet, they all shared the experience of being a victim of sexual abuse. It was amazing to see such clear themes emerge despite the vast differences between the children.

Although data analysis went quite smoothly, the process was not without any frustrations. I found myself irritated by my inability to read some of the words due to either the quality of the scanned documents or because of the children's spelling or handwriting. I wanted to be able to document every word, because I felt that each word was so important. I squinted at the computer screen, changed my angle, tried to see if a printed copy would be better, and consulted with my research assistant. In the end, less than 1% of the material was unknown. I realize that missing data is common in research, and I believe that the content that I was able to read and transcribe is useful in illustrating children's life before, during, and after sexual abuse.

An additional frustration that I experienced was related to the use of de-identified, archival data. Although the narratives provided a great deal of information, as a researcher I still had unanswered questions. My questions about what a particular statement meant as well as follow-up questions about the narratives' content could not be asked to the children in the study. Additionally, I was not able to meet with the children to discuss and verify the themes uncovered in the analysis. These drawbacks to the study were discussed in the limitations section in Chapter

Five. Even with the above challenges, as a researcher I feel proud that this study is one of only a handful to study CSA from the perspective of children.

Over the course of time that I spent with the data, I noticed my perspectives changed to some extent. At first I was overwhelmed with the details of the trauma. After awhile I was able to notice other aspects of the narratives in addition to the abuse accounts. For example, I noticed that many of these children had at least one adult in their life that cared about them and believed them when they told. Within the narratives were stories that described the impact these adults had (and continue to have) on the children. For example, one child shared that there is an adult at school who still checks up on her. Another narrative recorded how the police officer investigating the abuse reassured the child that no one was mad at her, and it was okay to tell.

I also noticed that in addition to having the support of safe, loving people, the children in the study possess incredible strength and resiliency. This is most apparent in children's positive feelings about their future in the chapter My Hopes and Dreams. One thing that I was not expecting to find in the narratives was numerous statements that children made about wanting to help others in the future. Many children expressed a desire to have a career in a helping field. Others said they would like to be a foster parent or adopt. Some shared ideas about helping underprivileged children and sharing their story with others. I kept thinking to myself that these are really incredible children.

I feel that through this dissertation process I grew as a researcher and increased my understanding of sexual abuse from the perspective of the child victim. It is my hope to communicate this information to individuals both within and outside of the field of counseling. I hope that it leads to improved treatments for children, trainings for practicing counselors and

students, and enhanced child sexual abuse prevention efforts. It was a privilege to conduct this study. It would not have been possible without the brave children who recorded their accounts of life before, during, and after sexual abuse in trauma narratives and the partnering community agency that is dedicated to helping children heal.

LIST OF REFERENCES

Achenbach, T. M. (1991). Integrative Guide to the 1991 CBCL/4-18, YSR, and TRF Profiles. Burlington, VT: University of Vermont, Department of Psychology.

Achenbach, T. M., & Rescorla, L. A. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Adler-Nevo, G., & Manassis, K. (2005). Psychosocial treatment of pediatric Posttraumatic Stress Disorder: The neglected field of single-incident trauma. *Depression & Anxiety, 22*(4), 177-189. doi:10.1002/da.20123

Alexander, P. C. (2009). Childhood trauma, attachment, and abuse by multiple partners. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 78-88. doi:10.1037/a0015254

Allport, G. W. (1942). *The use of personal documents in psychological science.* New York, NY: Social Science Research Council.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychological Association. (2010). Ethical Principles of Psychologists and Code of Conduct. Retrieved from http://www.apa.org/ethics/code/index.aspx

Anderson, K. M., & Hiersteiner, C. (2008). Recovering from childhood sexual abuse: Is a "storybook ending" possible? *American Journal of Family Therapy, 36*(5), 413-424. doi:10.1080/01926180701804592

Arata, C. M. (2002). Child sexual abuse and sexual revictimization. *Clinical Psychology Science and Practice, 9,* 135–164. doi:10.1093/clipsy/9.2.135

Aspelmeier, J. E., Elliott, A. N., & Smith, C. H. (2007). Childhood sexual abuse, attachment, and trauma symptoms in college females: The moderating role of attachment. *Child Abuse & Neglect: The International Journal, 31*(5), 549-566. doi:10.1016/j.chiabu.2006.12.002

Batten, S. V., Follette, V. M., Hall, M. L. R., & Palm, K. M. (2002). Physical and psychological effects of written disclosure among sexual abuse survivors. *Behavior Therapy, 33,* 107-122. doi:10.1016/S0005-7894(02)80008-9

Beck, A. T. (1963). Thinking and depression: Idiosyncratic content and cognitive distortions. *Achieves of General Psychiatry, 9,* 324-333. Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1964-06535-001&site=ehost-live

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York, NY: The Gilford Press.

Bendall, S., Jackson, H. J., Hulbert, C. A., & McGorry, P. D. (2008). Childhood trauma and psychotic disorders: A systematic, critical review of the evidence. *Schizophrenic Bulletin, 34*(3), 568–579, doi:10.1093/schbul/sbm121

Berliner, L., & Saunders, B. (1996). Treating fear and anxiety in sexually abused children: Results of a controlled two-year follow-up study. *Child Maltreatment, 1,* 294–309. doi: 10.1177/1077559596001004002

Bernstein, D., & Fink, L. (1998). Childhood Trauma Questionnaire: A retrospective self-report manual. San Antonio, TX: The Psychological Corporation.

Bolen, R., & Scannapieco, M. (1999). Prevalence of child sexual abuse: A corrective meta-analysis. *Social Service Review, 73,* 281–313. doi:10.1086/514425

Boote, D. N., & Beile, P. (2005). Scholars before researchers: On the centrality of the dissertation literature review in research preparation. *Educational Researcher, 34*(6), 3-15. doi: 10.3102/0013189X034006003

Borkan J. (1999). Immersion/crystallization. In B. F. Crabtree, & W. L. Miller (Eds.), *Doing qualitative research, 2nd ed.* Thousand Oaks, CA: Sage Publications.

Bradley, R. G., & Davino, K. M. (2002). Women's perceptions of the prison environment: When prison is "the safest place I've ever been." *Psychology of Women Quarterly, 26*, 351-359. Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search. ebscohost.com/login. aspx?direct=true&db=aph&AN=7728256&site=ehost-live

Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: Focus on PTSD. *Eating Disorders: The Journal of Treatment & Prevention, 15*(4), 285-304. doi:10.1080/10640260701454311

Briere, J. (1996a). *Therapy for adults molested as children* (2nd ed.). New York, NY: Springer Publishing Co.

Briere, J. (1996b). Trauma symptom checklist for children (TSCC) professional manual. Odessa, FL: Psychological Assessment Resources.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid, & C. Jenny (Eds.), *The APSAC handbook on child maltreatment* (2nd ed.) Newbury Park, CA: Sage Publications.

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. doi:10.1016/S0145-2134(01)00253-8

Briere, J., Kaltman, S., & Green, B. L. (2008). Accumulated childhood trauma and symptom complexity. *Journal of Traumatic Stress, 21*(2), 223-226. doi:10.1002/jts.20317

Briere, J. & Lanktree, C. (2008). *Integrative treatment of complex trauma for adolescents (ITCT-A): A guide for the treatment of multiply-traumatized youth*. Retrieved from http://johnbriere.com/articles.htm

Browne, A., Miller, B., & Maguin, E. (1999). Prevalence and severity of lifetime physical and sexual victimization among incarcerated women. *International Journal of Law and Psychiatry, 22,* 301-322. doi:10.1016/S0160-2527(99)00011-4

Carlson, B. E., Maciol, K., & Schneider, J. (2006). Sibling incest: Reports from forty-one survivors, *Journal of Child Sexual Abuse, 15*(4), 19-34. doi:10.1300/J070v15n04-02

Carrion, V. G., Weems, C. F., Ray, R., & Reiss, A. L. (2002). Toward an empirical definition of pediatric PTSD: The phenomenology of PTSD symptoms in youth. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(2), 166-173. doi:10.1097/00004583-200202000-00010

Cavanagh, M., Read, J., & New, B. (2004). Sexual abuse inquiry and response: A New Zealand training programme. *New Zealand Journal of Psychology, 33,* 137–144. Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=15592270&site=ehost-live

Celano, M., Hazzard, A., Webb, C., & McCall, C. (1996). Treatment of traumagenic beliefs among sexually abused girls and their mothers: An evaluation study. *Journal of Abnormal Child Psychology, 24,* 1–17. doi:10.1007/BF01448370

Centers for Disease Control and Prevention. (2005). *Adverse childhood experiences study: Data and statistics*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Retrieved from http://www.cdc.gov/nccdphp/ace/prevalence.htm#table

Chapman, D. P., Dube, S. R., & Anda, R. F. (2007). Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatric Annals, 37*(5), 359-364. Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2007-07785-009&site=ehost-live

Chasson, G. S., Vincent, J. P., & Harris, G. E. (2008). The use of symptom severity measured just before termination to predict child treatment dropout. *Journal of Clinical Psychology, 64*(7), 891-904. doi:10.1002/jclp.20494

Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network (NCTSN). (2004). *How to Implement Trauma-Focused Cognitive Behavioral Therapy*. Durham, NC: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/nccts/nav.do?pid=ctr_top_trmnt

Chu, A. T., DePrince, A. P., & Weinzierl, K. M. (2008). Children's perception of research participation: Examining trauma exposure and distress. *Journal of Empirical Research on Human Research Ethics, 3,* 49–58. doi:10.1525/jer.2008.3.1.49

Cicchetti, D., & Toth, S. L. (2006). Building bridges and crossing them: Translational research in developmental psychopathology. *Developmental Psychopathology, 18,* 619-622. Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-10905-001&site=ehost-live

Clandinin, D., & Connelly, F. (2000*). Narrative inquiry: Experience and story in qualitative research.* San Francisco, CA: Jossey-Bass Publishers.

Clark, K. B. (1980). Empathy: A neglected topic in psychological research. *American Psychologist, 35,* 187-190. doi:10.1037/0003-066X.35.2.187

Code of Federal Regulations. (2005). Title 45, Part 46.401-409: Policy for the Protection of Human Subjects, 45. Retrieved from http://ecfr.gpoaccess.gov/cgi/ t/text/text-idx?c= ecfr&tpl=%2Findex.tpl

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite randomized controlled study of sexually abused, multiply traumatized children with PTSD: Initial treatment outcome. *Journal of the American Academy of Child and Adolescent Psychiatry,43,* 393-402. Retrieved from ERIC database.

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, 34,* 42-50. doi:10.1097/00004583-199601000-00011

Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 1228-1235. doi:10.1097/00004583-199709000-00015

Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment outcome findings. *Child Maltreatment, 3,* 17-26. doi:10.1177/1077559598003001002

Cohen, J. A., & Mannarino, A. P. (2000). Predictors of treatment outcome in sexually abused children. *Child Abuse and Neglect, 24,* 983-994. doi:10.1016/S0145-2134(00)00153-8

Cohen, J. A., & Mannarino, A. P. (2008a). Disseminating and implementing trauma-focused CBT in community settings. *Trauma, Violence, & Abuse, 9*(4), 214-226. doi:10.1177/1524838008324336

Cohen, J. A., & Mannarino, A. P. (2008b). Trauma-focused cognitive behavioral therapy for children and parents. *Child and Adolescent Mental Health, 13*(4), 158-162. doi:10.1111/j.1475-3588.2008.00502.x

Cohen, J. A., Mannarino, A. P., Berliner, L., & Deblinger, E. (2000). Trauma-focused cognitive-behavioral therapy: An empirical update. *Journal of Interpersonal Violence, 15,* 1203-1223. doi:10.1177/088626000015011007

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

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse and Neglect: The International Journal, 29*(2), 135-145. doi:10.1016/j.chiabu.2004.12.005

Cole, K. L., Sarlund-Heinrich, P., & Brown, L. S. (2007). Developing and assessing effectiveness of a time-limited therapy group for incarcerated women survivors of

childhood sexual abuse. *Journal of Trauma & Dissociation, 8*(2), 97-121. doi:10.1300/J229v08n0207

Connolly, M., & Woollons, R. (2008) Childhood sexual experience and adult offending: An exploratory comparison of three criminal groups. *Child Abuse Review, 17*, 119-132. doi:10.1002/car.1019

Crabtree, B. F., & Miller, W. L. (Eds.) (1999). *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Crenshaw, D. A., & Hardy, K. V. (2007). The crucial role of empathy in breaking the silence of traumatized children in play therapy. *International Journal of Play Therapy*, *16*(2), 160-175. doi:10.1037/1555-6824.16.2.160

Crenshaw, D. A., & Mordock, J. B. (2004). An ego-strengthening approach with multiply traumatized children: Special reference to the sexually abused. *Residential Treatment of Children and Youth, 23*, 1-18. doi:10.1300/J007v21n03_01

Creswell, J. W. (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA: Sage Publications.

Creswell. J. W., & Miller, D. L. (2009). Determining validity in qualitative inquiry. *Theory into Practice, 39*(3), 124-130. Retrieved from Academic Search Premier database.

Davidson, G., Shannon, C., Mulholland, C., & Campbell, J. (2009). A longitudinal study of the effects of childhood trauma on symptoms and functioning of people with severe mental health problems. *Journal of Trauma & Dissociation, 10*(1), 57-68. doi:10.1080/15299730802485169

Davis, N. (1996). *Once upon a time: Therapeutic stories that each and heal.* Burke, VA: Author.

DeAngelis, T. (2007, March). A new diagnosis for childhood trauma? *Monitor on Psychology, 38*(3), 32-34. Retrieved from http://www.apa.org/monitor/mar07/diagnosis.aspx

DeBellis, M. D., Baum, A. S., Birmaher, B., Keshavan, M. S., Eccard, C. H., Boring, A. M., . . . Ryan, N. D. (1999). Developmental traumatology part I: Biological stress symptoms. *Biological Psychiatry, 45*, 1259-1270. doi:10.1016/S0006- 3223(99)00044-X

DeBellis, M. D., Burke, L., Trickett, P. K., & Putnam, F. W. (1996). Antinuclear antibodies and thyroid function in sexually abused girls. *Journal of Traumatic Stress Studies, 9,* 369-378. doi:10.1002/jts.2490090218

Deblinger, E., Lippman, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1,* 310-321. Retrieved from Academic Search Premier database.

Deblinger, E., Stauffer, L., & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreatment, 6,* 332-343. doi:10.1177/1077559501006004006

Deblinger, E., Steer, R., & Lippmann, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse & Neglect, 23,* 1371-1378. doi:10.1016/S0145-2134(99)00091-5

Denov, M. S. (2003). To a safer place? Victims of sexual abuse by females and their disclosures to professionals. *Child Abuse & Neglect, 27,* 47-61. doi:10.1016/S0145-2134(02)00509-4

Deters, P. B., & Range, L. M. (2003). Does writing reduce Posttraumatic Stress Disorder symptoms? *Violence and Victims, 18,* 569-580. doi:10.1891/vivi.2003.18.5.569

Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child and Adolescent Mental Health, 11*(4), 176-184. doi:10.1111/j.1475-3588.2005.00384.x

Dyregrov, K., Dyregrov, A., & Raundalen, M. (2000). Refugee families' experience of research participation. *Journal of Traumatic Stress, 13*(3), 413-426. doi:10.1023/A:1007777006605

Ehlers, A., & Clark, D. M. (2000). A cognitive model of Posttraumatic Stress Disorder. *Behavior Research and Therapy, 38*(4), 319-345. doi:10.1016/S0005-7967(99)00123-0

Elliott, M., Browne, K., & Kilcoyne, J. (1995). Child sexual abuse prevention: What offenders tell us. *Child Abuse & Neglect, 5*, 579-594. doi:10.1016/0145-2134(95)00017-3

Emerson, S. (1988). Female student counselors and child sexual abuse: Theirs and their clients. *Counselor Education and Supervision, 28*, 15-21. Retrieved from EBSCO*host*.

Feather, J. S., & Ronan, K. R. (2009). Trauma-focused CBT with maltreated children: A clinic-based evaluation of a new treatment manual. *Australian Psychologist, 44*(3), 174-194. doi:10.1080/00050060903147083

Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *The Future of Children, 4*(2): 31-53. doi:10.2307/1602522

Finkelhor, D., Hammer, H., & Sedlak, A. J. (2008, August). *Sexually assaulted children: National estimates and characteristics.* Bureau of Justice Statistics, US Department of Justice. Retrieved from http://www.ncjrs.gov/pdffiles1/ojjdp/214383.pdf

Finkelhor, D., Mitchell, K., & Wolak, J. (2001, March). *Highlights of the youth internet safety survey*. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice

and Delinquency Prevention. Retrieved from http://www.ncjrs.gov/pdffiles1/ojjdp/fs200104.pdf

Foa, E. B., Molnar, C., & Cashman, L. (1995). Change in rape narratives during exposure to therapy for Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 8,* 675-690. doi:10.1002/jts.2490080409

Foa, E. B., & Rothebaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD.* New York, NY: Guilford Press.

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25,* 275-282. doi: 10.1037/0735-7028.25.3.275

Frattaroli, J. (2006). Experimental disclosure and its moderators: A meta-analysis. *Psychological Bulletin, 132,* 823-865. doi:10.1037/0033-2909.132.6.823

Freyd, J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse.* Cambridge, MA: Harvard University Press.

Gaines, J. (2006). Law enforcement reactions to sex offender registration and community notification. *Police Practice and Research, 7,* 249-267. doi:10.1080/15614260600825448

Gardner, Y. H. (2008). *Counselors' affective responses to childhood sexual abuse disclosure* (Doctoral Dissertation). Retrieved from Proquest Dissertations and Theses database. (UMI No. 3331221)

Gidron, Y., Duncan, E., Lazar, A., Biderman, A., Tandeter, H., & Shvartztman, P. (2002). Effects of guided written disclosure of stressful experiences on clinic visits and

symptoms in frequent clinic attenders. *Family Practice, 19*,161-166. doi:10.1093/fampra/19.2.161

Gidron, Y., Peri, T., Connolly, J. F., & Shalev, A. Y. (1996). Written disclosure in Posttraumatic Stress Disorder: Is it beneficial for the patient? *Journal of Nervous and Mental Disease, 184*, 505–507. doi:10.1097/00005053-199608000-00009

Gil, E. (2006). *Helping abused and traumatized children: Integrating directive and non-directive approaches.* New York, NY: Guilford Press.

Glesne, C. (2006). *Becoming Qualitative Researchers: An Introduction* (3rd ed.). New York, NY: Pearson.

Gobin, R. L., & Freyd, J. J. (2009). Betrayal and revictimization: Preliminary findings. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(3), 242-257. doi:10.1037/a0017469

Gold, S. N. (2000). *Not trauma alone: Therapy for child abuse survivors in family and social context.* New York, NY: Taylor & Francis, Inc.

Goldfinch, M. (2009). 'Putting humpty together again': Working with parents to help children who have experienced early trauma. *Australian & New Zealand Journal of Family Therapy, 30*(4), 284-299. doi:10.1375/anft.30.4.284

Goodman, G. S., Quas, J. A., & Ogle, C. M. (2010). Child maltreatment and memory. *Annual Review of Psychology, 61*(1), 325-351. doi:10.1146/annurev.psych.093008.100403

Goodman, L., Dutton, M., & Harris, M (1995). Episodically homeless women with serious mental illness: Prevelance of physical and sexual assault. *American Journal of Orthopsychiatry, 65*(4), 468-478. Retrieved from Academic Search Premier.

Grbich, C. (2007). *Qualitative Data Analysis: An Introduction.* Los Angeles, CA: Sage Publications.

Green, E. J. (2008). Reenvisioning Jungian analytical play therapy with child sexual assault survivors. *International Journal of Play Therapy, 17*(2), 102-121. doi:10.1037/a0012770

Greenberg, J. B. (2001). Childhood sexual abuse and sexually transmitted diseases in adults: A review of implications for STD/HIV programs. *International Journal of STD & AIDS, 12*, 777-783. doi:10.1258/0956462011924380

Grossman, F. K., Sorsoli, L., & Kia-Keating, M. (2006). A gale force wind: Meaning making by male survivors of childhood sexual abuse. *American Journal of Orthopsychiatry, 76*(4), 434-443. doi:10.1037/0002-9432.76.4.434

Guba, E. H. (1978). *Toward a methodology of naturalistic inquiry in educational evaluation. Monograph 8.* Los Angeles, CA: UCLA Center for the Study of Evaluation.

Harker, T. (1997). Therapy with male sexual abuse survivors: Contesting oppressive life stories. In G. Monk, J. Winslade, K. Crocket, & D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope* (pp. 193-214). San Francisco, CA: Jossey-Bass.

Harvey, A. G., & Bryant, R. A. (1999). A qualitative investigation of the organization of traumatic memories. *British Journal of Clinical Psychology, 38,* 401-405. doi:10.1348/014466599162999

Hellawell, S. J., & Brewin, C. R. (2002). A comparison of flashbacks and ordinary autobiographical memories of trauma: Cognitive resources and behavioural observations. *Behaviour Research and Therapy, 40*(10), 1143-1156. doi:10.1016/S0005-7967(01)00080-8

Himelein, M. J., & McElrath, J. V. (1996). Resilient child sexual abuse survivors: Cognitive coping and illusion. *Child Abuse & Neglect, 20*, 747-758. doi:10.1016/0145-2134(96)00062-2

Hull, A.M. (2002). Neuroimaging findings in post-traumatic stress. *British Journal of Psychiatry, 181*, 102-110. doi:10.1192/bjp.181.5.433

Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S. O., & Dolatabadi, S. (2004). A comparison of CBT and EMDR for sexually abused Iranian girls. *Clinical Psychology and Psychotherapy, 11,* 358-368. doi:10.1002/cpp.395

Janoff-Bulman, R., & Frantz, C. M. (1997). The impact of trauma on meaning: From meaningless world to meaningful life. In M. Power & C. R. Brewin (Eds.), *The transformation of meaning in psychological therapies* (pp. 75-89). New York, NY: Wiley.

Jenmorri, K. (2006). Of rainbows and tears: Exploring hope and despair in trauma therapy. *Child & Youth Care Forum, 35*(1), 41-55. doi:10.1007/s10566-005-9002-7

Jensen, T. K., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. A. (2005). Reporting possible sexual abuse: A qualitative study on children's perspectives and the context for disclosure. *Child Abuse & Neglect, 29*(12), 1395-1413. doi: 10.1016/j.physletb.2003.10.071

Jones, F., & Morris, M. (2007). Working with child sexual abuse: A systemic perspective on whether children need to tell their therapist details of the abuse for healing to take place. *Journal of Family Therapy, 29,* 222-237. Retrieved from PsycINFO.

Jones, K. D. (1999). The Media and Megan's Law: Is Community Notification the Answer? *Journal of Humanistic Counseling, Education & Development, 38*(2), 80-88. Retrieved from EBSCO*host*.

Jones, K. D. (2002). The impact of learning about child abuse trauma. *Journal of Humanistic Counseling, Education, and Development, 41,* 45-51. Retrieved from EBSCO*host*.

Jones, K. D., Robinson, E. H., Minatrea, N., & Hayes, B. L. (1998). Coping with reactions to clients traumatized by child sexual abuse. *Journal of Mental Health Counseling, 20*, 332-343. Retrieved from EBSCO*host*.

Kaminer, D. (2006). Healing processes in trauma narratives: A review. *South African Journal of Psychology, 36*(3), 481-499. Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=24169990&site=ehost-live

Kassam-Adams, N. & Newman, E. (2005). Child and parent reactions to participation in clinical research. *General Hospital Psychiatry, 24*(5), 336-342. doi:10.1016/j.genhosppsych.2004.08.007

Katerndahl, D. A., Burge, S. K., Kellogg, N., & Parra, J. M. (2005). Differences in childhood sexual abuse experience between adult Hispanic and Anglo women in a primary care setting. *Journal of Child Sexual Abuse, 14*(2), 85-95. doi: 10.1300/J070v14n02_05

Keiley, M. K., Howe, T. R., Dodge, K. A., Bates, J. E., & Petit, G. S. (2001). The timing of child physical maltreatment: A cross-domain growth analysis of impact on adolescent externalizing and internalizing problems. *Developmental Psychopathology, 13,* 891-912. Retrieved from PsycINFO database.

Kilpatrick, D., Saunders, B., & Smith, D. (2003). Youth victimization: Prevalence and implications. U.S. Department of Justice, National Institute of Justice report. Retrieved from http://www.ncjrs.gov/pdffiles1/nij/194972.pdf

King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., . . . Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 1347-1355. doi:10.1097/00004583-200011000-00008

Kitzrow, M. A. (2002). Survey of CACREP-accredited programs: Training counselors to provide treatment for sexual abuse. *Counselor Education and Supervision, 42*, 107-118. Retrieved from EBSCO*host*.

Klempner, M. (2000). Navigating life review interviews with survivors of trauma. *Oral History Review, 27*(2), 67-83. Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=3759750&site=ehost-live

Kuiken, D., Dunn, S., & LoVerso, T. (2008). Expressive writing about dreams that follow trauma and loss. *Dreaming, 18*(2), 77-93. doi:10.1037/1053-0797.18.2.77

Lanktree, C., & Briere, J. (2008). *Integrative treatment of complex trauma for children (ITCT-C): A guide for the treatment of multiply-traumatized children aged eight to twelve years.* Retrieved from http://johnbriere.com/articles.htm

Lataster, T., van Os, J., Drukker, M., Henquet, C., Feron, F., Gunther, N., & Myin-Germeys, I. (2006). Childhood victimization and developmental expression of non-clinical delusional ideation and hallucinatory experiences: Victimization and non-clinical psychotic

experiences. *Social Psychiatry and Psychiatric Epidemiology, 41*(6), 423-428. doi:10.1007/s00127-006-0060-4

Laub. D., & Felman, S. (1992). *Testimony: Crises of witnessing in literature, psychoanalysis, and history*, New York, NY: Routledge.

Laumann, E., Paik, A., & Rosen, R. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association, 281*, 537-544. doi:10.1001/jama.281.6.537

Leander, L., Christianson, S. A., & Granhag, P. A. (2007). A sexual abuse case study: Children's memories and reports. *Psychiatry, Psychology and Law, 14*(1), 120-129, doi: 10.1375/pplt.14.1.120

Leckman, J. F., & Mayes, L. C. (2007). Nurturing resilient children. *Journal of Child Psychology and Psychiatry, 48*, 221-223. doi:10.1111/j.1469-7610.2007.01743.x

Levenson, J. S., D'Amora, D. A., & Hern, A. L. (2007). Megan's law and its impact on community re-entry for sex offenders. *Behavioral Sciences and the Law, 25*, 587-602. doi:10.1002/bsl.770

Levin, R., & Nielsen, T. A. (2007). Disturbed dreaming, Posttraumatic Stress Disorder, and affect distress: A review and neurocognitive model. *Psychological Bulletin, 133*, 482-528. doi:10.1037/0033-2909.133.3.482

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* Newbury Park, CA: Sage Publications.

Lindblom, K. M., & Gray, M. J. (2010). Relationship closeness and trauma narrative detail: A critical analysis of betrayal trauma theory. *Applied Cognitive Psychology, 24*, 1-19. doi:10.1002/acp.1547

Linley, P. A. (2003). Positive adaptation to trauma: Wisdom as both process and outcome. *Journal of Traumatic Stress, 16*(6), 601-610. doi:10.1023/B:JOTS.0000004086.64509.09

Lobbestael, J., Arntz, A., Harkema-Schouten, P., & Bernstein, D. (2009). Development and psychometric evaluation of a new assessment method for childhood maltreatment experiences: The interview for traumatic events in childhood (ITEC). *Child Abuse & Neglect: The International Journal, 33*(8), 505-517. doi:10.1016/j.chiabu.2009.03.002

Loewenstein, R. J. (1993). Dissociation, development and the psychobiology of trauma. *Journal of the American Academy of Psychoanalysists, 21*, 581-603. Retrieved from PsycINFO database.

Lowenstein, L. L. (1999). *Creative interventions for troubled children and youth.* Toronto, Canada: Champion Press.

London, K., Bruck, M., Ceci, S. J., & Shuman, D. W. (2005) Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law, 11*(1), 194-226. doi: 10.1037/1076-8971.11.1.194

Lundqvist, G., Hansson, K., & Svedin, C. G. (2004). The influence of childhood sexual abuse factors on women's health. *Nordic Journal of Psychiatry, 58*(5), 395-401. doi:10.1080/08039480410005963

Lundqvist, G., Hansson, K., & Svedin, C. G. (2009). Group therapy for women sexually abused as children: Social interaction, adjustment, and relationships before and after group therapy. *Psychoanalytic Social Work, 16*(2), 158-175. doi:10.1080/15228870903200335

Maltz, W. (2002). Treating the sexual intimacy concerns of sexual abuse survivors. *Sexual and Relationship Therapy, 17*(4), 321-327. doi:10.1080/1468199021000017173

Mannon, K., & Leitschuh, G. (2002). Child sexual abuse: A review of definitions, instrumentation, and symptomology. *North American Journal of Psychology, 4*(1), 149-160. Retrieved from Academic Search Premier.

McGregor, K., Thomas, D. R., & Read, J. (2006). Therapy for child sexual abuse: Women talk about helpful and unhelpful therapy experiences. *Journal of Child Sexual Abuse, 15*(4), 35-59. doi: 10.1300/J070v15n04_03

McNally, R. J. (2007). Betrayal trauma theory: A critical appraisal. *Memory, 15*(3), 280-294. doi:10.1080/09658210701256506

Merrill, L. L., Thomsen, C. J., Sinclair, B. B., Gold, S. R., & Milner, J. S. (2001). Predicting the impact of child sexual abuse on women: The role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology, 69,* 992-1006. doi:10.1037/0022-006X.69.6.992

Merscham, C. (2000). Restorying trauma with narrative therapy. Using the phantom family. *Family Journal, 8*(3), 282-286. doi:10.1177/1066480700083013

Miller, B. J., Cardona, J. R. P., & Hardin, M. (2007). The use of narrative therapy and internal family systems with survivors of child sexual abuse: Examining issues related to loss and

oppression. *Journal of Feminist Family Therapy, 18*(4), 1-27. doi:10.1300/J086v18n04_01

Mossige, S., Jensen, T. K., Gulbrandsen, W., Reichelt, S., & Tjersland, O. A. (2005). Children's narratives of sexual abuse: What characterizes them and how do they contribute to meaning-making? *Narrative Inquiry, 15*(2), 377-404. doi:10.1075/ni.15.2.09mos

Murray, J. B. (2000). Psychological profile of pedophiles and child molesters. *The Journal of Psychology, 134*(2), 211-224. doi:10.1080/00223980009600863

Nathan, P., & Ward, T. (2001). Females who sexually abuse children: Assessment and treatment issues. *Psychiatry, Psychology and Law, 8,* 44−45. doi:10.1080/13218710109525003

Nelson-Gardell, D. (2001). The voices of victims: Surviving child sexual abuse. *Child and Adolescent Social Work Journal, 18*(6), 401-416. Retrieved from Academic Search Premier.

Nisbet-Wallis, D. A. (2002). Reduction in trauma symptoms following group therapy. *Australian and New Zealand Journal of Psychiatry, 36*(1), 67-74. doi:10.1046/j.1440-1614.2002.00980.x

Nkongho, N. (2006). *Religious coping among sexually abused adolescent girls: A phenomenological investigation* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3218322)

Norcross, J. C. (Ed.) (2002). *Psychotherapy relationships that work: Therapists contributions and responsiveness to patients.* New York, NY: Oxford University Press, Inc.

Ogawa, Y. (2004). Childhood trauma and play therapy intervention for traumatized children. *Journal of Professional Counseling: Practice, Theory, & Research, 32*(1), 19-29.

Retrieved from http://ezproxy.lib.ucf.edu/login?URL=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2004-16009-002&site=ehost-live

Oz, S. (2005). The "wall of fear": The bridge between the traumatic event and trauma resolution therapy for childhood sexual abuse survivors. *Journal of Child Sexual Abuse, 14*(3), 23-47. doi:10.1300/J070v14n03_02

Parillo, K. M., Freeman, R. C., Collier, K., & Young, P. (2001). Association between early sexual abuse and adult HIV risky sexual behaviors among community-recruited women. *Child Abuse and Neglect, 25*, 335-346. doi:10.1016/S0145-2134(00)00253-2

Parker, A., Fourt, A., Langmuir, J. I., Dalton, E. J., & Classen, C. C. (2007). The experience of trauma recovery: A qualitative study of participants in the women recovering from abuse program (WRAP). *Journal of Child Sexual Abuse, 16*(2), 55-77. doi:10.1300/J070v16n02_04

Patton, M. Q. (2002). Chapter 5: Designing Qualitative Studies. *Qualitative Research & Evaluation Methods* (3rd Ed.). Thousand Oaks, CA: Sage Publications.

Pennebaker, J. W., & Beall, S. K. (1986). Confronting a traumatic event: Toward an understanding of inhibition and disease. *Journal of Abnormal Psychology, 95*, 274-281. doi:10.1037/0021-843X.95.3.274

Pennebaker, J. W., Colder, M., & Sharp, L. K. (1990). Accelerating the coping process. *Journal of Personality and Social Psychology, 58,* 528-537. doi:10.1037/0022-3514.58.3.528

Pennebaker, J. W., & Seagal, J. D. (1999). Forming a story: The health benefits of narrative. *Journal of Clinical Psychology, 55*(10), 1243-1254. doi:10.1002/(SICI)1097-4679(199910)55:10<1243::AID-JCLP6>3.0.CO;2-N

Pistorius, K. D., Feinauer, L. L., Harper, J. M., Stahmann, R. F., & Miller, R. B. (2008). Working with sexually abused children. *The American Journal of Family Therapy, 36,* 181-195. doi:10.1080/01926180701291204

Read, J., Goodman, L., Morrison, A. P., Ross, C. A., & Aderhold, V. (2004). Childhood trauma, loss and stress. In J. Read, L. Mosher, & R. Bentall (Eds.), *Model of madness: Psychological, social and biological approaches to schizophrenia* (pp. 223–252). Hove, England: Brunner-Routledge.

Reilly, P. L. (2000). *I promise myself: Making a commitment to yourself and your dreams.* Berkeley, CA: Conari Press.

Reyes, C. J., & Asbrand, J. P. (2005). A longitudinal study assessing trauma symptoms in sexually abused children engaged in play therapy. *International Journal of Play Therapy, 14*(2), 25-47. doi:10.1037/h0088901

Robinson, E. H., Rotter, J. C, Fey, M. A., & Robinson, S. L. (1991). Children's Fears: Toward a preventive model. *The School Counselor, 38*(3), 187-202. Retrieved from PsycINFO database.

Sandoval, J., Scott, A. N., & Padilla, I. (2009). Crisis counseling: An overview. *Psychology in the Schools, 46*(3), 246-256. doi:10.1002/pits.20370

Sar, V., Akyuz, G., Kugu, N., Ozturk, E., & Ertem-Vehid, H. (2006). Axis I dissociative disorder comorbidity in Borderline Personality Disorder and reports of childhood trauma. *Journal of Clinical Psychiatry, 67*(10), 1583-1590. doi:10.4088/JCP.v67n1014

Saywitz, K., Mannarino, A. P., Berliner, L., & Cohen, J. A. (2000). Treatment of sexually abused children and adolescents. *American Psychologist, 55*, 1040–1049. doi:10.1037/0003-066X.55.9.1040

Scheeringa, M. S., Salloum, A., Arnberger, R. A., Weems, C. F., Amaya-Jackson, L., & Cohen, J. A. (2007). Feasibility and effectiveness of cognitive-behavioral therapy for Posttraumatic Stress Disorder in preschool children: Two case reports. *Journal of Traumatic Stress, 20*(4), 631-636. doi:10.1002/jts.20232

Schmookler, E. L. (1996). *Trauma treatment manual.* Retrieved from http://park.org/Guests/Stream/trauma_manual.htm

Schore, A. N. (2003a). *Affect dysregulation and disorders of the self.* New York, NY: Norton.

Schore, A. N. (2003b). *Affect regulation and the repair of the self.* New York, NY: Norton.

Schoutrop, M. J. A., Lange, A., Hanewald, G., Davidovich, U., & Salomon, H. (2002). Structured writing and processing major stressful events: A controlled trial. *Psychotherapy and Psychosomatics, 71*, 151-157. doi:10.1159/000056282

Schoutrop, M. J. A., Lange, A., Hanewald, G., Duurland, C., & Bermond, B. (1997). The effects of structured writing assignments on overcoming major stressful events: An uncontrolled study. *Clinical Psychology and Psychotherapy, 4*, 179-185. Retrieved from Academic Search Premier database.

Sewell, K. W., & Williams, A. M. (2001). Construing stress: A constructivist therapeutic approach to posttraumatic stress reactions. In R. A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 293–310). Washington, DC: American Psychological Association.

Sheinberg, M., & True, F. (2008). Treating family relational trauma: A recursive process using a decision dialogue. *Family Process, 47*(2), 173-195. doi:10.1111/j.1545-5300.2008.00247.x

Shelby, J. S. (2000). Brief therapy with traumatized children: A developmental perspective. In H. G. Kaduson, & C. E. Schaefer, (Eds.), Short-term play therapy for children (pp. 69-104). New York, NY: Guilford Press.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* New York, NY: Guilford Press.

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being.* New York, NY: Norton.

Silverman, W. K., Ortiz, C. D., Viswesvaran, 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 and Adolescent Psychology, 37*(1), 156-183. doi:10.1080/15374410701818293

Sloan, D. M., & Marx, B. P. (2004). A closer examination of the structured written disclosure procedure. *Journal of Consulting and Clinical Psychology, 72,* 165-175. doi:10.1037/0022-006X.72.2.165

Sloan, D. M., Marx, B. P., & Epstein, E. M. (2005). Further examination of the exposure model underlying the efficacy of written emotional disclosure. *Journal of Clinical and Consulting Psychology, 73,* 549-554. doi:10.1037/0022-006X.73.3.549

Smyth, J. M., Hockemeyer, J., Anderson, C., Strandberg, K., Koch, M., O'Neill, H. K., & McCammon, S. (2002). Structured writing about a natural disaster buffers the effect of

intrusive thoughts on negative affect and physical symptoms. *Australasian Journal of Disaster, 1*. Retrieved from http://www.massey.ac.nz/~trauma/issues/2002-1/smyth.htm

Snyder, H. (2000, July). *Sexual assault of young children as reported to law enforcement: Victim, incident and offender characteristics*. Bureau of Justice Statistics, US Department of Justice. Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/saycrle.pdf

Snyder, H. N., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 national report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Retrieved from http://www.ojjdp.gov/ojstatbb/nr2006/downloads/NR2006.pdf

Sorsoli, L., Kia-Keating, M., & Grossman, F. K. (2008). "I keep that hush-hush": Male survivors of sexual abuse and the challenges of disclosure. *Journal of Counseling Psychology, 55*(3), 333-345. doi: 10.1037/0022-0167.55.3.333

Stinson, M. H., & Hendrick, S. S. (1992). Reported child sexual abuse in university counseling center clients. *Journal of Counseling Psychology, 39*, 370-374. doi: 10.1037/0022-0167.39.3.370

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2008). National Registry of Evidence-based Programs and Practices. Retrieved from http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=217

Tarakeshwar, N., Hansen, N. B., Kochman, A., Fox, A., & Sikkema, K. J. (2006). Resiliency among individuals with childhood sexual abuse and HIV: Perspectives on addressing sexual trauma. *Journal of Traumatic Stress, 19*(4), 449-460. doi:10.1002/jts.20132

Taylor, L. K., & Weems, C. F. (2009). What do youth report as a traumatic event? Toward a developmentally informed classification of traumatic stressors. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(2), 91-106. doi:10.1037/a0016012

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15,* 1-18. doi:10.1207/s1532796Child 12li1501_01

Terr, L. C. (1979). Children in Chowchilla. *The Psychoanalytic Study of the Child, 34,* 522-563.

Tomlinson, P. (2008). Assessing the needs of traumatized children to improve outcomes. *Journal of Social Work Practice, 22*(3), 359-374. doi:10.1080/02650530802396684

Tremblay, C., Hebert, M., & Piche, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims, *Child Abuse and Neglect, 23*(9), 929-945. doi:10.1016/S0145-2134(99)00056-3

Trickett, P. W., & Putnam, F. W. (1998). Developmental consequences of child sexual abuse. In P. K. Trickett & C. J. Schellenbach (Eds.), *Violence against children in the family and the community* (pp. 39-56). Washington, DC: American Psychological Association.

Trowell, J., Kolvin, I., Weeramanthri, T., Sadowski, H., Berelowitz, M., Glaser, D., Leitch, I. (2002). Psychotherapy for sexually abused girls: Psychopathological outcome findings and patterns of change. *British Journal of Psychiatry, 180,* 234-247. doi:10.1192/bjp.180.3.234

Tuval-Mashiach, R., Freedman, S., Bargai, N., Boker, R., Hadar, H., & Shalev, A. Y. (2004). Coping with trauma: Narrative and cognitive perspectives. *Psychiatry: Interpersonal and Biological Processes, 67*(3), 280-293. doi:10.1521/psyc.67.3.280.48977

Ullman, S. E. (2003). Social reactions to child sexual abuse disclosures: A critical review. *Journal of Child Sexual Abuse, 12*, 89-121. doi:10.1300/J070v12n01_05

Ullrich, P. M., & Lutgendorf, S. K. (2002). Journaling about stressful events: Effects of cognitive processing and emotional expression. *Annals of Behavioral Medicine, 24,* 244-250. doi:10.1207/S1532479Child 20BM2403_10

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). *Child Maltreatment 2009.* Retrieved from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can

Urman, M. L., Funk, J. B., & Elliott, R. (2001). Children's experiences of traumatic events: The negotiation of normalcy and difference. *Clinical Child Psychology and Psychiatry, 6*(3), 403-424. doi:10.1177/1359104501006003009

Vaddiparti, K., Bogetto, J., Callahan, C., Abdallah, A. B., Spitznagel, E. L., & Cottler, L. B. (2006). The effects of childhood trauma on sex trading in substance using women. *Archives of Sexual Behavior, 35*(4), 451-459. doi:10.1007/s10508-006-9044-4

Vandiver, D. M., & Walker, J. T. (2002). Female sex offenders: An overview and analysis of 40 cases. *Criminal Justice Review, 27,* 284−300. doi:10.1177/073401680202700205

van der Kolk, B. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.

Walker, D. F., Reid, H. W., O'Neill, T., & Brown, L. (2009). Changes in personal religion/spirituality during and after childhood abuse: A review and synthesis. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(2), 130-145. doi:10.1037/a0016211

Wang, C.-T., & Holton, J. (2007). *Total estimated costs of child abuse and neglect in the United States.* Chicago, IL: Prevent Child Abuse America. Retrieved from http://member.preventchildabuse.org/site/DocServer/cost_analysis.pdf?docID=144

Ward, T., & Beech, A. (2005). An integrated theory of sexual offending. *Aggression and Violent Behavior: A Review Journal, 11*, 44-63. doi:10.1016/j.avb.2005.05.002

Webster, R. E. (2001). Symptoms and long-term outcomes for children who have been sexually assaulted. *Psychology in the schools, 38(6),* 533-549. doi:10.1002/pits.1041

Welfare, A. (2008). How qualitative research can inform clinical interventions in families recovering from sibling sexual abuse. *Australian and New Zealand Journal of Family Therapy, 29*(3), 139-147. doi:10.1375/anft.29.3.139

Wethington, H. R., Hahn, R. A., Fuqua-Whitley, D., Crosby, A. E., Liberman, A. M., Price, L. N., . . . Sipe, T. A. (2008). The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: A systematic review. *American Journal of Preventive Medicine, 35*(3), 287-313. doi:10.1016/j.amepre.2008.06.024

Whisman, M. A. (2006). Childhood trauma and marital outcomes in adulthood. *Personal Relationships, 13*, 375-386.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York, NY: Norton.

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults. *Journal of Interpersonal Violence, 18,* 166-185. doi:10.1177/0886260502238733

Widom, C. S., Button, M. A., Czaja, S. J., & DuMont, K. A. (2005). Development and validation of a new instrument to assess lifetime trauma and victimization history. *Journal of Traumatic Stress, 18*(5), 519-531. doi:10.1002/jts.20060

Winkelspecht, S. M., & Singg, S. (1998). Therapist's self-reported training and success rates in treating clients with childhood sexual abuse. *Psychological Reports, 82*, 579-582.

Wolf, G. K., Reinhard, M., Cozolino, L. J., Caldwell, A., & Asamen, J. K. (2009). Neuropsychiatric symptoms of complex Posttraumatic Stress Disorder: A preliminary Minnesota Multiphasic Personality Inventory scale to identify adult survivors of childhood abuse. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 49-64. doi:10.1037/a0015162

Wright, M. O., Crawford, E., & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding and meaning-making. *Journal of Family Violence, 22*(7), 597-608. doi:10.1007/s10896-007-9111-1

Wurtele, S. K. (2009). Preventing sexual Abuse of children in the twenty-first century: Preparing for challenges and opportunities, *Journal of Child Sexual Abuse, 18*(1), 1-18. doi: 10.1080/10538710802584650