Delivers an effective, engaging new technique for treating childhood sexual abuse

Treating a confirmed or suspected case of childhood sexual abuse is undoubtedly one of the most challenging situations a clinician can face. This unique book, written by recognized experts on the evaluation and treatment of childhood sexual abuse, is the first to disseminate a comprehensive and integrative approach to treating child sexual abuse that combines the power of structured play therapy with cognitive-behavioral treatment. Created by the authors, game-based cognitive-behavioral therapy (GB-CBT) is a complete therapeutic package containing engaging techniques and effective strategies to treat the problems experienced by children and families impacted by sexual abuse.

The book provides the rationale, underlying theory, and step-by-step instructions for providing GB-CBT to families affected by child sexual abuse. Detailed descriptions of evidence-based techniques and required materials are included, along with reproducible game boards and other items needed to implement activities. These structured therapeutic games and role-plays are enjoyable and provide multiple opportunities for children to learn and rehearse such skills as emotional expression, anger management, relaxation strategies, social skills, social problem solving, and cognitive coping. A detailed session framework complete with behavioral expectations and reward systems, along with illustrative case examples, further demonstrates how to implement GB-CBT. Also included are recommendations for effective and comprehensive assessment procedures. The book describes activities for individual, conjoint child-caregiver, and group therapy that can be used in a multitude of therapeutic environments and can be incorporated into clinical practice across a variety of orientations. Additionally, it includes information about cultural considerations critical for effective delivery with diverse populations. The book also contains strategies for training and educating students and clinicians about GB-CBT.

**Key Features**

- Delivers an effective new method for treating child sexual abuse that combines structured play therapy with cognitive-behavioral therapy
- Written by the originators of GB-CBT, recognized experts in this field
- Designed for use in a variety of settings and with different therapeutic modalities
- Presents concrete strategies, step-by-step instruction, and required materials for treating problems related to child sexual abuse
- Includes illustrative case examples and a complete description of structured sessions with behavioral expectations and reward systems

**GAME-BASED COGNITIVE-BEHAVIORAL THERAPY FOR CHILD SEXUAL ABUSE**

**AN INNOVATIVE TREATMENT APPROACH**
Game-Based Cognitive-Behavioral Therapy for Child Sexual Abuse
Craig I. Springer, PhD, is a recognized expert in the field of evidence-based practices for childhood behavioral disorders and trauma. He currently holds the position of Director of the Psychological Services Clinic at the Graduate School of Applied and Professional Psychology at Rutgers University. Prior to his appointment at Rutgers, Dr. Springer was a supervising psychologist at Newark Beth Israel Medical Center’s Metropolitan Regional Child Abuse Diagnostic and Treatment Center, where he codeveloped and researched game-based cognitive-behavioral therapy (GB-CBT), and supervised programming for children and families impacted by child abuse and neglect. In collaboration with Dr. Misurell, he cofounded Psychology Innovations, LLC, which was formed to develop, disseminate, and promote the use of creative and effective therapeutic interventions. Dr. Springer received his PhD in clinical psychology from Fairleigh Dickinson University. He is a licensed psychologist in New York and New Jersey and is credentialed by the National Register of Health Service Psychologists. Dr. Springer serves on the Practice Guidelines Committee of the American Professional Society on the Abuse of Children and is a reviewer for the Journal of Child Sexual Abuse and Psychological Trauma: Theory, Research, Practice and Policy. He has given numerous presentations and workshops at regional and national conferences and is the author of several peer-reviewed journal articles and book chapters.

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Game-Based Cognitive-Behavioral Therapy for Child Sexual Abuse
An Innovative Treatment Approach

Craig I. Springer, PhD
Justin R. Misurell, PhD
To my mother, who will always be in my heart and memories, and my wife Sarah, who raises me up with her love, support, and patience. —CS

To my wife Keri and our daughter Sophia for inspiring me to be my best self. —JRM
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Foreword

The rates of childhood sexual abuse and complex trauma are rising. Each year approximately 5 million children experience some form of traumatic experience, with more than 2 million victims of physical and/or sexual abuse (Belluck, 2012). About a third of the children we treat meet diagnostic criteria for posttraumatic stress disorder (PTSD), with up to 50% of traumatized children suffering from PTSD nationwide. We see myriad symptoms in our child clients resulting from lack of trust in family members, distrust of adults in general, and feeling worthless, depressed, withdrawn, isolated, anxious, angry, defiant, and hypervigilant. They suffer from lack of sleep, nightmares, and refusing to go to bed, along with low self-esteem, low frustration tolerance, learning problems, developmental delays, poor social skills, and difficulty self-regulating. Some rage against the world through antisocial and sexualized behaviors while others withdraw into dissociation. The child’s safety and security is severed, creating a weak emotional foundation. Sexual abuse trauma, often complex, results in long-term and pervasive emotional impairment. The child’s core capacity to self-soothe, self-regulate, and connect interpersonally is shattered.

Many of the children we work with find they cannot or will not talk about their traumatic experiences, even in the most emotionally safe and caring of environments. Some children have been warned and threatened with punishment or bodily harm to themselves, a family member, or pet and are terrified to discuss their sexual abuse. Others harbor horrific images from their trauma that threaten to overwhelm weak and vulnerable defenses. They are afraid of letting the “genie out of the bottle” for fear it will cause a flood of emotions that could emotionally annihilate the child or those he or she loves. They may fear these strong emotions will remain resistant to going back in the “bottle” and will continue to wreak havoc once out. Play therapy and play-based interventions allow the child nonverbal ways to communicate the pain and horrors held within and make treatment playful, assisting in reducing resistance. Play therapy is developmentally based, developed from solid philosophic and theoretical underpinnings with empirically based research showing its positive impact (Bratton, Ray, Rhine, & Jones, 2005; Drewes, 2009; Reddy, Files-Hall, & Schaefer, 2005; Russ & Niec, 2011). Play is as natural to children as breathing. It is intrinsically motivating, an end in itself, transcending differences in ethnicity, language, and culture, and it is associated with positive emotions (Drewes, 2006, 2009; Lidz, 2002; Tharinger, Christopher, & Matson, 2011). Play is perhaps the most developmentally appropriate and powerful medium for children to build adult–child relationships, develop cause–effect thinking critical to impulse control, process stressful experiences, and learn social skills (Chaloner, 2001).
The presence of a therapist who can help the child feel heard, understood, and accepted (Gil, 1991; Schaefer & Drewes, 2010) allows the child the space to utilize the healing powers of play (Russ, Fiorelli, & Spannagel, 2011; Schaefer, 1993; Schaefer & Drewes, 2010). The use of play as therapy and play within therapy helps the therapist establish a working relationship with children, creating a corrective emotional experience, especially for those children who lack verbal self-expression and who may show resistance or an inability to articulate their feelings and issues (Haworth, 1964; Russ & Niec, 2011). Play in therapy can provide a child with the sense of power and control that comes from solving problems and mastering new experiences, ideas, and skills. As a result, it can help build feelings of confidence and accomplishment (Drewes, 2005). Play as therapy and play in therapy allow for healing to occur for children and their families. Through play-based therapy we can offer the child the necessary time, space, and treatment approach to fix presenting problems and make therapeutic change across the various different and multidimensional psychological disorders (Drewes, Bratton, & Schaefer, 2012).

Sexual abuse traumas are often multilayered, complex, and multidetermined; therefore, a multifaceted prescriptive and integrative treatment approach is needed (Drewes, Bratton, & Schaefer, 2012). An integrative approach is very critical in working with sexual abuse trauma. Gil (2006) states, “Evidence also suggests that trauma memories are imbedded in the right hemisphere of the brain, and that interventions facilitating access to and activity in the right side of the brain may be indicated. The right hemisphere of the brain is most receptive to nonverbal strategies that utilize symbolic language, creativity and play” (p. 68). Thus, playful and pleasurable activities within therapy have been found to be helpful and necessary in helping traumatized and abused children heal as well as create their healing trauma narratives (Drewes & Cavett, 2012; Gil, 2006; Perry, 2009; van der Kolk, 2005).

Since its origin, cognitive-behavioral therapy (CBT) has incorporated the medium of play (Knell, 1993) to help nurture children’s affect regulation, teach coping skills, correct cognitive distortions, provide psychoeducation, and help abused children develop integrative narratives of traumatic events, thereby organizing fragmented memories (Meichenbaum, 2010). CBT has also utilized play as a means of helping to improve parent–child relationships (Meichenbaum, 2009).

Utilizing play-based techniques within structured CBT treatment can be very useful with children who are challenging to engage in treatment and may respond well when the therapeutic environment is playful and when play-based techniques are utilized by a playful therapist, all of which can offer relief from intensely emotionally charged work in dealing with feelings and sexual abuse experiences.

By blending play-based techniques into CBT (Drewes, 2009), the delivery of CBT can be applied while not affecting CBT theoretical underpinnings. In child sexual abuse (CSA) treatment it has become “clear that children respond very differently to therapy than adults and the element of play becomes a crucial ingredient in engaging children in the therapy process as does the important involvement of parents” (Briggs, Runyon, & Deblinger, 2011, p. 169). Difficult and emotionally laden trauma material can be more easily digested with play-based techniques becoming a sort of “enzyme” (Goodyear-Brown, 2009) that dissolves the painful connection to traumatic memories, thereby easing the discomfort and increasing control and confidence within the child. A new pairing can then occur, the basis of which becomes associated “with laughter,
playful competition, pride and feelings of courage and confidence” (Briggs, Runyon, & Deblinger, 2011, p. 174; Deblinger & Heflin, 1996). Research has shown that the most effective sexual abuse treatment approaches utilize the parent as part of the teaching and practice of skills for the child.

CBT and play-based techniques help to gain the child’s interest and maintain attention, as well as process and comprehend each of the components of sexual abuse treatment through a multimodal approach that developmentally and culturally taps into the natural learning style and life experiences of children. Without a playful aspect to these components, children may view treatment activities as though they are formal, academic tasks and become disinterested or refuse to participate.

We want to have the tools necessary to use in our therapeutic work with sexually abused children. But where does one find a book that can help walk us through a CBT and play-based treatment approach that is prescriptive, integrative, and fun to use? How can we find techniques that will help us work with our elementary and middle-school traumatized child clients?

Happily, Craig Springer and Justin Misurell have created such a tool, offering us a toolkit of resources in Game-Based Cognitive-Behavioral Therapy for Child Sexual Abuse. This thorough, highly detailed, and strength-based book is structured in a step-wise fashion, allowing the reader to follow it systematically in working with traumatized clients. They make sexual abuse treatment fun, engaging, collaborative, and experiential.

Part II addresses practice issues for the clinician (competencies, assessment and treatment planning, and engagement and motivation). The next part gets to the heart of game-based CBT, detailing individual, dyadic, and group approaches, as well as caregiver group therapy. Part IV, Therapeutic Materials, goes through each of the components necessary to address sexual abuse, from rapport building and personal space and boundaries issues to psychoeducation, abuse processing, and personal safety skills. A plethora of structured therapeutic games are outlined in full detail within each section, including age range, necessary materials, and step-by-step implementation for individual, child group, and caregiver group treatments. Comprehensive case studies illustrate the implementation of game-based CBT and bring to life the application of the material discussed.

Springer and Misurell have given the time and thoughtfulness to highlight special considerations in dealing with supervision, cultural competence, knowledge and experience, and multidisciplinary considerations. This excellent book is rounded out with each section rich with research and didactic material around CSA and treatment. It is indeed a complete compendium for working with sexually abused elementary and school-age children.

Springer and Misurell have thought of everything in this comprehensively detailed book. This gem of a book ends with a special addendum: a great compendium of all the necessary accessories needed for each activity/game along with a list of resources. The clinician can feel confident and ready to immediately implement the structured therapeutic games within the game-based CBT treatment approach.

After reading through Game-Based Cognitive-Behavioral Therapy for Child Sexual Abuse, I found myself, a 30+-year seasoned CSA and trauma child/play therapist, enriched, validated, and supported on a deep level. My work is now much more expanded by the rich compendium of creative and easy-to-implement structured therapeutic game-based techniques offered for individual, child group, and caregiver group.
So reader, sit back. Enjoy. This will become a much used book in your professional library!

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REFERENCES


Preface

Game-based cognitive-behavioral therapy (GB-CBT) is an integrative treatment model that incorporates evidence-based cognitive-behavioral therapy (CBT) with structured play therapy. GB-CBT enhances existing empirically supported principles of effective treatment for childhood difficulties and disorders. It bolsters strengths through the use of fun and interactive techniques, which can increase client engagement and enjoyment. Additionally, GB-CBT contains a rich toolkit of concrete clinical strategies that make providing treatment more accessible, practical, and straightforward for both novice and experienced mental health clinicians. These techniques include structured therapeutic games, role-plays, and a delineated session structure complete with behavioral expectations and reward systems. Furthermore, GB-CBT provides a forum for enhancing the therapeutic relationship and increasing collaboration by enabling clinicians to use strategic self-disclosure and to participate directly in games and activities alongside clients.

Structured therapeutic games are directive and rule-governed therapeutic activities that are enjoyable and playful and provide multiple opportunities for learning and rehearsing skills. Additionally, the games maximize experiential learning through the universal language of play by reducing defenses, allowing for verbal as well as nonverbal communication, and fostering the development of relationships. Role plays are also used to facilitate the generalizability of learning to other settings by turning the therapy office into a practice field for real life. A delineated session structure involving reward systems intricately connected to the games serves to enhance client interest and motivation. Furthermore, through active participation and sharing, clinicians are able to communicate authenticity and openness, contributing to client trust and comfort.

Several empirical investigations have found that GB-CBT is effective in reducing behavioral problems and trauma-related symptoms and improving strengths among children who have experienced sexual abuse. Although GB-CBT has been developed with a child maltreatment population, the model is transdiagnostic, containing therapeutic strategies and games that can be used to address a host of problems frequently encountered by children and families. The foundation of the model focuses on building social and emotional skills, including emotional expression, anger management, relaxation, and coping strategies. These skills are important for all children regardless of their specific needs and can be used to enhance treatment outcomes for a variety of childhood problems and difficulties including attention deficit hyperactivity disorder (ADHD), social skills deficits, anxiety, and depression. However, additional work needs to be done in order to expand GB-CBT to comprehensively address a wider range of clinical populations.
This book provides the rationale, theoretical underpinnings, and instructions for providing GB-CBT for children and families impacted by child sexual abuse (CSA). More specifically, curriculum included in this volume focuses on working with elementary and middle school-age children and their nonoffending caregivers. Chapters 1 to 5 discuss the background and structural characteristics of the model and review practice-related issues. Chapters 6 to 8 outline various treatment modalities (i.e., individual and conjoint child–caregiver therapy, and child and nonoffending caregiver group therapy) and provide case studies to illustrate how GB-CBT can be practically utilized to address client needs. Chapters 9 to 17 are curriculum-based and contain detailed descriptions of all GB-CBT treatment components along with step-by-step instructions of all therapeutic games and activities. The final section of this book, entitled “Therapeutic Materials,” includes reproducible handouts and props (e.g., game cards and boards) needed to play the therapeutic games and conduct the activities described in the curriculum-based chapters. These materials can also be found online at www.springerpub.com/game-based-cbt-for-child-sexual-abuse-supplemental-materials. Professionals can utilize this book in two ways: (a) The book can be used as a treatment manual in order to comprehensively administer GB-CBT for CSA, and (b) games and activities can be selected piecemeal and used within the context of another therapeutic approach (e.g., psychodynamic, client-centered, CBT, etc.).
Acknowledgments

This book represents the product of over 8 years of collaboration between the authors and many cups of coffee. Although our gratitude to caffeine is indescribable, it pales in comparison to the appreciation we feel for the many individuals who made this book possible. We would like to acknowledge the following colleagues at the Metropolitan Regional Diagnostic and Treatment Center (RDTC) at Newark Beth Israel Medical Center (NBIMC) for providing the resources and guidance needed for the development and implementation of game-based cognitive-behavioral therapy (GB-CBT): Lina Acosta, Christine Baker, Doris Chodoroff, Peg Foster, Marsha McMillan, Caridad Moreno, Donna Pincavage, Shameika Pugsley, Aileen Torres, and Alison Strasser Winston. We would also like to thank the many graduate students for their dedication and contributions over the years. Specifically, we would like to mention a number of graduate students who contributed to articles on GB-CBT: Giselle Colorado, Atara Hiller, Amy Kranzler, Lindsay Liotta, and Desiree Romaguera.

Our appreciation and gratitude also goes out to Keri Logosso-Misurell and the late congressman Donald Payne for their assistance in obtaining a Federal Appropriations Grant, which contributed to the advancement of the GB-CBT approach. Additionally, we appreciate Jackie Lowe, Rose Zeltser, Marsha Fisher, Emory Cabrera, and Blair Finkelstein at Children’s Aid and Family Services (CAFS) as well as Barbara Bonner, Jane Silvosky, and Jimmy Widdifield at the University of Oklahoma Health Sciences Center for their assistance in obtaining and executing a federally funded grant through the Office of Juvenile Justice and Delinquency Prevention (OJJDP). We would also like to thank Mark Ali and Gina Iosim of the Essex County Prosecutor’s Office (ECPO), who provided valuable insights regarding the legal process involved in child sexual abuse cases. Furthermore, we express gratitude to David Sims, Tracy Mays, and Mary Branek of New Jersey’s Division of Child Protection and Permanency (DCP&P) for their collaboration and dedicated service to Essex County’s families.

Several colleagues and professionals in the field have supported and encouraged this project. We would specifically like to thank the following: Brett Biller, James Campbell, Yoav Cohen, Anthony D’Urso, Ronald Field, Rozaline Goldman, Liana Lowenstein, Fawn McNeil-Haber, Debra Nelson-Gardell, and Max Shmidheiser. A special thanks goes out to Sarah Springer for her professional insights regarding many of the therapeutic games and activities. We are tremendously grateful to Dean McKay for helping us navigate the publishing process and Athena Drewes for supporting our work and for contributing a
Foreword to this volume. Several professional organizations helped to highlight the utility of GB-CBT over the past few years. We would particularly like to acknowledge Kendra Hayes with the National Association of Social Workers–New Jersey Chapter and James Campbell with American Professional Society on the Abuse of Children (APSAC) and the University of Wisconsin-Madison. Thanks also to the many colleagues who volunteered to be photographed for the curriculum, including Dion Barnes, Kayla Belnavis, Carly Bosacker, Charisse Carrion, Martha Darius, Karena Ferrer, Romelia Freydel, Safiyyah Islam Horne, Hugo Jimenez, Amanda Addolorato Mcdonald, Marsha McMillan, Neha Mistry, Christina Ortiz, Elizabeth Paterno, Donna Pincavage, Kimberly Roberts, Diana Roopchand, Stacy Royal, Shamira Scott, Diane Sequeira, Diane Snyder, Janine Straccamore, Eric Sturm, Mario Suarez, Nick Tellez, Monica Weiner, Zoe Wydroug, and Karen Zambrano.

We would like to thank Sheri W. Sussman and the team at Springer Publishing Company for their hard work, dedication, accessibility, and personalized attention that led to the fruition of this book. Most importantly, we would like to acknowledge all of the children and families who have participated in the GB-CBT Program. Your courage and strength is an inspiration to our work.
This chapter will provide an overview of child sexual abuse (CSA) including its definition, prevalence rates, perpetrator characteristics, short- and long-term impact on functioning, and risk and protective factors.

CHILD SEXUAL ABUSE DEFINED

Although the legal definition of CSA varies from state to state, CSA is most often defined as the act of engaging a minor in sexual behavior in which they are unable to or unwilling to consent (Berliner, 2011). This broad definition covers a variety of behaviors including fondling; digital and penile penetration of the vagina, buttocks, and/or mouth; exploiting children’s bodies in films and photographs; and exposure of the child to adult sexual behavior and/or nudity. CSA involves a power differential (e.g., difference in knowledge, strength, age, maturity, resources, and/or gratification of the act) between the perpetrator and victim and can involve coercion, manipulation, or the use of force.

PREVALENCE OF CSA

It is difficult to determine the actual number of individuals who have experienced sexual abuse. Some of the difficulties in obtaining accurate information about prevalence rates include underreporting of sexual abuse incidents by survivors (i.e., only 38% of survivors disclose abuse; Broman-Fulks et al., 2007), failure to report incidents to authorities by caregivers and professionals after discovering abuse, different definitions of what constitutes sexual abuse, and a lack of uniformity in data collection methods across jurisdictions (Berliner, 2011). For example, in some states, record keeping does not distinguish between CSA and other forms of child maltreatment by Child Protective Service agencies (Goodyear-Brown, Fath, & Myers, 2012). Additionally, researchers investigating sexual abuse prevalence rates often rely on retrospective data gathered through interviews with adult survivors of CSA. This method is subject to error related to the time lapse since the abuse took place. Collecting data from different sources contributes to variation in estimates of prevalence.
Studies have estimated that 20% to 25% of females and 5% to 17% of males will have experienced some form of sexual abuse by the age of 18 (Cohen, Mannarino, & Deblinger, 2006; U.S. Department of Health and Human Services, 2012). Other studies have estimated the numbers to be lower, with 16.8% of females and 7.9% of males reportedly experiencing sexual abuse as a child (Putnam, 2003). In a national representative telephone survey, researchers determined there to be a lifetime CSA incident rate of approximately 9% (Finkelhor, Turner, Ormrod, & Hamby, 2009). Annually, the U.S. government compiles incident rates of child abuse and neglect from each state and reports the findings. In 2012, the most recent year in which such data was available, it was estimated that approximately 672,600 children were victims of child abuse or neglect (U.S. Department of Health and Human Services, 2013). Of these, approximately 9.3% (62,936) were victims of sexual abuse (U.S. Department of Health and Human Services, 2013), and 78.5% of child victims were 14 years of age and under (U.S. Department of Health and Human Services, 2013). Although exactly how many individuals are impacted by CSA in the United States is unknown, it is clear that this problem affects a substantial number of children and families and has a significant negative impact on society.

PERPETRATOR CHARACTERISTICS

CSA is most often perpetrated by someone familiar with the child survivor. In fact, upward to 71% of cases are perpetrated by someone who knew the child prior to the abuse, contrary to common societal warnings of “stranger danger” (Finkelhor, Hamme, & Sedlak, 2008; Finkelhor, Ormrod, & Turner, 2009). Studies of perpetrator identification reveal that of the cases of sexual abuse where the perpetrator was familiar with the survivor fathers or stepfathers are the offender in approximately 16% of cases, while the remaining percentage of cases are most often perpetrated by other acquaintances such as paramours, family friends, and community members who have contact with the child (Finkelhor, Ormrod, & Turner, 2009; Hanson et al., 2006). Although the majority of sexual offenses are committed by adult males, a significant proportion of sexual abuse cases are perpetrated by juveniles (35.6%), with approximately 17% of arrests for sexual offenses involving individuals under the age of 18 (Finkelhor, Ormrod, & Chaffin, 2009; Kirsch, Fanniff, & Becker, 2011). Though there are cases involving female perpetrators, these cases are relatively rare (5%; Finkelhor et al., 2008).

SHORT-TERM IMPACT

CSA may result in a myriad of behavioral and emotional difficulties which varies greatly among children. The diversity of reactions can include maladaptive beliefs and cognitive distortions, impairments in social and emotional functioning, and behavioral difficulties. Common symptoms associated with CSA include internalizing problems, externalizing behaviors, trauma-related symptoms, and sexually inappropriate behaviors.

Although internalizing problems are a frequently encountered category of symptoms following CSA, because they occur within the individual, they can be difficult to detect and their severity underestimated. Internalizing problems include anxiety, depression, negative self-concept, sleep and appetite disturbances, withdrawal, feelings of shame and guilt, and somatic problems such as headaches and stomachaches.
Children impacted by CSA also tend to have higher rates of externalizing behaviors when compared to peers who have not been abused. Externalizing problems involve the expression of distress directed toward others. These difficulties include disruptive behavior, inattention, impulsivity, aggression, anger, hyperactivity, oppositionality, and school difficulties (Berliner, 2011). These behaviors are observable and often distressing for both the individual and others. As a result they may lead to disciplinary responses by authority figures (e.g., caregivers, educators, and law enforcement). Furthermore, externalizing behaviors can also have a negative impact on children’s interpersonal relationships.

Trauma-related symptoms are commonly observed among children who have experienced CSA. These difficulties include intrusion (e.g., recurrent, involuntary, intrusive thoughts and/or reactions; flashbacks; and nightmares), avoidance (e.g., alterations in thoughts and mood in relation to the traumatic event), arousal and reactivity (e.g., worry, hypervigilance, agitation), and sexual concerns (e.g., sexual preoccupations and distress). Research has indicated that upward of a third of children who are sexually abused meet the full diagnostic criteria for posttraumatic stress disorder (PTSD) and many more experience at least some of the symptoms of PTSD (Putnam, 2003; Ruggiero, McLeer, & Dixon, 2000).

Children who experience sexual abuse are more likely to develop inappropriate sexual behaviors than their peers (Goodyear-Brown et al., 2012). These behaviors vary widely and may include excessive or public masturbation, voyeuristic behaviors (e.g., watching other people getting undressed), undressing in front of others, touching others in a sexual manner, and imitating adult sexual behavior. Research has shown that approximately one third of children who have experienced CSA will develop such behaviors (Friedrich, 1993). A possible reason for the development of such behaviors is that they may be learned from the boundary violations committed by the person who abused them. This may subsequently lead to difficulty discerning between appropriate and inappropriate behaviors. It is also possible that they may view sexualized behavior as a means of showing or receiving affection and/or a means of securing attention. Furthermore, children may have discovered that engaging in sexual behaviors can be physically stimulating and as such, self-reinforcing.

LONG-TERM IMPACT

Research has found that CSA is linked to a host of difficulties in adolescence and adulthood including smoking, substance abuse, self-injury, suicidality, school problems, frequent sexual activity at an earlier age, more sexual partners, higher risk of contracting sexually transmitted infections, higher rates of teen pregnancy, and unstable relationships (Chartier, Walker, & Naimark, 2007; Hussey, Chang, & Kotch, 2006).
Children who have experienced sexual abuse are also at greater risk of being revictimized (Lalor & McElvaney, 2010). Additionally, CSA has been linked to long-term mental health problems in adulthood including substance abuse, eating disorders, anxiety, and depression (Brier & Elliott, 2003).

CSA has also been found to negatively impact physical health in adulthood (Kendall-Tackett, 2012). The Adverse Childhood Events (ACEs) study resulted in groundbreaking research that found a link between childhood traumatic events and adult health problems. Adverse events are organized into three separate categories including abuse, neglect, and household dysfunction. The ACEs study found that individuals with ACEs were more likely to have a variety of medical problems in adulthood including hypertension and heart disease, asthma, and chronic obstructive pulmonary disease (Felitti et al., 2001). Additional problems include chronic pain, gastrointestinal difficulties, increased health care use, sleep disturbances, and elevated stress hormones (Kendall-Tackett, 2012).

**RISK FACTORS**

There are a number of risk factors that may increase the likelihood of developing behavioral and emotional difficulties following CSA. Preabuse risk factors include a history of trauma; premorbid difficulties in functioning including the presence of psychological distress prior to the abuse; physical, emotional, and/or psychological disabilities; caregivers with histories of substance abuse and/or domestic violence; and family conflict and dysfunction (Berliner, 2011; U.S. Department of Health and Human Services, 2013). In general, the more invasive the abuse, such as in cases in which the victim was penetrated or when violence was used by the perpetrator, the greater the level of symptomatology (Ruggerio et al., 2000). Postabuse risk factors include level of familial support and the type of response that children receive when they disclose. Research has found that when children receive a negative response, such as when protective and supportive actions are not taken, there is a greater likelihood that they will develop behavioral and emotional difficulties (Bernard-Bonnin, Herbert, Daignault, & Allard-Dansereau, 2008).

**PROTECTIVE FACTORS**

Although the negative effects of CSA are plentiful, it should be noted that not all survivors of CSA develop symptoms, and over time many difficulties show a pattern of spontaneous improvement (Berliner, 2011). Studies have consistently found that upward to a third of children who experience sexual abuse do not present with symptoms (Kendall-Tackett et al., 1993). These asymptomatic children may be resilient and never develop behavioral and emotional difficulties regardless of whether or not they receive treatment (Saunders, 2012). Several protective factors have been found that mitigate the formation and persistence of symptoms following CSA. These protective factors include familial support, a willingness to participate in treatment, and the innate ability to persevere in the face of adversity, which has been referred to as resiliency (Goodyear-Brown et al., 2012). Research has found that supportive postabuse responses and family involvement in treatment contributes to improved outcomes (Cohen et al., 2006; Dowell & Ogles, 2010).