Best Practices in Sexual Abuse Evaluations

Angela Kaplan, BA, Eric Kothari, D.Min., Psy.D.

Best practices in sexual abuse evaluations include three factors: (a) A clear and concise understanding of factors involved in the on-set of sexual abuse, including concerns about discrepancies in disclosure of abuse and family factors associated with abuse; (b) Second, a clear understanding of the evaluation process, and how evaluations are conducted; and (c) finally, recommendations for treatment following evaluations. These three factors constitute the required knowledge to engage in the best practice in conducting sexual abuse evaluations.

When an individual in the psychological community becomes aware of the presence of child sexual abuse, there are many issues that need to be addressed. Among these issues is not only recognizing what symptoms are presented by the child, but also to look at children who may be vulnerable to future abuse at the hands of both family members and strangers. The way that others react to the child's disclosure of abuse is also a valuable piece of information that the therapist should note when they are first evaluating the case presented to them, due to the fact that the reactions of others may either help to end the abuse, or to only make the situation worse. It is also important to look at any psychological distress that the abused individual may present, as well as possible syndromes, such as the child sexual abuse accommodation syndrome. It is also important to decide which treatment methods need to be implemented, as well as what therapeutic interventions would be best to treat individuals who have experienced the trauma of sexual abuse.

In order to understand child sexual abuse, it is important to define what child sexual abuse is, as well as what constitutes abuse between an adult and a child. According to Finkelhor (1994), the term child sexual abuse covers a wide range of acts.

In general, legal and research definitions of child sexual abuse require two elements: (1) sexual activities involving a child and (2) an "abusive condition" such as coercion or a large age gap between the participants, indicating lack of consensuality. According to Kempe (1978), sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles. The term child sexual abuse includes a variety of sexual activities, including intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography (Putnam, 2003).

It is also important to recognize that sexual activities involving a child refer to certain activities that many lead to sexual stimulation, whether these include contact sexual abuse or noncontact sexual abuse. According to Finkelhor (1994), contact sexual abuse is the touching of the sexual portions of the child's body (genitals or anus) or touching the breasts of pubescent females, or the child's touching the sexual portions of a partner's body. Contact sexual abuse is of two types: (1) Penetration, which includes penile, digital, and object penetration of the vagina, mouth, or anus, and (2) Nonpenetration, which includes fondling of sexual portions of the child's body, sexual kissing, or the child's touching sexual parts of a partner's body. Noncontact sexual abuse usually includes exhibitionism, voyeurism, and the involvement of the child in the making of pornography (Finkelhor, 1994). Sometimes verbal sexual propositions or harassment (such as making lewd comments about the child's body) are included as well. Abusive conditions further exist when the child's partner has a large age or maturational

advantage of the child, the child's partner is in a position of authority or in a caretaking relationship with the child, or the activities are carried out against the child using force or trickery (Putnam, 2003).

According to the National Incidence Study of Child Abuse and Neglect, which is a federally funded research project, there were approximately 149,800 cases of sexual abuse known to professionals in 1992, which was the peak amount of cases that have been seen in recent years (Sedak, 1991). However, since this rate was reported, there has been a drop in substantiated or indicated cases of abuse, with approximately 88,000 cases existing in 2000, which represents a drop of 41% from the peak estimates of 1994 (U.S. Department of Health and Human Services, 2002). It has been reported that between 12% to 35% of women (average 16.8%) and 4% to 9% of men (average 7.9%) reported an unwanted sexual experience prior to the age of eighteen (Gorey and Leslie, 1997). It is important to note that girls are at about 2.5 to 3 times higher risk than boys, however boys are often underrepresented in psychiatric samples, due to a variety of variables related to shame over possible homosexual assumptions, or feelings that no abuse took place, especially if the perpetrator is a women (Fergusson et al., 1996). Age is also an associated factor to sexual abuse, with 10% of victims between the ages 0 and 3 years, 28.4% of victims between the ages 4 and 7 years, 25.5% of victims between the ages 8 and 11 years, and 35.9% of victims over the age of 12 (U.S. Department of Health and Human Services, 1998).

Research has revealed that children who have one or more parents who are distant or absent leads to a significantly higher risk factor for child sexual abuse. It has also been suggested in a study by Mullen et al (1993) that the presence of a stepfather doubles the

risk for girls to be abused either by the stepfather or by other men. The environmental factors of parental inadequacy, unavailability, conflict and a poor parent-child relationship are high risk factors for all types of future abuse (Finkelhor, 1994). It has also been noted that children with alcoholic, drug abusing, or emotionally unstable parents are also at risk, as are children with highly punitive parents. Finkelhor (1994) noted that these factors increase the child's risk for abuse in two ways. First, it was noted that they decrease the quantity and quality of supervision and protection that children receive. Second, the children from these environments become needy and deprived of proper emotions. These children then become very vulnerable to predators who offer affection and some form of friendship. In a study noted in an article by Paine and Hansen (2002), seventy-two male inmates who were in jail for child sexual abuse were asked how they selected their child victims. Most of these subjects stated that they preferred abusing their own children, or choosing children who were "passive, quiet, troubled, lonely children from single parent or broken homes." They also stated that they targeted children who were quiet and withdrawn and appeared vulnerable because they were very young or rather open, friendly and trusting. It has not been found that race or socioeconomic status lead to higher risk of sexual abuse.

Most sexual abuse is committed by men, with 90% of the abusers being male, while females make up the remaining 10% of abuse cases (Allen, 1991). In studies of past child sexual abuse, it was reported that perpetrators who are in the same family as the victim make up between one-third and one-half of all perpetrators against girls and about one-eight to one-tenth of all perpetrators against boys. It should be noted that

acquaintance perpetrators, such as neighbors, teachers, coaches, religious leaders, and peers make up a large proportion of abusers as well (Kendall et al., 1993).

When a psychologist suspects that sexual abuse may be occurring, there are various symptoms that may be presented by the child victim. Those in an evaluation capacity must recognize that children who have suffered sexual abuse may show no physical signs, and that abuse may go undetected unless a physician spots evidence of forced sexual activity. However, there are behavioral clues to sexual abuse, including inappropriate interest in or knowledge of sexual acts, seductive behavior, reluctance or refusal to undress in front of others, extra aggression or, at the other end of the spectrum, extra compliance and fear of a particular person or family member. Of the behavioral problems that have been noted by researchers, sexualized behaviors have been most closely linked to child sexual abuse (Putnam, 2003). These overly sexualized behaviors are exhibited most often in younger children, in children abused at younger ages, and when examination is closely dated to when the abuse occurred. It has also been noted in a study by Widom and Ames (1994) that a history of child sexual abuse, but not a history of physical abuse or neglect, is associated with a significantly increased rate for sex crimes and prostitution arrests for both males and females.

Research by Finkelhor & Browne (1985), indicated that the experience of sexual abuse can be divided into four trauma-causing factors: traumatic sexualization, betrayal, powerlessness, and stigmatization. These four factors affect the cognitions and emotions of those who have been victimized, and can lead to long-term effects for these individuals. This can also lead to children having low feelings of worth and the belief that they are powerless. Traumatic sexualization refers to the inappropriate shaping of a

child's sexuality and the dysfunction of interpersonal skills in these children. This can occur through the exchange of affection, attention, privileges and gifts in return for sexual behavior. Due to these exchanges, the child learns to use their sexuality as a way of manipulating others to behave and feel the way that the child would like (Finkelhor & Browne, 1985). Betrayal refers to the child's feelings when they discover that they were victimized by someone they formerly trusted. They may feel that their morality has been manipulated and corrupted. These feelings of betrayal may not simply be toward the people who abused them, but individuals who they feel allowed this to happen as well. Powerlessness occurs when the will and desires of the child are continually ignored. Due to the fact that the child's body and space are repeatedly ignored and invaded by the perpetrator, the child will begin to feel that they have no power (Finkelhor & Browne, 1985). This may be further exacerbated by the way that the abuser keeps the confidence of the young child, including threats to the child and their family. Finally, stigmatization refers to the negative associations that are communicated to the child due to their experiences of abuse. These experiences then come to represent the child's image of themselves and will lead to negative feelings about themselves. This may come about because the abuser may blame the victim for the sexual activity, demean the victim, and lead the victim to feel shame about the abuse and think that it was not abuse, but rather was consensual. This may be brought about further due to biases from other individuals that they disclose their abuse to. If people either don't believe them, or make the abuse seem as if the child is partially responsible, a great deal of stigmatization and shame may occur within the child (Finkelhor & Browne, 1985).

Often, many individuals regard abuse of any nature, whether physical or sexual, as a family matter, which does not need to be dealt with outside of the family. However, this is very not a healthy way of looking at abuse, especially if the abuser is another family member. As noted by Kempe (1978), in cases in which the child has been abused by a stranger, parents often involve the police, where an incidence report is created, the pediatrician is notified to examine the child if sexual contact has occurred, and therapists become involved in order to provide long-term supportive therapy. However, upon the discovery of incest, the family and community often react in a very different way, often with very little support from the family, and often, no prosecution of the perpetrator(s).

When children choose to disclose that they have been abused, these disclosures should be taken very seriously, especially if the abuser was a family member. According to Paine and Hansen (2002), a child's self-disclosure of sexual abuse is a critical component in initiating intervention to halt the abuse, address its immediate effects, and decrease the likelihood of a negative long-term outcome. As research indicates, most child victims delay disclosing the abuse for long periods of time, and by not telling, this may prolong the experience of abuse and allow the abuser to continue harming the victim. According to the National Children's Advocacy Center (Carnes, 2000), "forensic evaluation is a process of extended assessment of a child when the child is too frightened or young to be able to fully disclose their experiences on an initial forensic interview…for many children, abuse disclosure is a process, not an event…reluctance is commonplace and difficult to overcome in suspected child sexual abuse cases." Some professionals have even suggested that children who disclose easily and do not recant their initial disclosure, should be suspect and should not be easily believed (London et al.

2005). Many individuals who eventually choose to disclose their abuse suffer from a syndrome titled the child sexual abuse accommodation syndrome.

The child sexual abuse accommodation syndrome was originally proposed by Summit (1983), and stated that many children who are victims of abuse exhibit the five categories of this syndrome. The five categories proposed are (1) secrecy, (2) helplessness, (3) entrapment and accommodation, (4) delayed, conflicted and unconvincing disclosure and (5) retraction. In cases of abuse, it was noted that the only consistent impression gained by the child is one of danger and fear based on secrecy. This secrecy will make it clear to the child that the abuse they are experiencing is bad and dangerous and brings about a feeling of fear and danger to the child. A child may also feel helpless due to the fact that they are overpowered by their abuser, or may not be believed by the individuals that they may choose to disclose the abuse. These victims may also experience entrapment and accommodation, in which the child may learn to accommodate to the sexual abuse. As noted in London et al. (2005), children who have been sexually abused may fear the abuser and the possible negative consequences that they fear may come about by disclosing the abuse, so they make accommodating efforts to accept the abuse and keep it secret in order to survive the sexual abuse. Delayed, unconvincing disclosure may also be experienced by victims of abuse, in which they may never disclose the abuse, or may delay the disclosure, which may cast doubt on their credibility. Finally, retraction of the disclosure often happens. In many cases, children experience disbelief and lack of support, which may lead them to retract their disclosure in order to undo the imagined damage and bring about "normalcy" in their environment (Summit, 1983).

It has also been noted that in many cases in which the child may disclose the abuse, failure to report the abuse is rather high. A study by Berliner & Conte (1995) found that nearly one child in ten who disclosed their abuse reported that their disclosure was not believed. In many cases, there was an overwhelming lack of intervention in the abuse, which was credited to disbelief. In a study noted in Pain and Hansen (2002), nearly 52% of adult incest survivors stated that their abuse continued for a year or more following their initial disclosure. While all fifty states require that all professionals report cases of known or suspected abuse to proper authorities, it has been reported that a significant number of professionals who are required to report abuse fail to do so (Paine and Hansen, 2002).

When individuals do choose to disclose the abuse, the importance of treatment of this individual, as well as proper interventions, is vital to their psychological health. As noted in Edgardh and Ormstad (2000), it is very important for individuals who are screening for sexual abuse conduct interviews that frame questions in very specific language regarding different sexually abusive acts, rather than general single screening questions, which may lead to a higher chance of retraction of their original disclosure. Thus the use of standardized interviewing protocols often provide the most accurate data collection. Equally, there is strong evidence suggesting that use of audio or video recording of the interview protects the collected data if, in fact, there are challenges to the findings in any subsequent legal proceedings. Permission for such recording is provided by the legal caregiver in advance of the interview.

Best practices in the evaluations of child abuse include a number of important variables. These include:

1. Malingering and symptoms exaggeration are important factors to rule out as one evaluates data and interviews individuals in which there is suspicion of abuse. It is important to note that individuals who are sexually abused as children may attribute symptoms to sexual abuse that do not originate at a particular source. Such false attribution may be the result of malingering or symptom exaggeration.
2. Family and community comparisons include evaluating the sexual tendencies of so-called non-abused siblings (if any), especially in contexts in which the child is raised. Whereas such comparisons tend to be imperfect, they provide collateral data for the evaluator.
3. Pre and post comparisons of abuse suggest that an evaluator attempt to determine the condition of a plaintiff prior to an incident and compare it to the condition afterward.
4. Collateral interviewing of peers, caregivers, teachers, and other authority figures implicated in the person's life provide important insights about behavioral changes that may have resulted from exposure to abuse. In many cases it has been noted that caregivers of the child have noticed significant changes in behavior, even if they were unaware of abuse at the time (Putnam, 2003).
5. Comprehensive review of mental health records of the plaintiff are important data in that they may provide an effective anchor for determining the extent of damage caused by the abuse.

6. Finally, evaluation for the role of Post Traumatic Stress Disorder (PTSD) may be important for the proper evaluation of abuse because there has been a documented co-morbidity of diagnosis of PTSD in individual who have documented sexual abuse (Putnam, 2003).

In cases in which sexual abuse is confirmed the best practice is referral to the local Child Protective Services (CPS). CPS is legally obligated to investigate referrals and act in the best interest of the child. In cases in which the referral for the sexual abuse interview has come from CPS, and sexual aggression, impulsivity and depression are exhibited, targeted intervention is required due to the fact that these behaviors are self-perpetuating (Nurcombe et al., 2000). The best practice is to refer these children to clinicians who have a documented expertise in the treatment of child sexual abuse. Treatment expertise has to do with ways in which these clinicians deploy known treatment methodologies that target the history of abuse, the symptoms of the abuse, and frame the treatment within the larger goal of recovery.

Treatment of asymptomatic children and symptomatic children is an important theme in the clinical literature. In a study by Putnam (2003), it was noted that not all sexually abused children have serious psychiatric symptoms, and that during evaluations, nearly 40% of sexually abused children presented no symptoms. This may be due to more resiliency or a masking coping style. These asymptomatic children should be evaluated for additional risks such as family substance abuse, mental illness, domestic violence, or other family dysfunction. It was recommended that psychoeducational intervention designed to prevent further victimization, to clarify and normalize feelings and to educate parents is recommended (Putnam, 2003). The treatment of symptomatic

children is quite different. These children are generally moderately to seriously symptomatic at some point during the abuse process. It has been noted that cognitive-behavioral therapy (CBT) has been found to be effective for some symptoms in sexually abused children. In a study by Deblinger et al. (1996), it was found that groups who received CBT showed significant improvement due to the fact that therapists worked directly with the child, and relieved the most PTSD symptoms and internalizing, externalizing and behaviors that were sexually inappropriate.

In an article from Cohen et al. (2000), various approaches of cognitive behavioral therapy were described for treating children who had experienced the trauma of sexual abuse. The first technique described was exposure/direct discussion of the traumatic event. It was noted that through the process of repeated exposure, remembering the trauma and reminders of the trauma were not as emotional over time, and would lead to less negative emotions. During the technique of imaginal flooding, researchers suggest that specific anxiety-provoking scenes are identified and imagined through clinical interviews. During this process, the child is then asked to rate the degree of distress that they are experiencing (Cohen et al., 2000). In the technique of gradual exposure, the children are encouraged to first describe a less upsetting episode of trauma, and gradually begin to describe more upsetting episodes of trauma as time goes by, which will lead to less anxiety. These children are asked to talk about the event and to note how stressful it was, and the therapist is asked to note the child's ability to tolerate the increased levels of exposure.

Cognitive Processing Therapy was also noted as being very effective. Cognitive Processing Therapy focuses specific attention on self-blame, survivor guilt and changing

the view of the trauma related to the sexual abuse. Another problem with children's cognition was confusion about who was responsible for the abuse that occurred. In order to correct the errors in cognition, the therapists work in three steps. The first step requires the identification of the child's current thoughts. The second step involves both the therapist and child evaluating the reasoning of the child for their distorted thinking regarding the abuse. The final step requires one to change the incorrect cognitions to accurate cognitions. Another type of cognitive behavioral therapy is cognitive coping. In this form of therapy, children learn to challenge their negative thoughts and replace them with more positive alternative thoughts. In these cases, rather than being fearful of other individuals, they will learn that they need to replace these negative thoughts that they hold about other individuals with positive thoughts, in order to not be fearful (Cohen et al., 2000).

It is also important to look at relaxation techniques and stress management for children who experience the trauma of sexual abuse. Often these children will suffer from depression, high anxiety and post traumatic stress disorder (PTSD). During Relaxation and Breathing Technique Therapy, children learn to relax their muscles and control their breathing, which leads to a relaxed state of being. This technique is also important because children can perform this in both therapy sessions, and on their own, when feeling stressed and upset. During Stress Management Therapy, children learn relaxation interventions to reduce anxiety in stressful situations. While Stress Management has been found to be helpful, cognitive therapy provides more benefits for decreasing PTSD in these children.

Other forms of therapy have also been found to be quite effective for children who are suffering from PTSD due to their abuse. According to Foa et al. (2000), play therapy is an important therapeutic technique because it uses play as a projective technique. Play therapy uses both play and other nonverbal techniques, such as drawings, puppets, dolls, etc. to enhance the comfort of the child. During play therapy the child may be asked to engage in play by themselves, or to engage in play using dolls, etc. with the therapist in order to tell a story, possibly regarding experiences they encountered during their abuse. As noted by Landreth (2001), as play therapy sessions progress, many of the children's feelings and attitudes are expressed in a symbolic manner, either through toy to toy, toy to invisible person, child to imaginary person, child to real person, and child to the object of their feelings. It was noted that at the conclusion of play therapy, children learn to take responsibility for their own feelings and express themselves in open and honest ways. The child's uniqueness is now allowed to come about, which helps in beginning the process of knowledge about themselves.

It is important to look at intervention methods as well as treatment methods. By looking at intervention methods, individuals who may be suffering from abuse may be helped further due to greater understanding and support from others. In the book, Violence in America (1991), it was noted that there is an increase in public and professional education to teach people how to detect and disclose instances of sexual abuse in general. Due to this new awareness, there has been an increase in the number of cases that have been reported, especially since sexual abuse was brought into public discussion during the 1970's. It is also important to look at the intervention technique of preventive education. These programs are designed to teach children how to better

defend themselves against predators and to encourage children to disclose any cases of attempted sexual abuse. It was stated that these programs have three main goals; (1) to explain what sexual abuse is, (2) to inform children that they have the right and obligation to refuse sexual activity, and (3) encourage them to tell someone about abuse or attempted abuse (Rosenberg, 1991). Treatment programs for victims and their families are also a vital tool in child sexual abuse cases. These programs mix individual, family and group therapy and are provided to offer support to individuals and families who have suffered from abuse. Finally, it is important to look at the intervention technique of treatment programs for offenders. These programs may help, however it should be noted that criminal sanctions should still be kept in place to assure the offender's participation and to keep them away from children. These programs mainly focus on individual and group psychotherapy, behavior modification, social skills training, and some drug treatment methods that may help. This is rather controversial, due to some cases in which certain offenders seem to not be amenable to treatment, and are still a threat to children (Rosenberg, 1991).

By looking at the research on child sexual abuse, it is apparent that this problem is widespread and covers children from all areas of society. The psychological damage is also problematic and can lead to depression, anxiety and PTSD in children who suffer from abuse. It is important to note what symptoms may be presented in children who suffer from abuse, and to be open to their disclosure of abuse. Too often, children's pleas for help are ignored, which allows the abuse to continue unhindered for possibly years to come. When a child does chose to disclose abuse, it is vital to begin the process of treatment in order to help the child realize that they are not at fault, that they will get

better and that they are good people. While CBT has been found to be a very effective form of therapeutic treatment, it is also important for children to have a supportive environment as well. Without support from those around them, children may not be able to get better and may note be able learn to cope with the trauma that they have experienced. By having treatment options, as well as a positive support system around them, there is reason believe that children may learn to live lives that are framed in the larger context of being a survivor rather than a victim.

References

Allen, C. Women and Men Who Sexually Abuse Children: A Comparative Study, Safer Society Press, 1991.

Berliner L. & Conte J.R. (1995) The Effects of Disclosure and Intervention on Sexually Abused Children. *Child Abuse and Neglect*. 19, 371-384.

Carnes, C.N. (2000) *Forensic Evaluation of Children When Sexual Abuse is Suspected (2nd Edition)*. National Children's Advocacy Center.

Cohen, Judith A., Mannarino, Anthony P., Berliner, Lucy & Deblinger, Esther (2000) Trauma-Focused Cognitive Behavioral Therapy for Children and Adolescents: An Empirical Update. *Journal of Interpersonal Violence*. 15, 1202-1223.

Deblinger E., Lippman J., Steer R. (1996) Sexually Abused Children Suffering Post-Traumatic Stress Symptoms: Initial Treatment Outcome Findings. *Child Maltreatment*. 1, 310-321.

Edgardh, K. & Ormstad, K. (2000) Prevalence and Characteristics of Sexual Abuse in a National Sample of Swedish Seventeen-Year-Old Boys and Girls. *Acta Paediatrics*. 88, 310-319.

Fergusson D., Lynskey M., Harwood L. (1996) Childhood Sexual Abuse and Psychiatric Disorder in young Adulthood: Prevalence of Sexual Abuse and Factors Associated with Sexual Abuse. *Journal of American Academic Child and Adolescent Psychiatry*. 35, 1355-1364.

Finkelhor, David. (1994) Current Information on the Scope and Nature of Child Sexual Abuse. *Sexual Abuse of Children*. 4, 31-53.

Finkelhor, David & Browne, Angela. (1985) The Traumatic Impact of Child Sexual

Abuse: A Conceptualization. *American Journal of Orthopsychiatry*. 55.

Foa, Edna B., Keane, Terence M., & Friedman, Matthew, J., Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies. Guilford Press, 2000.

Goren K., Leslie D. (1997) The Prevalence of Child Sexual Abuse: Integrative Review Adjustment for Potential Response and Measurement Bias. *Child Abuse and Neglect.* 21, 391-398.

Kempe, C. Henry (1979) Sexual Abuse, Another Hidden Pediatric Problem: The 1977 C. Anderson Aldrich Lecture. *Pediatrics*. 62, 382-389.

Kendall-Tackett, K.A., Williams L.M., & Finkelhor, D. (1993) Impact of Sexual Abuse on Children: A Review and Synthesis of Recent Empirical Studies. *Psychological Bulletin*. 113, 164-180.

Landreth, Garry L. Innovations in Play Therapy: Issues, Process & Special Populations. Routledge Mental Health, 2001.

London, Kamala, Bruck, Maggie, Ceci, Stephen J., & Shuman, Daniel 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, 194-226

Mullen P., Martin J., Anderson J., Romans S., Herbison G. (1993) Childhood Sexual Abuse and Mental Health in Adult Life. *British Journal of Psychiatry*. 163, 721-732.

Paine, Mary L. & Hansen, David J. (2002) Factors Influencing Children to Self-Disclose Sexual Abuse. *Clinical Psychology Review*. 22, 271-295.

Putnam, Frank W. (2003) Ten-Year Research Update Review: Child Sexual Abuse.

Journal of American Academic Child Adolescent Psychiatry. 42, 269-278.

Rosenberg, Mark L. & Fenley, Mary Ann. Violence in America: A Public Health Approach. Oxford, 1991.

Sedak, A (1991) *National Incidence and Prevalence of Child Abuse and Neglect: 1998.* Revised Report.

Summit, Roland C. (1983) The Child Sexual Abuse Accommodation Syndrome. *Child Abuse & Neglect*. 7, 177-193.

U.S. Department of Health and Human Services (1998) *Child Maltreatment 1996: Reports from the States to the National Child Abuse and Neglect Data System.* Washington, DC.

U.S. Department of Health and Human Services, Press Release, April 19, 2002.

Widom C. & Ames M. (1994) Criminal Consequences of Childhood Sexual Victimization. *Childhood Abuse and Neglect*. 18, 303-318.